DEACONESS HOSPITAL, INC.

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 Deaconess Hospital, Inc. and Board of Managers for Deaconess Women's Hospital of Southern Indiana LLC ("the Governing Boards"). 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"). Governing Documents are readily available on the Medical Staff Office page at Deaconess.com.

(1) REQUEST FOR PRIVILEGES

a. Each practitioner's application for privileges shall include a specific request for the privileges that the applicant wishes to exercise.

b. Practitioners may apply for additional privileges at any time by submitting a request for additional privileges to the Medical Staff Office. This request shall be handled as an expansion of the practitioner's 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 CEOs or their designees. Its purpose is to provide a preliminary, non-binding opinion as to whether the potential applicant meets the minimum criteria for Medical Staff membership. At the request of a potential applicant or on initial receipt of an application, the Chief Medical Officer may contact the interested party and discuss with the applicant 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 for herein.

(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 of privileges.

(2) OBJECTIVES

a. To assist in fulfilling the responsibility of the Hospitals 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.

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 Boards.

(3) PROCEDURE

a. An applicant will be sent the following materials:
    1. an application form or instructions on accessing the online CAQH form,
    2. a copy of instructions to access the Medical Staff Governing Documents on Deaconess' website,
    3. a delineation of privileges form(s) appropriate to the applicant's specialty or training.

b. The Medical Staff Office must receive the following items for an application to begin being processed:
    1. a completed and signed application or CAQH form and request for privileges,
    2. payment of the application fee,
    3. an applicant signed and dated Consent, Undertakings and Release of Liability form,
    4. a copy of current professional liability insurance and certificate of qualification as a health care provider under the Indiana Patients Compensation Act,

c. Verification tasks on an application can begin only after numbers (b) 1, 2, and 3 are submitted. All materials must be submitted prior to consideration by 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 personnel, and Medical Staff representatives or peer review committees to consult with others who have been associated with the applicant and/or who have information bearing on his or her competence and qualifications;

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

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

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

(6) authorizes and consents to Hospital representatives, including members of peer review committees, providing other hospitals, medical associates, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information concerning the applicant, and releases Hospital representatives, including members of peer review

committees, from liability for doing so, provided the furnishing of information is done in good faith and without malice;

(7) signifies that the applicant has read the current Medical Staff Governing Documents and agrees to abide by their provisions in regard to the application for appointment to the medical staff.

(8) acknowledges the applicant has the burden of producing adequate information for proper evaluation of the applicant's physical, mental, or emotional health status, or the applicant's professional conduct and ethical qualifications for medical staff appointment and clinical privileges and for resolving any issues about such qualifications;

(9) agrees to immediately report to the Medical Staff Office any voluntary or involuntary limitation, suspension or loss of licensure; limitation or loss of professional liability insurance; suspension, exclusion, or termination by any federal or state regulatory body; or voluntary or involuntary limitation, suspension, or revocation of medical staff membership, status, and/or clinical privileges at any other hospital or licensed health care facility; and

(10) agrees to exhaust any and all administrative remedies available under Medical Staff Bylaws and/or Fair Hearing Plan in connection with an adverse recommendation or decision before utilizing any other means of obtaining medical staff membership and/or clinical privileges including legal action.

E. PROCESSING TASKS

(1) Letters of verification will be sent to parties able to verify the statements contained in the application regarding the applicant's education, work history, military service, residency and fellowship training, peer recommendations, 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 an adverse action, shall not give right to a hearing or appeal, and shall not be reported to the Medical Licensing Board 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 National Practitioner Data Bank;
f. AMA physician profile, where applicable;
g. Criminal background check

F. DEPARTMENTAL INTERVIEW

(1) It is the department Chief's or Chief designee's responsibility to arrange an interview with the applicant and to document comments regarding the interview for inclusion on the applicant's folder. The Chief or designee 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 Chief or designee may recommend that:
1. the practitioner be appointed as a member of the medical staff with certain specifically delineated privileges;
2. the practitioner be rejected for appointment as a member of the medical staff; or
3. the application be deferred to Credentials Committee for further consideration.

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) When 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.

(3) As part of the process of making its recommendation, the Credentials Committee may meet with the applicant to discuss any aspect of the 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 after the Credentials Committee has determined the application is complete.

(5) The applicant may at this time be granted temporary privileges by the CEO of the Hospital or his/her designee and the Medical Staff President or his/her designee for a period not to exceed 120 days, but only in these cases receiving a favorable recommendation from the Credentials Committee.

H. MEC PROCEDURE. The MEC may act upon a forwarded application in one of the three ways:
   a. send to the Governing Board with favorable recommendation;
   b. notify the applicant of a proposed adverse recommendation subject to the applicant's rights to a hearing and appeal; or
   c. 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 or electronic board vote quorum. The Board will hear from the President of the Medical Staff who will provide the recommendations of the Credentials Committee and the MEC regarding medical staff membership and the recommendation of the Chief of the applicant's department regarding privileges requested. The Board shall then decide whether to approve the applicant's request for medical staff membership and determine which privileges to grant to the applicant, which may be qualified by any probationary conditions relating to such privileges. Any adverse decisions by the Board will be handled in the manner outlined in the Medical Staff Fair Hearing Plan, Exhibit A of the Medical Staff Bylaws. 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) The decision of the Board will be communicated to the applicant by the Hospital CEO or his/her designee via electronic delivery.

J. BASIS FOR RECOMMENDATION 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 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 agents of the Governing Boards. The Medical Staff shall make recommendations to the Boards 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 acknowledgement 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 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 appropriated staff officer;
(4) accept consultation and proctoring assignments;
(5) participate in the educational programs of the staff and Hospitals;
(6) provide proof of continuous professional liability insurance for all privileges requested and payment of the surcharge to qualify the practitioner as a health care provider under the Indiana Medical Malpractice Act and promptly notify the Hospital in writing of any change in or termination of such insurance coverage while a member of the medical staff;
(7) 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;
(8) demonstrate, on request, his or her continuing qualification to exercise specific privileges;
(9) submit, on request, to an appropriate examination or testing of the applicant's physical, mental, and emotional health;
(10) certify compliance with all state and federal statutes and regulations and hospital policies governing referrals, billing for services rendered to patients at Deaconess facilities, and conflicts of interest and obligation to document compliance on request;
(11) conduct himself and herself at all times at Deaconess facilities 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. ACKNOWLEDGEMENT 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 Boards 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 Hospitals;
(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 Hospitals to the Governing Boards, their agents and/or employees;
(4) release from liability and hold harmless all persons, organizations, the Hospitals, the Governing Boards, 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 Hospitals;
(5) be willing to appear for personal interviews in regard to his or her application;
(6) have read the Medical Staff 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 Deaconess facilities, and conflicts of interest and obligation to document compliance on request; and

(8) conduct himself or herself at all times at Deaconess facilities 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. ALLIED HEALTH CARE PROVIDERS

A. APPLICATION. Application for appointment as an allied health care provider is to be submitted in writing on such a form as designed by the Credentials Committee and approved by the Board of Directors of Deaconess Hospital, Inc. and Board of Managers for Deaconess Women's Hospital of Southern Indiana LLC ("the Governing Boards"). 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"). Governing Documents are readily available on the Medical Staff Office page at Deaconess.com.

B. PROCESSING THE APPLICATION

(1) PURPOSE. To define the steps for appropriately processing each application for allied health care providers for appointment or requests for privileges.

(2) OBJECTIVES

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

b. 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 Boards.

(3) PROCEDURE

a. An applicant will be sent the following materials:

1. an application form or instructions on accessing the online CAQH form,
2. a copy of instructions to access the Medical Staff Governing Documents on Deaconess' website,
3. a delineation of privileges form(s) appropriate to the applicant's specialty or training.

b. The Medical Staff Office must receive the following items for an application to begin being processed:

1. a completed and signed application or CAQH form and request for privileges,
2. payment of the application fee,
3. an applicant signed and dated Consent, Undertakings and Release of Liability form,
4. a copy of current professional liability insurance and certificate of qualification as a health care provider under the Indiana Patients Compensation Act, and
5. a copy of the Collaborating Practice Agreement with a medical staff member, if applicable.

c. Verification tasks on an application can begin only after numbers (b) 1, 2, and 3 are submitted. All materials must be submitted prior to consideration by any medical staff committees or officials.

C. PROCESSING TASKS

(1) Letters of verification will be sent to parties able to verify the statements contained in the application regarding the applicant's education, work history, military service, training, peer recommendations, 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.

(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 an adverse action, shall not give right to a hearing or appeal, and shall not be reported to the appropriate Licensing Board 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 National Practitioner Data Bank;
f. Criminal background check

D. DEPARTMENTAL INTERVIEW

(1) It is the department Chief's or Chief designee's responsibility to arrange an interview with the applicant and to document comments regarding the interview for inclusion on the applicant's folder. The Chief or designee 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 Chief or designee may recommend that:
   1. the practitioner be appointed as a member of the allied health staff with certain specifically delineated privileges;
   2. the practitioner be rejected for appointment as a member of the allied health staff; or
   3. the application be deferred to Credentials Committee for further consideration.

E. 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.

(3) As part of the process of making its recommendation, the Credentials Committee may meet with the applicant to discuss any aspect of the 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.

A recommendation shall be made to the MEC within 60 days after the Credentials Committee has determined the application is complete.

(5) The applicant may at this time be granted temporary privileges by the CEO of the Hospital or his/her designee and the Medical Staff President 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.

F. 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 the application be deferred for further consideration, or that the applicant be rejected for privileges as an allied health care provider.

(2) When the recommendation of the MEC is favorable to the applicant, the CEO 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 (30) 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 CEO 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 either exercised or has been deemed to have waived, the right to a review.

(5) If the applicant waives or is deemed to have waived the 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.

G. 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 CEO 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 duty 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 IV. 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) completion of any required education and compliance modules mandated by Hospital, Accreditation or CMS;

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

(3) Cooperation with other Hospital personnel;

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

(5) Interpersonal skills and relationships with patients, colleagues, the public and the Governing Board; and

(6) Attestation of required number of hours of AMA Category I Continuing Medical Education (CME) related to the applicant's specialty to maintain state license within the preceding two years.

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 the training and skill in exercising the privilege, the applicant for reappointment shall be so notified and shall be given the options of dropping the privileges in question or 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 Chief, 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 Indiana Medical Licensing Board or other relevant licensing board and by the National Practitioner Data Bank;

(8) Information from the applicant on any challenges to the applicant's 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 President of the Medical 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 an application back to the Credentials Committee for further investigation or recommendation, and in such case, the Credentials Committee shall act as an investigating committee. The 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 CEO 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 or her 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 application for reappointment 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 IV.A.(2).

ARTICLE V. PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES

A. PHYSICIAN ASSISTANTS. Physician assistants must be registered with the Hospitals to provide specified health care at the Hospitals as (1) an employee of a Hospital, (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 collaborative practice agreement with a physician member of the Medical Staff with Active, Senior or Courtesy Staff privileges. Collaborative practice agreements must be with MDs or DOs, not with DDSs or DPMs.

(1) REGISTRATION PROCESS

a. Physician assistants shall apply for approval on forms provided by the CEO of the Hospital or his/her designee which shall require submission of the collaborative practice agreement under which the physician assistant wishes to work. The application shall also include proof of qualification under the Indiana Patient's Compensation Fund and payment of the surcharge for the Fund.
b. The Credentials Committee shall review each application and proposed collaborative practice agreement and make a recommendation concerning registration to the MEC.
c. The MEC shall determine whether the physician assistant 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 collaborative practice agreement as it may think best. The agreement of the physician assistant and the collaborating 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 collaborative practice agreement approved by the Licensing Board.
e. The registration of any physician assistant terminates automatically with the termination of the collaborative practice agreement with the applicant's collaborating physician or the suspension or termination of the medical staff privileges of the collaborating physician.

B. ADVANCED PRACTICE NURSES. Advanced practice nurses shall include certified nurse-midwives, nurse practitioners and clinical nurse specialists as defined by Indiana Code §25-23-1-1 and 848 IAC Art. 4. Advanced practice nurses must perform their duties under collaborative practice agreements with physicians but need not be the employees of physicians. Collaborative practice agreements must be with MDs or DOs, not with DDSs or DPMs. Advanced practice nurses must be registered with the Hospitals to provide specified health care at the Hospitals as (1) an employee of a Hospital, (2) the employee of a physician member of the Medical Staff with Active, Senior or Courtesy privileges or (3) an employee of a physician group or an independent contractor who has a collaborative practice agreement with a physician member of the Medical Staff with Active, Senior or Courtesy Staff privileges.

(1) REGISTRATION PROCESS

a. Advanced practice nurses shall apply for approval on forms provided by the CEO of the Hospital or his/her designee which shall require submission of the collaborative practice agreement under which the advanced practice nurse wishes to work. The application shall also include proof of qualification under the Indiana Patient's Compensation Fund and payment of the surcharge for the Fund.
b. The Credentials Committee shall review each application and proposed collaborative practice agreement and make a recommendation concerning registration to the MEC.
c. The MEC shall determine whether the advanced practice nurse should be approved for registration, 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 collaborative practice agreement as it may think best. The agreement of the advanced practice nurse and the collaborating 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 collaborative practice agreement approved by the Nursing Board.

e. The registration of any advanced practice nurse terminates automatically upon the termination of the collaborative practice agreement with his or her collaborating physician or the suspension or termination of the medical staff privileges of the collaborating physician.

ARTICLE VI. 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 the 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 the procedures outlined in the Medical Staff Bylaws for amendments to the Rules and Regulations.

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

(6) Delineation of privileges should at minimum be reviewed every 24 months by the department.

B. NEW TREATMENT PROCEDURES OR MODALITIES

(1) All new procedures, treatments or modalities that have not previously been assigned to a department 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(s) or committee(s) 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 necessary special instruments or equipment not currently available at the Hospitals.

C. EXPANSION OF SKILL

(1) Request for expansion of skill to the Medical Staff or as an allied health care provider shall be made 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.

(2) FACTORS TO BE CONSIDERED. Each request concerning the expansion of skill and the granting of specific privileges shall be based upon the practitioner's current competence as demonstrated by information and evaluations including:

a. a copy of current license and controlled substance registration for Indiana, if applicable;

b. a copy of current professional liability insurance and certificate of qualification as a health care provider under Indiana Patient's Compensation Act;

c. a copy of the DEA certificate appropriate for the professional address that the applicant will maintain in the Deaconess area, if applicable;
d. a report from the National Practitioner Data Bank;
e. Verification of the applicant's education, training, recommendations, experience, and proctor recommendation, if applicable.

(3) The Credentials Committee shall make an independent assessment of privileges for the applicant based on the request and the supporting documents provided by the Medical Staff Office and other information as required by the circumstances. The Credentials Committee will make a recommendation concerning the expansion of skill to the MEC.
(4) At its next regular meeting after the Credentials Committee, the MEC shall review the expansion of skill request, supporting documents provided by the Medical Staff Office and the Credentials Committee recommendation.
(5) The MEC's recommendation may accept, modify, reject, delete, or add such terms and conditions to the expansion of skill requests as it may think best, subject to the final approval of the Governing Board.
(6) The Governing Board shall make all final decisions concerning expansion of skill to the Medical Staff or as an allied health care provider.
(7) The applicant is notified of the decision via electronic delivery.

ARTICLE VII. 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 CEO, President of the Medical Staff, or the Chief Medical Officer 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 VIII. 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 Boards.
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 Regulation applies as well to the formulation, adoption, and amendment of this Credentialing Manual, in which is part of the Rules and Regulations of the Medical Staff.

ARTICLE IX. ADOPTION

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

DocuSigned by:
Jamie Davison, MD
9520AB39B07B48C...
President/Medical Staff
6/6/2025
Date

B. GOVERNING BOARDS. This Credentialing Manual is approved and adopted by the resolution of the Governing Boards 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 HOSPITAL, INC.

DocuSigned by:
Jeff Justice
C780B72C54C84E2...
Secretary/Board of Directors
6/7/2025
Date

DEACONESS WOMEN'S HOSPITAL OF SOUTHERN INDIANA, LLC

Signed by:
Cheryl Wathen
A10B857S5E1A437...
Secretary/Board of Directors
6/9/2025
Date