Contents

DEACONESS HENDERSON HOSPITAL

CREDENTIALING MANUAL

ARTICLE I. APPOINTMENT PROCEDURES FOR PHYSICIANS AND DENTISTS

A. APPLICATION. Application for staff appointment is to be submitted in writing on such form as designed by the Credentials Committee and approved by the Board of Directors of Methodist Health, Inc. d/b/a Deaconess Henderson Hospital ("the Governing Board"). Applicants shall be provided with a copy of the Medical Staff Bylaws, Fair Hearing Plan, Rules and Regulations, and Credentialing and Organization Manuals (the "Governing Documents").

(1) REQUESTS FOR PRIVILEGES

a. Each practitioner's initial application and reapplication for privileges shall include a specific request for the privileges that he or she wishes to exercise.

b. Practitioners may apply for additional privileges at any time by making a special application for additional privileges. This special application shall be handled as an initial application for privileges.

B. PRE-APPLICATION PROCEDURE

(1) PRE-APPLICATION. An optional pre-application process exists to screen and provide information to potential applicants. It may be instituted at the request of the potential applicant, or the Hospital Chief Administrative Officer or his/her designee. Its purpose is to provide a preliminary, non-binding opinion as to whether or not the potential applicant meets the minimum requirements for medical staff membership. At the request of a potential applicant or on initial receipt of an application, the Chief Administrative Officer or his/her designee may contact the interested party and discuss with him or her the minimum requirements. If the interested party wishes to withdraw an inquiry or application at that time, it shall be done without constituting an adverse action. If the interested party wishes to proceed, the process shall continue as provided.

(2) APPLICATION

a. An applicant will be given an application if requested, regardless of any recommendation based upon the pre-application process.

b. All pre-application forms for which application is not recommended will be reviewed for appropriateness at the next scheduled meeting of the Credentials Committee.

c. Failure to qualify for appointment because of failure to meet the minimum requirements does not require a report to the National Practitioner Data Bank.

C. PROCESSING THE APPLICATION

(1) PURPOSE. To define the steps for appropriately processing each application for medical staff appointment or request for privileges.

(2) OBJECTIVES

a. To assist in fulfilling the responsibility of the Hospital that patients afforded care at the facilities will have care rendered by individuals appropriately qualified to do so.

b. To afford each eligible applicant an equal opportunity to be appointed to the medical staff. No individual shall be denied appointment on the basis of gender, race, creed, color, or national origin.

c. To gather adequate current clinical and other information pertaining to education, training and relevant experience, health and professional conduct to be reviewed by the appropriate individuals and committees prior to rendering a final recommendation to the Governing Board.

(3) PROCEDURE

a. An applicant will be sent the following materials:

(1) an application form or instructions on accessing the online application and CAQH forms,

(2) a copy of the medical staff Governing Documents,

(3) a delineation of privileges form(s) appropriate to his or her specialty and training.

b. The Medical Staff Office must then receive the following items for an application to be considered complete:

(1) a completed and signed application and CAQH form and request for privileges,

(2) a copy of current Kentucky license and controlled substance registration for Kentucky,

(3) a copy of current professional liability insurance with limits of at least $1,000,000 per occurrence and $3,000,000 annual aggregate,

and agreement to promptly notify the Hospital in writing of any change in or termination of such insurance coverage;

(4) two letters of recommendation sent directly to the Chief Administrative Officer or his/her designee from practitioners with the same licensure who have recently worked with the applicant and directly observed medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, professionalism and any limitations on the ability to provide care to patients caused by the applicant's health,

(5) the names and complete addresses of the chiefs or chairpersons of each service or department of any and all hospitals or other institutions at which the applicant has worked or trained, and

(6) a copy of the DEA certificate appropriate for the professional address that the applicant will maintain in the Deaconess Henderson Hospital area.

(7) A valid picture ID issued by a state or federal agency (driver's license or passport)

c. Verification tasks on an application can begin only after numbers (b) 1and 4 are submitted. All materials must be submitted prior to presentation to any medical staff committees or officials.

D. EFFECT OF APPLICATION. The applicant must sign the application, and in doing so:

(1) signifies his or her willingness to appear for interviews in regard to his or her application;

(2) authorizes Hospital and medical staff representatives and personnel or peer review committees to consult with others who have been associated with him or her and/or who have information bearing on his or her competence and qualifications;

(3) consents to inspection by personnel of peer review committees of all records and documents that would otherwise be confidential or privileged that may be material to an evaluation of his or her professional qualifications and competence to carry out the clinical privileges he or she requests, of his/her status, and of his or her professional conduct and ethical qualifications;

(4) releases from any liability all individuals and organizations who provide information to Hospital representatives, including personnel of peer review committees, for their acts performed in good faith in connection with evaluation of him or her or his or her credentials;

(5) releases from any liability all individuals and organizations who provide information to Hospital representatives, including personnel of peer review committees, in good faith, including otherwise privileged or confidential information, records, and documents that may be material to an evaluation of his or her professional qualifications and competence to carry out the clinical privileges he or she requests, of his or her physical, mental or emotional health status, and of his or her professional conduct and ethical qualifications for staff appointment and clinical privileges;

(6) authorizes and consents to Hospital representatives, including personnel of peer review committees, providing other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information concerning him or her, and releases Hospital representatives, including personnel of peer review committees, from liability for doing so, provided that such furnishing of information is done in good faith and without malice; and

(7) signifies that he or she has read the current medical staff Governing Documents and agrees to abide by their provisions in regard to his or her application for appointment to the medical staff.

E. PROCESSING TASKS

(1) Letters of verification will be sent from the Medical Staff Office to parties able to verify the statements contained in the application regarding the applicant's education, work history, military service, residency and fellowship training, letters of recommendation, state licensure, hospital staff membership, and previous practice experience.

(2) A confidential and secure folder or electronic file containing all application materials will be maintained by the Medical Staff Office. The contents of this folder or file will not be available for the applicant's inspection except as outlined in the Fair Hearing Plan of the Medical Staff Bylaws.

(3) The applicant shall be notified of any problems in obtaining and verifying the information required, and it shall be the applicant's obligation to obtain the required information. If the application is deemed to be incomplete in any way, or if information needed for its processing is not forthcoming or is unverified the applicant shall be notified in writing, but no further action will be taken until the application is completed or information received. Any application that remains incomplete sixty (60) days after notification to the applicant shall be deemed withdrawn prior to initiation of investigation of the applicant's credentials. Withdrawal of incomplete applications as specified above shall not be considered adverse action, shall not give right to a hearing or appeal, and shall not be reported to the Kentucky Board of Medical Licensure or National Practitioner Data Bank.

When collection and verification is accomplished, all such information shall be presented to the Credentials Committee for appropriate action.

(4) Verification and collection of additional information

The Medical Staff Office shall seek to verify and collect additional information as follows:

a. information from present and past insurance carriers concerning claims, suits, and settlements (if any);

b. completed administrative and clinical reference questionnaires from all significant past practice settings which shall include questions directed to the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, professionalism and any limitations on the ability to provide care to patients caused by the applicant's health;

c. a report documenting the applicant's current inpatient clinical work;

d. verification of licensure status in all current and past states of licensure;

e. a direct report from the Federation of State Medical Licensing Boards when indicated;

f. a direct report from the National Practitioner Data Bank, OIG and SAM.gov;

g. verify training with the medical school and AMA if necessary;

h. criminal background check; and

i. board certification or board eligibility.

F. DEPARTMENTAL INTERVIEW

(1) The applicant is given the name and telephone number of the Chair of the department for which he or she is applying. It is the applicant's responsibility to arrange an interview with the Chair of the department. The interview may be conducted by the Chair, the Chief of Staff, or by a designee within the department and may be conducted via telephone or videoconference. It is the department Chair's responsibility to document comments regarding the interview for inclusion in the applicant's folder. The Chair should comment on his or her knowledge of the applicant's training and experience and review with the applicant his or her requested privileges. The report should include documentation of any telephone calls made to references or others having knowledge of the applicant.

a. The Chair may recommend that:

(1) the practitioner be appointed as a member of the medical staff with certain specifically delineated privileges;

(2) he or she be rejected for appointment as a member of the medical staff; or

(3) his or her application be deferred for further consideration within thirty (30) days.

G. CREDENTIALS COMMITTEE PROCEDURE

(1) The Credentials Committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the Committee, whether the applicant has established and meets all of the necessary qualifications for the category of medical staff and/or specific clinical privileges requested by the applicant.

(2) Where appropriate, as part of this process, the Credentials Committee may require an impartial physical or mental examination of the applicant and shall require that the results be made available for the Committee's consideration. Such examinations and report may, if appropriate, be required prior to the Committee's making of a recommendation, or, if appropriate, after privileges are granted.

(3) As part of the process of making its recommendation, the Credentials Committee may meet with the applicant to discuss any aspect of his or her application, qualifications, and privileges requested.

(4) The Credentials Committee, after review of the available material, may choose one of three courses of action regarding staff membership:

a. forward application to the Medical Staff Executive Council ("MEC") with a positive recommendation;

b. forward to MEC with a recommendation against granting membership; or

c. table the application for a period not to exceed thirty (30) days, in which time further information and/or interviews will be obtained or will occur.

A recommendation shall be made to the MEC within 60 days of receipt of a completed application to the Medical Staff Office.

(5) In accordance with Article VI(F) of the Medical Staff Bylaws, the applicant may at this time be granted temporary privileges by the Chief Administrative Officer of the Hospital or his/her designee and the Chief of Staff or his/her designee for a period not to exceed 120 days, but only in those cases receiving a favorable recommendation from the Credentials Committee.

H. MEC PROCEDURE. The MEC may act upon a forwarded application in one of three ways:

(1) send to the Governing Board with a favorable recommendation;
(2) notify the applicant of a proposed adverse recommendation subject to the applicant's rights to a hearing and appeal; or (3)

table for a period not to exceed thirty (30) days.

I. GOVERNING BOARD ACTION

(1) The application then proceeds to the respective Governing Board for final determination at their next regularly scheduled meeting. The Board will hear from the Chief of Staff the recommendations of the Credentials Committee and the MEC regarding staff membership and the recommendation of the Chief of the applicant's department regarding privileges requested. The Board shall then make a decision regarding whether to accept the applicant's membership on the Hospital medical staff and then make a decision as to which privileges to grant the applicant. Any adverse decisions by the Board will be handled in a manner outlined in the Medical Staff Fair Hearing Plan, Exhibit A of the Medical Staff Bylaws.

(2) The decision of the Board will be communicated to the applicant by the Hospital Chief Administrative Officer or his/her designee via first class mail.

J. BASIS FOR RECOMMENDATIONS AND ACTIONS. The report of each individual or group, including the Board, required to act on an application must state the reasons for each recommendation or action taken, with specific reference to the completed action and all other documentation considered. Any dissenting views at any point in the process must also be reduced to writing, supported by reasons and references, and transmitted with a majority report.

ARTICLE II. GENERAL

A. MEDICAL STAFF ROLE. In assessing the credentials of applicants, the medical staff shall act only as the agent of the Governing Board. The medical staff shall make recommendations to the Board concerning the applicant’s appointment as a member of the medical staff or as an allied health care provider as well as delineation of specific privileges for each applicant.

B. DELEGATION OF COLLECTION OF CREDENTIALING INFORMATION. The Hospital and medical staff may delegate the collection and/or verification of credentialing information to an external organization.

C. TIMETABLES. The timetable for action upon applications shall be goals subject to good faith compliance, and failure to comply with any such deadlines after good faith efforts have been made shall not give rise to any rights or causes of action deriving from this manual.

D. ACKNOWLEDGMENT OF PRACTITIONER OBLIGATIONS. Every application for appointment to the medical staff or for privileges as an allied health care provider shall contain the applicant's specific acknowledgment of every medical staff and allied health care provider's obligation to:

(1) provide continuous care and supervision of his or her patients;

(2) abide by the Medical Staff Bylaws, rules and regulations and Hospital and, as applicable, Health System policies and procedures as they exist at the time of application and as they may thereafter be amended;

(3) accept committee assignments and such other reasonable duties and responsibilities that may be assigned to him or her by the appropriate staff officer;

(4) accept consultation and proctoring assignments;

(5) participate in the educational programs of the staff and Hospital;

(6) complete and document a medical history and physician examination for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration. Prior to surgery, or a procedure requiring anesthesia services, complete an update, documenting any changes in the patient’s condition, within twenty-four (24) hours after registration or in-patient admission;

(7) provide proof of continuous professional liability insurance and promptly notify the Hospital in writing of any change in or termination of such insurance coverage while a member of the medical staff;

(8) acknowledge the provisions of Section 413 of the Health Care Improvement Act of 1986 which permit the recovery of reasonable attorney's fees and costs in the defense of any suit brought by a practitioner concerning clinical privileges when the defendants have acted in compliance with the standards set forth in the Act;

(9) demonstrate, on request, his or her continuing qualification to exercise specific privileges;

(10) submit, on request, to an appropriate examination or testing of his or her physical, mental and emotional health;

(11) certify compliance with all state and federal statutes and regulations and hospital policies governing referrals, billing for services rendered to patients at Hospital, and conflicts of interest and obligation to document compliance on request;

(12) conduct himself or herself at all times at Hospital without discrimination or harassment on the basis of race, color, religion, national origin, disability which with or without reasonable accommodation does not prevent the performance of the essential functions of a job or access to medical care, age, sex, sexual orientation, or any other unlawful or impermissible criterion.

E. ACKNOWLEDGMENT OF APPLICANT OBLIGATIONS. Each application for appointment to the medical staff or for privileges as an allied health care provider shall contain the applicant's agreement to:

(1) abide by the ethical principles of his or her professional association as well as the Deaconess Health System Code of Conduct;

(2) authorize the members of the medical staff as agents of the Governing Board to investigate and to gather any information which would otherwise be confidential and privileged concerning the applicant with regard to qualifications to exercise privileges in the Hospital;

(3) authorize all persons and organizations to release information that would otherwise be confidential and privileged regarding the applicant's qualifications to exercise privileges in the Hospital to the Governing Board, their agents and/or employees;

(4) release from liability and hold harmless all persons, organizations, the Hospital, the Governing Board, personnel of peer review committees, their agents, employees and all others who participate in good faith in providing, receiving, evaluating and acting upon such information including confidential information, regarding the applicant's qualifications for privileges at the Hospital;

(5) be willing to appear for personal interviews in regard to his or her application;

(6) have read the Bylaws, Fair Hearing Plan, Rules and Regulations of the medical staff, Credentialing and Organization Manuals and to abide by them;

(7) certify compliance with all state and federal statutes and regulations and hospital policies governing referrals, billing for services rendered to patients at Hospital, and conflicts of interest and obligation to document compliance on request; and

(8) conduct himself or herself at all times at Hospital without discrimination or harassment on the basis of race, color, religion, national origin, disability which with or without reasonable accommodation does not prevent the performance of the essential functions of a job or access to medical care, age, sex, sexual orientation, or any other unlawful or impermissible criterion.

ARTICLE III. PROVISIONAL APPOINTMENT

A. CONDITIONS AND DURATION OF INITIAL APPOINTMENT. Provisional practitioners may be observed by proctors assigned to them by the Credentials Committee or MEC with the advice of the Chair of the department(s) involved. Proctors are to evaluate the medical care provided by the practitioner including, where appropriate, personal observation of diagnostic or surgical procedures, interpretation of diagnostic studies, and consultations. Proctors may base their reports in part on medical care that they have personally observed at other hospitals. Proctors who evaluate patient care provided by provisional practitioners are conducting peer review as agents of the Governing Board. The proctors' reports are confidential peer review material that shall not be part of or be mentioned in a patient's medical records. Proctors shall not be considered to be providing medical services to a patient being observed and shall not

charge for any proctoring. Probationers agree as a condition of application and/or membership to cooperate fully with their proctors and to hold them harmless and release them absolutely from any claim or cause of action for all acts, omissions and reports made in good faith while serving as proctors.

B. OBLIGATIONS AND RIGHTS. Active Provisional Medical Staff members' obligations and rights as Staff Members are enumerated in Section XI(A) of the Medical Staff Bylaws.

C. SUCCESSFUL CONCLUSION. After fulfilling the provisional requirements, and upon recommendation of the respective department, MEC, and approval by the Governing Board, the provisional status of the practitioner's appointment will be lifted. At the end of the provisional period of one year, an individual's probationary status may be lifted, an individual may be denied appointment, or his or her provisional status may be extended for a year, but no longer. If, at the end of the provisional period, the individual practitioner's appointment is terminated, the practitioner shall be given written notice of such termination by the Chief Administrative Officer of the Hospital or his/her designee as provided under the Fair Hearing Plan, Section 1(d). The adversely affected practitioner shall have a right to a hearing and appeal concerning the termination as provided in the Fair Hearing Plan.

ARTICLE IV. ALLIED HEALTH CARE PROVIDERS

A. PROCEDURE FOR APPLICATION

(1) FORM. Applications for appointment as an allied health care provider shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Board after consultation with the Credentials Committee and MEC.

(2) INFORMATION. The application shall include the following information:

a. The applicant's professional qualifications, including undergraduate and graduate education, training and experience;

b. The names of at least two practitioners (one with the same licensure) who have had extensive experience in observing and working with the applicant and who will provide adequate statements pertaining to medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism and any limitations on the ability to provide care to patients caused by the applicant's health;

c. Whether the applicant's application and/or clinical privileges at any other Hospital or institution have ever been denied, subjected to disciplinary action, revoked, suspended, reduced, or not renewed;

d. Whether the applicant's application for or membership in local, state or national professional societies or his or her licensure to practice any profession and/or narcotics license, if applicable, in any jurisdiction has ever been denied, subjected to disciplinary action, suspended, voluntarily surrendered, or terminated;

e. A copy of the applicant's current Kentucky license to practice, as well as copies of his or her CSR and DEA certificates appropriate for the Deaconess Henderson Hospital area;

f. Proof of professional liability insurance with limits of at least $1,000,000 per occurrence and $3,000,000 annual aggregate, and agreement to promptly notify the Hospital in writing of any change in or termination of such insurance coverage;

g. The applicant's malpractice experience, including a consent for the release of information from his or her present and past malpractice insurance carriers; and

h. criminal background check.

(3) SUBMISSION OF APPLICATION. The completed application for privileges as an allied health care provider shall be submitted to the Medical Staff Office. Upon receipt of the completed application, the Chief Administrative Officer of the Hospital or his/her designee shall:

a. Verify licensure, certifications, educational training, post graduate experiences and other references, from primary sources whenever possible;

b. Collect letters of reference, conduct criminal background check and gather such other information as required in the Medical Staff Bylaws and as circumstances require, including any inquiry regarding any information on the application which is held by the Kentucky Licensing Boards or other relevant agency and by the National Practitioner Data Bank;

c. If the Medical Staff Office or its designee is unable to obtain certain pertinent information, he or she shall notify the applicant in writing, who shall have the burden of obtaining the required information. No action will be taken on an application deemed to be substantially incomplete; any application remaining incomplete for sixty (60) days thereafter shall be deemed withdrawn; and

d. Transmit the application and all supporting materials to the Credentials Committee for evaluation.

B. CREDENTIALS COMMITTEE PROCEDURE

(1) The Credentials Committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the Committee, whether the applicant has established and meets all of the necessary qualifications for the category of allied health care provider and/or specific clinical privileges requested by the applicant.

(2) Where appropriate, as part of this process, the Credentials Committee may require an impartial physical or mental examination of the applicant and shall require that the results be made available for the Committee's consideration. Such examinations and report may, if appropriate, be required prior to the Committee's making of a recommendation, or, if appropriate, after privileges are granted.

(3) As part of the process of making its recommendation, the Credentials Committee may meet with the applicant to discuss any aspect of his or her application, qualifications, and privileges requested.

(4) The Credentials Committee, after review of the available material, may choose one of three courses of action regarding appointment as an allied health care provider:

a. forward application to the MEC with a positive recommendation;

b. forward to MEC with a recommendation against granting appointment; or

c. table the application for a period not to exceed thirty (30) days, in which time further information and/or interviews will be obtained or will occur.

C. MEC PROCEDURE

(1) At its next regular meeting after receipt of the application, reports, and recommendation of the Credentials Committee, the MEC shall determine whether to recommend to the Governing Board that the applicant be granted privileges as an allied health care provider, that his or her application be deferred for further consideration, or that he or she be rejected for privileges as an allied health care provider.

(2) When the recommendation of the MEC is favorable to the applicant, the Chief Administrative Officer of the Hospital or his/her designee shall promptly forward the written recommendation, together with all supporting documentation, to the Governing Board. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such privileges.

(3) When the recommendation of the MEC is to defer the application for further consideration, it may be followed up within thirty-one (31) days with a subsequent recommendation for privileges as an allied health care provider, with specified clinical privileges, or for rejection of the application;

(4) When the recommendation of the MEC is adverse to the applicant in respect to clinical privileges, the Chief Administrative Officer of the Hospital or his/her designee shall promptly notify the applicant in writing. The applicant shall be entitled to request a review as set out in Section VI(D)(b) of the Medical Staff Bylaws. No such adverse recommendation shall be forwarded to the Governing Board until after the applicant has exercised or has been deemed to have waived his or her right to a review.

(5) If the applicant waives or is deemed to have waived his or her right to a review, the report and recommendation of the MEC shall be forwarded to the Governing Board for appropriate action. The MEC's adverse recommendation shall remain effective pending final action by the Governing Board.

D. GOVERNING BOARD PROCEDURE

(1) The Governing Board shall make all final decisions concerning granting of privileges to allied health care providers. The Board shall make such final decisions after there has been a recommendation from the medical staff, as provided in the Medical Staff Bylaws, or after the Board has notified the medical staff and determined that the staff has failed to act in a timely manner. The Board shall never be bound by the medical staff recommendations and shall always exercise its independent discretion as the ultimate peer review body of the Hospital.

(2) When the decision of the Governing Board is adverse to the applicant with respect to clinical privileges, and such decision is not based on a prior adverse recommendation by the MEC, then the Chief Administrative Officer of the Hospital or his/her designee shall promptly notify the applicant. The

applicant shall be entitled to request a review as set out in Section VI(D)(b) of the Medical Staff Bylaws.

(3) No applicant shall be entitled to more than one review on any matter which shall have been the subject of action by the MEC, Governing Board, and/or a duly authorized committee of the Board.

(4) If the applicant waives or is deemed to have waived his or her right to a review of the Board's adverse decision, the Board's decision shall become a final decision.

ARTICLE V. PROCEDURE FOR REAPPOINTMENT

A. APPLICATION FOR REAPPOINTMENT

(1) Application for reappointment to the medical staff or as an allied health care provider shall be made triennially on a form prescribed by the Governing Board in consultation with the medical staff, which shall include indication of the type of clinical privileges being requested. Reappointment to the Honorary Affiliate category does not require application.

(2) The application shall be submitted to the Medical Staff Office one hundred twenty (120) days before the reappointment expiration date.

B. FACTORS TO BE CONSIDERED. Each recommendation concerning the reappointment of a practitioner and the granting of specific privileges shall be based upon the practitioner's current competence as demonstrated by all the information and evaluations required for an initial application including:

(1) If the practitioner does not have quality data to be used for references, two letters of recommendation sent directly to the Chief Administrative Officer or his/her designee from practitioners with the same licensure who have recently worked with the re-applicant and directly observed medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, professionalism and any limitations on the ability to provide care caused by the re-applicant’s health;

(2) As part of the requirements of the Kentucky Board of Medical Licensure, attendance at department meetings where mandated and participation in staff affairs; completion of any required CME;

(3) Compliance with Hospital and Health System policies and procedures and Medical Staff Bylaws and Rules and Regulations;

(4) Cooperation with other Hospital personnel;

(5) Use of conferred privileges in an efficient manner consistent with the financial well-being of the Hospital;

(6) Relations with patients, colleagues, the public and the Governing Board;

(7) Documentation of 50 hours of AMA Category I Continuing Medical Education (CME) related to his or her specialty within the preceding two years; and

(8) Payment of the reappointment fee.

C. EFFECT OF PAST PRIVILEGES. No reappointment shall be granted solely because the practitioner exercised such privileges in the past at this or any other hospital.

D. LOW OR NO USE OF CERTAIN PRIVILEGES. If a practitioner fails to make use of privileges granted to an extent sufficient to judge his or her training and skill in exercising the privilege, the applicant for reappointment shall be so notified and shall be given the options of dropping the privilege or privileges in question or of providing information from another institution or training program sufficient to make that judgment. The MEC also has the option of requiring some form of focused professional practice evaluation, such as monitoring, chart review or proctoring.

E. INFORMATION OBTAINED. Upon receipt of the completed application for reappointment, the Medical Staff Office shall obtain:

(1) From the Medical Records Department, a report of any problems or concerns relating to accuracy, timeliness and sufficiency of the applicant's medical records, including legibility and completeness of documentation of patient records;

(2) All incident/occurrence reports that bear on the applicant's ability to exercise privileges in the Hospital;

(3) From the Utilization Review Committee, an evaluation of the applicant's past utilization of Hospital resources;

(4) From the quality improvement department, any information concerning the applicant's current competence or professional conduct, including statistical data on performance, outcomes, complications, etc. on the individual applicant in comparison to his or her peers in the aggregate, and any reports that resulted in discussion of the practitioner’s care in a review meeting;

(5) From the applicant's department Chair, a report concerning the applicant's competence and professional conduct in regard to specific clinical privileges requested;

(6) A report on any quality-of-care matters that have been raised by any peer review activity;

(7) Information held by the Kentucky Board of Medical Licensure. OIG, SAM.gov or other relevant licensing board and by the National Practitioner Data Bank;

(8) Information from the applicant on any challenges to his or her licensure, DEA or CSR registration, criminal charges, adverse results of any Medicare or Medicaid audits, professional liability claims made, settled or that resulted in judgments against the applicant since the last credentialing process, corrective actions initiated or taken by any peer review organization outside of the hospital, any voluntary or involuntary relinquishment, limitation, or change in membership or privileges exercised at any other health care institution, and any developments which evidence any change in the applicant's physical, mental or emotional health that may bear on his or her ability to provide patient care.

F. When the information listed in Section V.E has been obtained, the Medical Staff Office shall forward the application and supporting documents to the Credentials Committee.

G. CREDENTIALS COMMITTEE PROCEDURE

(1) The Credentials Committee shall make an independent assessment of privileges for the applicant based on the application and supporting documents provided by the Medical Staff Office, as well as other information as required by the circumstances, which may include, but is not limited to:

a. Interview(s) with the applicant;

b. Additional information from the applicant or other sources concerning competence, professional conduct, training and medical education; and

c. A requirement that the applicant submit to appropriate physical and/or mental health evaluation and/or testing.

(2) The Credentials Committee shall submit a written report and recommendation concerning specific privileges for the applicant to the MEC at a meeting prior to the applicant's reappointment expiration date.

H. MEC PROCEDURE

(1) At its next regular meeting after receipt of the application, report and recommendation of the Credentials Committee, the MEC shall determine whether to recommend to the Governing Board that the applicant be reappointed to the medical staff or as an allied health care provider as well as what specific privileges should be granted.

(2) When the MEC recommendation is favorable to the applicant with respect to specific privileges, the Chief of Staff or his/her designee shall promptly forward the written recommendation to the Governing Board. All recommendations shall contain the specific privileges recommended, as well as any probationary conditions relating to such privileges. The MEC may refer a MEC reapplication back to the Credentials Committee for further investigation or recommendation, and in such case, the Credentials Committee

shall act as an investigating committee. The re-applicant shall be entitled to the rights of a practitioner under Section IX(A)(3) of the Medical Staff Bylaws.

(3) When the MEC recommendation is adverse to a current member of the Medical Staff with respect to appointment or specific privileges, the Chief Administrative Officer of the Hospital or his/her designee shall promptly notify the applicant by certified mail, return receipt requested, or by personal delivery. The notice shall comply with the requirements set out in the Fair Hearing Plan, Section 1(d). The applicant may exercise or waive his rights to a hearing and appeal as specified in the Fair Hearing Plan. When the MEC recommendation is adverse to an allied health care provider with respect to renewal of privileges, the applicant shall be entitled to request a review as set out in Section VI(D)(b) of the Medical Staff Bylaws.

(4) Thereafter, the procedure to be followed on reapplication shall be the same as specified above for initial application.

I. GOVERNING BOARD PROCEDURE

(1) The Governing Board shall make all final decisions concerning reappointment to the medical staff or as an allied health care provider, as well as the granting of specific privileges. The procedure to be followed shall be the same as that for initial applications.

(2) Reappointment shall be for a period of not more than three (3) years, and will be on staggered terms, as provided in Section V.A. (2).

ARTICLE VI. PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES

A. GENERAL. The general category of allied health care providers is covered above in Article IV. Physician assistants and advanced practice registered nurses are subcategories of allied health care providers. More specific information with regard to these subcategories is set forth below.

B. PHYSICIAN ASSISTANTS. Physician Assistants must be registered with the Hospital to provide specified health care at the Hospital as (1) the employee of a Hospital or (2) the employee of a physician member of the medical staff with Active, Senior or Courtesy Staff privileges or (3) an employee of a physician group who has a supervisory agreement with a physician member of the medical staff with Active, Senior or Courtesy Staff privileges. Supervisory agreements must be with MDs or DOs.

(1) REGISTRATION PROCESS

a. Physician assistants shall apply for approval on forms provided by the Chief Administrative Officer of the Hospital or his/her designee which shall require submission of the supervisory agreement under which the physician assistant wishes to work.

b. The Credentials Committee shall review each application and make a recommendation concerning registration to the MEC.

c. The MEC shall determine whether the physician extender should be approved, subject to the approval of the Governing Board.

d. The MEC's recommendation may accept, modify, reject, delete or add such terms and conditions to the supervisory agreement as it may think best. The agreement of the physician assistant and the supervising physician must be given in writing to any such terms and conditions before the matter is forwarded to the Governing Board. Such modifications may further restrict but not expand any supervisory agreement approved by the Kentucky Board of Medical Licensure.

e. The registration of any physician assistant terminates automatically with the termination of the supervisory agreement with his or her supervising physician or the suspension or termination of the medical staff privileges of the supervisory physician.

C. ADVANCED PRACTICE REGISTERED NURSES. Advanced practice registered nurses (APRNs) shall include certified nurse midwives, certified nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists who are certified in at least one population focus as defined by KRS §314.011. APRNs may only engage in prescribing or dispensing non-scheduled legend drugs under collaborative agreements for prescriptive authority for non-scheduled drugs (CAPA-NS). (unless exempt from a CAPA-NS requirement by completing 4 years of prescribing as an APRN) APRNs may only prescribed controlled substances under a collaborative agreement (CAPA-CS) with a physician member of the medical staff in the same or similar practice with Active, Senior or Courtesy Staff privileges. APRNs must be registered with the Hospital to provide specified health care at the Hospital as (1) the employee of a Hospital or (2) the employee of a physician member of the medical staff with Active, Senior or Courtesy Staff privileges or (3) as an independent contractor providing services to a patient under the direction of a physician member of the medical staff with Active, Senior or Courtesy Staff privileges.

(1) REGISTRATION PROCESS

a. APRNs shall apply for approval on forms provided by the Chief Administrative Officer of the Hospital or his/her designee which shall require submission of the collaborative agreement(s) under which the APRN wishes to work.

b. The Credentials Committee shall review each application and proposed collaborative agreement(s) and make a recommendation concerning registration to the MEC.

c. The MEC shall determine whether the APRN should be approved for registration, subject to the approval of the Governing Board.

ARTICLE VII. DELINEATION OF PRIVILEGES

A. PROCEDURE

(1) The responsibility to delineate the requirements of each privilege to be granted by the medical staff shall be assigned to a particular department or departments or committee.

(2) The Credentials Committee will recommend to the MEC which department or committee should be responsible for delineation of the requirements of each privilege to be granted by the medical staff.

(3) The department or committee so designated as the department responsible for delineating the requirements for the privilege may establish minimum training and/or experience requirements that must be met by an applicant to be eligible to apply for a given privilege.

(4) Recommended requirements must be approved as amendments to the rules and regulations of the department or committee establishing the minimum training and/or experience requirements and must follow all of the procedures outlined in the Medical Staff Bylaws for amendments to the Rules and Regulations.

(5) The Medical Staff Office shall maintain a delineation for privileges form for each department which establishes requirements for the privileges assigned to that department.

B. NEW TREATMENT PROCEDURES OR MODALITIES

(1) All new procedures, treatments or modalities that have not previously been assigned to a department or departments or committee for the delineation of privileges shall be presented to the Credentials Committee in writing for designation as to:

a. Whether privileging is necessary;

b. If found necessary, which department or committee should have the responsibility for delineating the requirements necessary for the granting of privileges for that procedure, treatment or modality; and

c. A written request for review should be made by a member of the medical staff that has an interest in performing the procedure, and should include a detailed description of the proposed procedure, treatment or modality, including any special instruments or equipment not currently available at the Hospital.

ARTICLE VIII. DISASTER SITUATIONS

In the event of a mass disaster, when the emergency management plan has been activated, medical staff members and employees may not be able to provide all the care required by individuals seeking treatment at our facilities. Under such circumstances, the Chief Administrative Officer, Chief of Staff, or their designee is authorized to grant disaster privileges or permission to treat patients to volunteer physicians, nurses, and other professionals upon receipt of satisfactory evidence that such individuals are currently licensed in some state or otherwise capable of providing services to patients. Section VII(G) of the Medical Staff Bylaws sets forth a variety of different bases on which volunteers can be considered eligible for disaster privileges. Notwithstanding any existing delineation of privileges or scope of authority, during a mass disaster current medical staff members, employees and volunteers are authorized to take whatever steps they reasonably believe are necessary to save or preserve the life or health of patients or to protect the public health.

ARTICLE IX. AMENDMENT

A. AMENDMENT. This Credentialing Manual may be amended or repealed, in whole or in part, by a resolution of the MEC recommended to and adopted by the Governing Board.

B. RESPONSIBILITIES AND AUTHORITY. The procedure outlined in the Medical Staff and Hospital Corporate Bylaws regarding medical staff responsibility and authority to formulate, adopt, and recommend the Medical Staff Bylaws and amendments thereto and the Medical Staff Rules and Regulations applies as well to the formulation, adoption, and amendment of this Credentialing Manual, which is part of the Rules and Regulations of the Medical Staff.

ARTICLE X. ADOPTION

A. MEDICAL STAFF. This Credentialing Manual was adopted and recommended as rules and regulations of the Medical Staff to the Governing Board by the MEC in accordance with and subject to the Medical Staff Bylaws.

_____
Chief of Staff/Medical Staff

_____
Date

B. GOVERNING BOARD. This Credentialing Manual is approved and adopted by the resolution of the Governing Board as rules and regulations of the medical staff after considering the Medical Staff Executive Council's recommendations and in accordance with and subject to the Hospital governing documents.

DEACONESS HENDERSON HOSPITAL

By:_____
President/Board of Directors

_____
Date

Adopted:	MEC	10/20/2020
	DHH Board of Directors	10/22/2020
Revised:	MEC	03/15/2022
	DHH Board of Directors	03/24/2022
Revised:	MEC	01/17/2023
	DHH Board of Directors	01/26/2023
Revised:	MEC	
	DHH Board of Directors	
Revised:	MEC	
	DHH Board of Directors	