**THE CREDENTIALING MANUAL OF**

**Indiana University Health Jay, Inc.**

**A MANUAL OF THE MEDICAL STAFF BYLAWS**

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# **PREAMBLE**

As set forth in the Medical Staff Bylaws and Medical Staff Rules & Regulations of Indiana University Health Jay, Inc., only an Admitting Practitioner shall admit patients in the Hospital. Other providers (i.e. physician, dentist, oral and maxillofacial surgeons, podiatrist, optometrist, psychologist or allied health professionals) may provide medical or health-related services to patients once he or she has been duly granted Membership and Clinical Privileges, as applicable, pursuant to the Medical Staff Bylaws and this Credentialing Manual. The requirements, qualifications, and procedures for appointment and reappointment to the Medical Staff and granting of Clinical Privileges are set forth in Medical Staff Bylaws and this Credentialing Manual. Membership on the Medical Staff constitutes neither an employee nor independent contractor relationship with the Hospital unless such a relationship is separately established directly between the Hospital with a member of the Medical Staff or Allied Health Professional through a contractual arrangement or employment arrangement. In the event of any conflict between the Medical Staff Bylaws and Related Manuals, and a specific contractual arrangement between the Hospital and a Member or Allied Health Professional, the language of the contractual or employment arrangement will control.

Clinical Privileges granted to Members or Allied Health Professionals shall be determined by the Board of Directors of Indiana University Health Jay, Inc., in accordance with the Medical Staff Bylaws and this Credentialing Manual. All determinations regarding the granting or denial of Clinical Privileges shall be based upon the written criteria as recommended by the Medical Staff and established by the Board for the granting of Clinical Privileges as further outlined in the Medical Staff Bylaws, this Credentialing Manual and other Related Manuals.

DEFINITIONS

The following definitions apply to the Medical Staff Bylaws and Related Manuals. The use of capitalization when defining terms is intended for convenience purposes only and shall not affect the meaning or interpretation of such terms throughout these Bylaws and Related Manuals.

**ADVERSELY AFFECTING** or **ADVERSE EFFECT** includes reducing, restricting, suspending, revoking, denying, or failing to renew Clinical Privileges or Membership on the Medical Staff of the Hospital.

**ADMINISTRATIVE DECISION** or **ADMINISTRATIVE ACTION** or **ADMINISTRATIVE RECOMMENDATION** means any decision, action or recommendation by the Medical Staff’s Executive Committee ("MEC") or the Board of Directors of Indiana University Health Jay, Inc. ("Board" or Governing Body"), including, not necessarily limited to restrictions, suspensions, terminations, denials or limitations on Membership and/or Clinical Privileges decisions, that are made or taken without a prior hearing for reasons related to administrative circumstances as set forth in these Bylaws and Related Manuals.

**ADMITTING PRACTITIONER** means members of the Medical Staff with admitting privileges and a Nurse Practitioner who is a member of the Allied Health Staff with admitting privileges.

**ADVERSE DECISION** or **ADVERSE ACTION** or **ADVERSE RECOMMENDATION** means any decision, action or recommendation by the MEC or the Board of Directors of Indiana University Health Jay, Inc. ("Board" or Governing Body"), including decisions, actions, and recommendations approved by the Governing Body following a recommendation by the MEC, that are based on the competence or professional conduct of the affected practitioner and that have the effect of, or would result in, the reduction, restriction, suspension, revocation, denial or failure to renew Clinical Privileges or Membership on the Medical Staff of the Hospital. Actions or recommendations that are not based on the competence or professional conduct of the affected practitioner shall not constitute an "adverse action" or "adverse recommendation" and shall not give rise to any rights to a hearing or appellate review unless otherwise expressly provided for in these Medical Staff Bylaws and Related Manuals. Restrictions, suspensions, terminations, denials, actions, recommendations, or limitations on Membership and/or Clinical Privileges for administrative reasons are not adverse actions.

**ALLIED HEALTH STAFF** means Allied Health Professionals who satisfy the qualifications and conditions for appointment to the Allied Health Staff contained in the Medical Staff Bylaws, this Credentialing Manual, Related Manuals and the Allied Health Care Provider Policy. The Allied Health Staff is not a category of the Medical Staff, but is included in this Credentialing Manual for convenient reference. For ease of use, any reference in this Credentialing Manual or associated policies to “members” shall include Allied Health Staff unless specifically limited to members of the Medical Staff (i.e. Allied Health Care Professionals are not entitled to the hearing and appeals procedures set forth in the Medical Staff’s Corrective Action and Fair Hearing Plan).

**“AHP”** or **ALLIED HEALTH PROFESSIONAL** means any individually licensed or certified health care provider who is not a Physician, who has an independent or dependent scope of practice, and who may qualify to exercise specified Clinical Privileges within the Hospital. Upon the granting of Clinical Privileges, AHPs are not Members of the Medical Staff. The procedural rights afforded to AHPs who have been granted Clinical Privileges are set forth in the Credentialing Manual.

"Independent AHPs" are those individuals who exercise independent medical judgment within the scope of his/her license or certificate and are permitted by the Hospital to provide care, treatment and services without direction or supervision. Independent AHPs must be employed by a Member or the Hospital unless the President and MEC agree that an exception is warranted to fulfill a significant patient need. Independent AHPs may include dentists, podiatrists, optometrists, psychologists, licensed advanced practice nurses, licensed physical, occupational and speech therapists, dieticians, and such other individuals approved by the Board from time to time.

"Dependent AHPs" are those individuals who do not exercise independent medical judgment within the scope of his/her license or certificate and/or are not permitted by the Hospital to provide care, treatment and services without direction or supervision. Only those Dependent AHPs employed by a Member are subject to the following Medical Staff credentialing and privileging process. Hospital employed or contracted Dependent AHPs are subject to the Hospital’s employment policies and the terms of the individual’s employment relationship. Dependent AHPs include licensed physician assistants, licensed practical nurses, surgical assistants or surgical technicians, and such other individuals approved by the Board from time to time.

**APPELLATE REVIEW BODY** means the Board, or a committee appointed by the Board under the Corrective Action and Fair Hearing Plan, that will hear a request for appellate review properly filed and pursued by an Applicant or Practitioner.

**APPLICANT** means any individually licensed or certified health care provider, including Physicians and AHPs, who is applying for Membership on the Medical Staff, Clinical Privileges, or permission to provide health care services as appropriate at the Hospital.

**BOARD** or **GOVERNING BODY** shall mean the Board of Directors of Indiana University Health Jay, Inc., which has the overall responsibility for the conduct and performance of the Hospital

**CLINICAL PRIVILEGES** mean Board-granted privileges, permission, and other circumstances by which Members and AHPs may furnish medical care or other patient care services to patients at the Hospital and to utilize Hospital resources necessary to provide such services.

**CODE OF CONDUCT** means any Board-approved Code of Conduct applicable, in full or in part, to Applicants, Members and/or AHPs.

**CONFLICTED MEDICAL STAFF MEMBER** means a Member who is determined by the Hospital to be an immediate family member of an affected practitioner, is in direct economic competition with an affected practitioner, or is reasonably unavailable to serve on the Hearing Committee or Appellate Review Body.

**DIRECT ECONOMIC COMPETITION** means those situations or circumstances when two individuals share the same Clinical Privileges, or where their medical/health care practices otherwise substantially overlap, such that the individuals compete to provide the same type of services to the same type of patient.

**GOOD STANDING** means being under no form of suspension or restriction of any kind regarding Medical Staff appointment or Clinical Privileges at the Hospital and/or at any other health care facility or organization.

**HOSPITAL** means Indiana University Health Jay, Inc., which is an Indiana nonprofit corporation , whose purpose is to serve as a general hospital providing patient care and in-service education.

**HOSPITAL ADMINISTRATION** means those individuals defined as "Administrative Staff" in the Hospital Bylaws.

**HOSPITAL BYLAWS** shall refer to the Bylaws of Indiana University Health Jay, Inc.

**MEDICAL EXECUTIVE COMMITTEE** or **MEC** means the Executive Committee of the Medical Staff of Indiana University Health Jay, Inc.

**MEDICAL STAFF** means all Physicians who are duly appointed by the Board as Members of the Medical Staff.

**MEDICAL STAFF BYLAWS** or **BYLAWS** shall refer to the Medical Staff Bylaws and Related Manuals of Indiana University Health Jay, Inc., as duly approved by its Medical Staff and Board, and as more fully described in such documents.

**MEMBER** means any Physician who has been duly appointed by the Board as a Member of the Medical Staff.

**MEMBERSHIP** means to have the duly appointed status of being a Member of the Medical Staff of Indiana University Health Jay, Inc.

**NUMBER OF DAYS** or **DAYS** means "calendar days" (i.e. including Saturday, Sunday, and legal holidays) unless the due date falls on a Saturday, Sunday or legal holiday, in which event the due date shall be the first day immediately following which is not a Saturday, Sunday, or legal holiday.

**PARTY** or **PARTIES** means the practitioner(s) who requested the evidentiary hearing or, when applicable, appellate review and the body or bodies upon whose adverse action a hearing or appellate review request is predicated.

**PEER REVIEW COMMITTEE** or **PROFESSIONAL REVIEW BODY** means the Board, the MEC, any committee of the Medical Staff or Board, or their designated personnel and agents having the responsibility for evaluation, recommendation or making a determination concerning qualifications of a professional health care provider (as defined by Indiana Statute), patient care rendered by a professional health care provider, or the merits of a complaint against a professional health care provider. Peer Review Committee or Professional Review Body functions shall include the review of competence and professional conduct of professional health care providers leading to determinations concerning the granting of Clinical Privileges or Medical Staff Membership, the scope and condition of such Clinical Privileges or Membership, and the modification of such Clinical Privileges or Membership.

**PERFORMANCE IMPROVEMENT** refers to activities related to the continuous improvement of patient care, patient safety and the assurance of quality of care in the Hospital and its related activities, and includes such activities when referred to by other terms, such as, but not limited to, quality assurance, quality assessment, continuous quality improvement, and total quality management.

**PERSONNEL OF A PEER REVIEW COMMITTEE** means not only members of a peer review committee, but also all of such Hospital employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves such peer review committee in any capacity, including any person under contract or other formal agreement with the Hospital.

**PHYSICIAN(S)** mean doctors of medicine or osteopathy who are licensed to practice medicine in the State of Indiana, who are subject to the Federal Health Care Quality Improvement Act of 1986, and who are Members of, or Applicants to, the Medical Staff.

**PRESIDENT OF THE MEDICAL STAFF** or **MEDICAL STAFF PRESIDENT** or **CHIEF OF THE MEDICAL STAFF** means the individual duly elected by the Medical Staff to serve as the primary elected Medical Staff officer holding the responsibilities and obligations set forth in these Bylaws.

**PRESIDENT** means the individual appointed by the Board to act as President of the Hospital with the delegated responsibility of overall management of the Hospital and its operations.

**PROFESSIONAL REVIEW ACTION** means an action or recommendation of a peer review committee, taken in the course of a professional review activity, based upon a practitioner's competence or professional conduct (which conduct affects or could adversely affect the health or welfare of a patient or patients), and which adversely affects (or may adversely affect) the Clinical Privileges or Membership on the Medical Staff. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence.

**PROFESSIONAL REVIEW ACTIVITY** or **PEER REVIEW ACTIVITY** means any of the functions of a peer review committee including a formal decision of such a committee not to take an action or make a recommendation.

**RELATED MANUALS** means those manuals that are a part of these Medical Staff Bylaws and include a Corrective Action and Fair Hearing Plan, the Medical Staff Credentialing Manual, and the Medical Staff Rules and Regulations.

**SERVICE** or **CLINICAL SERVICE** refers to any one of the various divisions of the Medical Staff organization.

**SPECIAL NOTICE** means written notification sent by certified or registered mail, return receipt requested, sent by Federal Express or other similar organization with verified delivery, and/or personally delivered by hand. All requests, statements and other communications made by Special Notice shall be copied to the Medical Staff President and the President.

Words used in these Bylaws and Related Manuals shall be read interchangeably as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws and Related Manuals.

# **ARTICLE IMEDICAL STAFF CATEGORIES**

The Medical Staff of Indiana University Health Jay, Inc. is comprised of the following categories:

## 1.1 Active Staff

1.1-1 Qualifications

The Active Staff shall consist of those Physicians who meet the qualifications set forth in Article II below, who are actively engaged in the care of patients in the Hospital, and are regularly involved in Medical Staff activities or functions. Members of the Active Staff are required to attend at least fifty percent (50%) of the regularly scheduled meetings of the Medical Staff. Otherwise, determinations of regularity are made in the sole discretion of the MEC.

1.1-2 Responsibilities

Each member of the Active Staff shall:

(a) Assume all the functions and responsibilities of appointment to the Active Staff, including compliance with all requirements and conditions for granted Clinical Privileges, care for unassigned patients, consultation, and teaching assignments.

 (b) Participate in performance improvement and monitoring activities including evaluating Members, as assigned by the Medical Staff President.

1.1-3 Prerogatives

Members of the Active Staff who are in Good Standing shall be entitled to vote, serve on Medical Staff Committees, and hold office without restriction.

## 1.2 Courtesy Staff

1.2-1 Qualifications

The Courtesy Staff shall consist of Physicians who meet the qualifications set forth in Article II below, but who only occasionally admit or co-admit patients to the Hospital, or who act only as consultants. Physicians whose primary practice location is primarily Indiana University Health Jay, Inc. are not eligible for Courtesy Staff. Courtesy Staff Members who admit or co-admit more than twenty-four (24) patients in the Medical Staff year must apply for a transfer to Active Staff Membership. There is no limit on consultations performed by Courtesy Staff Members.

1.2-2 Responsibilities

Except as otherwise provided in these Bylaws, each Member of the Courtesy Staff shall assume all the functions and responsibilities of appointment to the Courtesy Staff, including compliance with all requirements and conditions for granted Clinical Privileges, consultation and teaching assignments, and other responsibilities as assigned by the Medical Staff President within the scope of granted Clinical Privileges.

 1.2-3 Prerogatives

Courtesy Staff are encouraged to attend Medical Staff meetings and participate in educational sessions, but may only serve on Medical Staff committees by appointment of the Medical Staff President. Courtesy Staff may not vote or hold office.

## 1.3 Visiting Staff

1.3-1 Qualifications

Membership on the Visiting Staff may be granted to those Physicians who meet the qualifications set forth in Article II below, but who are faculty visiting from other institutions to conduct medical education or research or who are participants in a residency or fellowship training program approved by the MEC and the Board. Visiting Staff are not eligible for admitting privileges, may not serve as the primary or attending physician, and shall provide professional services only under the supervision of a Member of the Active Medical Staff. All appointments to the Medical Staff as a Member of the Visiting Staff will be for the Board approved duration (i.e. term of written agreement with the Hospital) of the Member’s medical education, research, or training program and will terminate automatically at the end of the Member’s medical education, research, or training program.

1.3-2 Responsibilities

Each Member of the Visiting Staff shall assume those responsibilities required of their medical education, research, or training program.

 1.3-3 Prerogatives

Visiting Staff are encouraged to attend Medical Staff meetings, but may not serve on Medical Staff committees, vote or hold office.

## 1.4 Honorary Staff

1.4-1 Qualifications

Honorary Staff shall consist of Physicians who have retired from an active medical practice and at the time of their retirement were Members in Good Standing of the Active Medical Staff with an outstanding reputation.

Honorary Staff are not required to meet and maintain the qualifications of Section 2.1 herein.

1.4-2 Responsibilities

Each Member of the Honorary Staff shall assume only those responsibilities obtained through special assignment by the Medical Staff President.

 1.4-3 Prerogatives

Honorary Staff may attend Medical Staff meetings and educational programs. Honorary Staff are not required to apply for reappointment. Members appointed to Honorary Staff shall not be eligible for Clinical Privileges, to vote, to hold office or to serve on Medical Staff committees, unless by appointment of the Medical Staff President.

**1.5 Telemedicine Staff**

1.5-1 Qualifications

Any Admitting Practitioner may provide services and care for patients in the Hospital via telemedicine link, subject to appliable Hospital policies and law. The category of Telemedicine Staff is intended for those Physicians who routinely or totally provide health care services via telemedicine link. Telemedicine Staff:

(a) Do not otherwise qualify as Members of the Active Staff, but meet the general qualifications set forth in Section 2.1. If permitted by applicable state and federal law and accreditations requirements, the MEC may make an exception to these general qualifications for an out-of-state Physician if the Physician is appropriately licensed in the State of Indiana and otherwise deemed qualified by the MEC;

(b) Possess appropriate clinical and professional expertise;

(c) Are willing and able to schedule or appropriately respond when requested to render clinical services within their area of competence; and

(d) Demonstrate active participation in the active or similar medical staff category of another hospital or otherwise be eligible for such participation.

1.5-2 Responsibilities

(a) Each Member of the Telemedicine Staff may assume only those responsibilities assigned by the MEC.

1.5-3 Prerogatives

Telemedicine Staff shall be entitled to:

(a) Exercise such Clinical Privileges as are granted pursuant to Article V;

(b) Telemedicine Staff are encouraged to attend Medical Staff meetings, but may not serve on Medical Staff committees, vote or hold office.

1.5-4 Appointment and Reappointment

Telemedicine Applicants for initial appointment or reappointment to the Medical Staff and for Clinical Privileges at the Hospital may apply by submission of the same application or application with equivalent content as specified therein. All determinations regarding equivalent content will be made by the MEC. Applicants seeking appointment to the Medical Staff and who are seeking telemedicine Clinical Privileges may, but need not, be processed pursuant to the complete appointment procedure described in Article II. Alternatively, in the case of Applicants who intend to provide telemedicine services under a written agreement between the Hospital and a distant-site hospital or entity, the MEC may make recommendations to the Board regarding such Applicants in reliance upon the privileging decision of the distant site hospital or entity and in compliance with applicable federal and/or state law and accreditation standards.

## 1.6 Provisional Staff

1.3-1 Qualifications

The Provisional Staff shall consist of Physicians who meet the qualifications set forth Sections 1.1 or 1.2, above, and who immediately prior to their application and appointment were not Members (or were no longer Members) in good standing of this Medical Staff. Provisional Staff status shall not be applicable to applicants to the Visiting, Staff, Telemedicine Staff or Honorary Staff.

 1.3-2 Prerogatives

The Provisional Staff shall be entitled to:

(a) exercise such Clinical Privileges as are granted pursuant to Article V;

(b) to attend Medical Staff meetings and participate in educational sessions, but may only serve on Medical Staff committees by appointment of the Medical Staff President. Provisional Staff may not vote or hold office.

 1.3-3 Observation of Provisional Staff Member/FPPE

Each Provisional Staff Member (as well as current Members of the Medical Staff requesting new or additional Clinical Privileges) shall undergo a period of Focused Professional Practice Evaluation in order evaluate the Member's proficiency in the exercise of Clinical Privileges initially granted. Provisional Staff Members shall also undergo review in order to evaluate the Member's overall eligibility for continued staff Membership and advancement within staff categories. The extent, nature and duration of the period of FPPE shall be determined by the MEC, in consultation with the pertinent Clinical Service Chairperson, in accordance with the Hospital's policy for FPPE.

1.3-4 Action at Conclusion of Provisional Staff Status

 If following the period of FPPE the Member has satisfactorily demonstrated his or her ability to exercise the Clinical Privileges initially granted and otherwise appears qualified for continued Medical Staff Membership, then the Member shall be automatically appointed to the Active or Courtesy Staff, as appropriate, upon recommendation by the MEC, with approval of the Board. In all other cases, the MEC shall determine, following consultation with the pertinent Clinical Service Chairperson, whether the period of FPPE should be extended and/or whether some other action should be considered, as permitted by these Bylaws and Related Manuals.

# **ARTICLE IIINITIAL APPOINTMENT**

## 2.1 Qualifications for Appointment

 2.1-1 Threshold Eligibility Criteria

Appointment to the Medical Staff is a privilege that shall be extended only to professionally competent Physicians who initially and continuously meet the qualifications, standards, and requirements set forth in the Bylaws, this Credentialing Manual, and such other policies as are adopted from time to time by the MEC and the Board. All Physicians practicing medicine in the Hospital, unless granted Clinical Privileges for emergency or temporary purposes, must first be appointed as Members of the Medical Staff. Appointment, if granted by the Board, shall be for a period of not more than two (2) years.

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges or a scope of practice, the Physician must, as applicable:

(a) Possess a current, unlimited license to practice medicine in the State of Indiana, including Drug Enforcement Administration (DEA) registration and Controlled Substance Registration (CSR). Telemedicine Staff, radiologists, pathologists and any other Members that have no occasion to prescribe controlled substances may be exempt, at the discretion of the MEC and Board, from maintaining DEA and CSR registration;

(b) Possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Hospital and to qualify and maintain status as a health care provider under Indiana’s Medical Malpractice Act (I.C. 34-18-et seq.);

(c) Have successfully completed an accredited ACGME/NCFMEA or OGME residency training program in the specialty in which the Applicant seeks Clinical Privileges or in a specialty acceptable to the Medical Staff and Board;

(d) Be board certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties (“ABMS”), the AOA, the American Board of Oral and Maxillofacial Surgery, or the ADA, as applicable. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five (5) years shall be eligible for Medical Staff appointment. However, in order to remain eligible, applicants must achieve board certification in their primary area of practice within five (5) years from the date of completion of their residency or fellowship training;

 (e) Maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification shall be assessed at reappointment;

 (f) Must show evidence to the Medical Staff, through its offices, of earning fifty (50) hours of AMA approved Category I continuing medical education credits during the preceding two (2) years beginning two (2) years past their residency or fellowship training completion; and

(g) Can demonstrate to the satisfaction of the MEC the necessary:

1) Background, education, experience, training, and demonstrated competence;

2) Adherence to the ethics of their profession;

3) Good reputation and character, including the Applicant's physical, mental and emotional health (including evidence of immunity to Rubella and be free of active TB as evidenced by such tests as may be required by the Hospital from time to time;

4) Have never been convicted of a felony, with the exception of a felony that in the opinion of the MEC and the Board does not adversely affect the Applicant's ability to practice in a safe manner; have not engaged in criminal conduct, or similar occurrences or conduct; and

5) A demonstrated history of consistently acting in a professional, appropriate, harmonious, and collegial manner with others, all of which with sufficient adequacy to assure the Medical Staff that any patient treated by the Applicant in the Hospital will be provided quality medical care and that the Hospital and Medical Staff will be able to operate in an orderly and effective manner.

## 2.2 Waiver of Threshold Eligibility Criteria

Waivers of threshold eligibility criteria shall not be granted routinely. No one is entitled to a waiver. An application from an applicant who does not meet the threshold criteria for appointment, reappointment, clinical privileges, or scope of practice shall not be processed unless the Governing Body has granted the requested waiver. A request for a waiver shall only be considered if the applicant provides information sufficient to demonstrate that his or her qualifications are equivalent to, or exceed, the criterion in question and that there are exceptional circumstances that warrant a waiver. The Governing Body’s determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a “denial” of appointment, reappointment, clinical privileges, or scope of practice and the applicant who requested the waiver is not entitled to a hearing.

## 2.3 No Entitlement to Appointment

2.3-1 No individual shall be entitled to appointment to the Medical Staff or the exercise of specified Clinical Privileges in the Hospital merely by virtue of the fact that such individual:

(a) Is licensed to practice a profession in Indiana or any other state;

(b) Is a member of any particular professional organization;

(c) Has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility; or

(d) Resides in the geographic service area of the Hospital as defined by the Board.

## 2.4 Non-Discrimination Policy

No individual shall be denied Medical Staff Membership or Clinical Privileges on the basis of sex, race, creed, religion, color, national origin, handicap, or on the basis of any criteria unrelated to the delivery of quality patient care , professional qualifications, or the Hospital's purposes, needs and capabilities, and others qualifications provided for in the Bylaws or this Credentialing Manual.

## 2.5 Conditions of Appointment

 2.5-1 Duties of Members

Appointment to the Medical Staff requires each Member to assume such reasonable duties and responsibilities as the Medical Staff or the Board shall require, whether provided for in the Bylaws or by Medical Staff policy.

 2.5-2 Code of Conduct

All Members of the Medical Staff agree to abide by the Code of Conduct approved by the Board and as may be amended from time to time by the Board in its sole discretion. All Members are expected to relate in a positive and professional manner to other health care professionals within the Hospital, and to cooperate and work collegially with Medical Staff leadership and Hospital Administration, management, Hospital employees, volunteers and contract staff and Medical Staff’s generally recognized ethical principles applicable to the Applicant's or Member's profession.

# **ARTICLE III APPLICATION PROCESS**

## 3.1 Information

3.1-1 Applications for appointment to the Medical Staff shall be in writing and submitted on paper or electronically on forms approved by the President on behalf of the Board upon recommendation of the MEC.

3.1-2 The application shall contain a request for specific Clinical Privileges desired by the Applicant and shall require detailed information concerning the Applicant's professional qualifications and experience including:

(a) The names and complete addresses of at least two (2) Physicians who have had recent extensive experience in observing and working with the Applicant, and who can provide adequate information pertaining to the Applicant's present professional competence and character. These references may not be from individuals associated or about to be associated with the Applicant in professional practice or personally related to the Applicant. At least one (1) reference shall be from the same specialty area as the Applicant;

(b) The names and complete addresses of the chairpersons of each department of all hospitals or other health care institutions at which the Applicant has worked or trained (*i.e*., the individuals who served as chief or chairperson at the time the Applicant worked in the particular department);

(c) Information as to whether the Applicant's medical staff appointment or Clinical Privileges have ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced or not renewed at any other hospital or health care facility;

(d) Information as to whether the Applicant has ever voluntarily or involuntarily withdrawn his/her application for appointment, reappointment, and Clinical Privileges, or resigned from the medical staff or from employment before final decision by a hospital's or health care facility's governing board;

(e) Information as to whether the Applicant's license to practice any profession in any state, or Drug Enforcement Administration/Controlled Substance Registration license is or has ever been suspended, modified, terminated, restricted or is currently being challenged. Each application shall include a list or copy and verification of all the Applicant's current licenses to practice, as well as copies of DEA, CSR, medical school diploma, and certificates from all post graduate training programs completed;

(f) Information as to whether the Applicant has currently in force professional liability insurance coverage that covers the Clinical Privileges the Applicant or member seeks to exercise at the Hospital. The Applicant must meet participation requirements and qualified health care provider status of the Indiana Medical Malpractice Act;

(g) A consent to the release of information from the Applicant's present and past professional liability insurance carriers;

(h) Information concerning the Applicant's professional litigation experience, specifically information concerning pending claims, final judgments or settlements: (i) the substance of the allegations, (ii) the findings, (iii) the ultimate disposition, and (iv) any additional information concerning such proceedings or actions as the MEC or the Board may deem appropriate;

(i) Information concerning any professional misconduct proceedings and any malpractice actions involving the Applicant in Indiana or any other state, whether such proceedings are closed or still pending;

(j) Information concerning the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid, any other government sponsored health care program, or any private or public medical insurance program, and information as to whether the Applicant is currently under investigation;

(k) Current information regarding the Applicant's physical, mental and emotional health to the extent this may bear on patient safety and the quality of care provided;

(l) Information as to whether the Applicant has ever been convicted of, plead guilty or no contest, or whether charges are pending with regard to a violation of a federal, state, or local law relating to the use, manufacturing, distribution, or dispensing of controlled substances, or any offense, misdemeanor, or felony in any state with details about any such instance;

(m) A complete chronological listing of the Applicant's professional and educational appointments, employment, or positions;

(n) Information confirming United States citizenship and/or visa status of the Applicant;

(o) A signed Authorization for Release of Information and Signature Attestation document;

(p) A signed Physician Notification Statement document;

(q) The Applicant's signature; and

(r) Such other information as the Board or MEC may require.

3.1-3 The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as a criterion for appointment, reappointment, and the granting of Clinical Privileges. However, the mere presence of verdicts, settlements or claims shall not, in and of themselves, be sufficient to deny appointment or particular Clinical Privileges. The evaluation shall consider the extent to which verdicts, settlements, or claims evidence a pattern of care that raises questions concerning the individual's clinical competence, or whether a verdict, settlement, or claim in and of itself, represents such deviation from standard medical practice as to raise overall questions regarding the Applicant's clinical competence, skill in the particular clinical privilege or general behavior.

## 3.2 Basic Responsibilities of Applicants and Members

3.2-1 The following basic responsibilities and representations shall be applicable to every Applicant for appointment and Member for reappointment as a condition of consideration for their application and as a condition of continued Membership if granted:

(a) An obligation to provide appropriate continuous care and supervision to all patients within the Hospital for whom the individual has responsibility;

(b) An agreement to abide by all Hospital policies, including the Hospital Bylaws and Medical Staff Bylaws and Related Manuals;

(c) An agreement to accept Medical Staff committee assignments and such other reasonable duties and responsibilities as shall be assigned;

(d) An agreement to provide to the Hospital, with or without request, and, as it occurs, new or updated information that is pertinent to any question on the application form;

(e) An agreement to undergo, at the expense of the Applicant or Member (as applicable) any mental and/or physical examination requested by the Medical Executive Committee, Board or other authorized committee that is requested to ensure an Applicant’s fitness to practice.

(f) A statement that the Applicant or Member has received or otherwise had an opportunity to review a copy of the Medical Staff Bylaws and Related Manuals, and that the Applicant and Member has agreed to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether appointment to the Medical Staff and/or Clinical Privileges are granted;

(g) A statement of the Applicant's and Member’s willingness to appear for personal interviews about the application;

(h) A statement that any misrepresentation, misstatement, or omission from the application, whether intentional or not, shall constitute cause for automatic and immediate rejection of the application on administrative grounds;

(i) An obligation to use the Hospital and its facilities sufficiently to allow the Hospital, through assessment by appropriate Medical Staff committees to evaluate in a continuing manner the current competence of the Applicant and Member;

(j) An agreement that the hearing and appeal procedures set forth in the Corrective Action and Fair Hearing Plan shall be the sole and exclusive remedy with respect to any professional review action taken at this Hospital;

(k) An agreement to abide by all emergency service call policies of the Hospital and Medical Staff, including the Bylaws and Related Manuals, and such other reasonable duties and responsibilities as assigned. This agreement includes an acknowledgement that a failure to abide by such policies is subject to enforcement and/or disciplinary action under the Corrective Action and Fair Hearing Plan; and

(l) Agreement to abide by the Code of Conduct as approved by the Board and as may be amended from time to time by the Board in its sole discretion.

3.2-2 The following requirements shall be applicable to every Applicant and Member as a condition of consideration of their application, and as a condition of continued Membership, if granted:

(a) To refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(b) To refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

(c) To refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

(d) To seek consultation whenever medically appropriate or necessary;

(e) To promptly notify the President or his/her designee of any change in eligibility with third-party payers or for participation in governmental health care programs, including Medicare and Medicaid, and any sanctions imposed or recommended by the U.S. Department of Health and Human Services, and/or the receipt of a professional review organization citation and/or quality denial letter concerning alleged quality problems in patient care;

(f) To abide by the Board’s Code of Conduct and Medical Staff’s generally recognized ethical principles applicable to the Applicant's or Member's profession;

(g) To participate in the monitoring and evaluation activities of the Medical Staff;

(h) To complete in a timely manner the medical and other required records for all patients as required by the Medical Staff Bylaws and Related Manuals, and other applicable policies of the Hospital;

(i) To work cooperatively with Members, AHPs, nursing staff and other Hospital personnel so as not to adversely affect patient care and disrupt Hospital and Medical Staff operations;

(j) To promptly pay any applicable Medical Staff dues and assessments;

(k) To authorize the release of all information necessary for an evaluation of the individual's qualifications for initial or continued appointment, reappointment, and/or Clinical Privileges;

(l) To agree to hold harmless and release the Hospital, its officers, directors, the Medical Staff, or anyone acting by or for the Hospital and its Medical Staff for any matter relating to the application for appointment, reappointment or Clinical Privileges, or relating to the evaluation of the Applicant's or Member’s qualifications on any matter related to appointment, reappointment or Clinical Privileges; and

(m) To extend to and recognize immunity for the Hospital, its Medical Staff, and all individuals acting by or for the Hospital and/or its Medical Staff for all matters relating to professional review actions, including appointment, reappointment, and assessment for Clinical Privileges or the Applicant's or Member’s qualifications for the same, to the fullest extent as provided for under federal and state law

3.2-3 Each Applicant and Member expressly agrees to these foregoing responsibilities and requirements as conditions of appointment and continuing Membership.

## 3.3 Burden of Providing Information

3.3-1 The Applicant or Member shall have the burden of producing adequate information for a proper evaluation of background, competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications to the satisfaction of the MEC and Board.

3.3.2 The Applicant or Member shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.

3.3-3 Until the Applicant or Member has provided all information requested by the MEC and Board, all applications for appointment, reappointment, and Clinical Privileges will be deemed incomplete and will not be processed. If information provided in an application for appointment, reappointment, or privileges changes during the course of review or otherwise during the period of appointment, then the Applicant or Member has the burden to promptly and accurately notify the Medical Staff Office at the Hospital of the change. Any change resulting from a voluntary or involuntary restriction, limitation, suspension or revocation of licensure, certification, or medical staff membership or privileges at any hospital or health care facility must be immediately reported (certainly in less than 48 hours) by the Applicant or Member (after having knowledge of the matter) to both the President and Medical Staff Office.

## 3.4 Authorization to Obtain Information

The following statements and representations shall be included on each application and form a part of this Credentialing Manual. Each is an express condition applicable to all Applicants, Members, and to all others having or seeking Clinical Privileges at the Hospital. By applying for appointment, reappointment or Clinical Privileges, the Applicant and Member expressly accepts these conditions during the processing and consideration of the application, whether appointment or Clinical Privileges are granted. This acceptance also applies during the time of any appointment or reappointment.

3.4-1 Immunity

 By submitting an application for appointment or reappointment and to the fullest extent permitted by applicable federal and state law, and to the fullest extent permitted by applicable federal and state law, each Applicant and Member releases from any and all liability, and recognizes and extends immunity to the Medical Staff and Hospital, their peer review committees, authorized representatives, including directors, officers, staff, Hospital employees, and agents, with respect to any acts, omissions, communications, documents, recommendations or disclosures involving the Applicant or Member and that concern the following:

(a) Applications for appointment, reappointment or Clinical Privileges, including temporary Clinical Privileges;

(b) Evaluations concerning reappointment or changes in Clinical Privileges;

(c) Proceedings for suspension or reduction of Clinical Privileges or for revocation of Medical Staff appointment or any other disciplinary sanction;

(d) Investigative suspensions;

(e) Hearings and appellate reviews;

(f) Medical care evaluations;

(g) Utilization and performance reviews;

(h) Other activities relating to the quality of patient care or professional conduct;

(i) Matters, inquiries, or investigations (whether preliminary or formal) concerning the Applicant's or Member's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and/or

(j) Any other matter that might directly or indirectly relate to the Applicant's or Member's competence, to patient care or to the orderly operation of the Hospital or any other hospital or health care facility.

3.4-2 Authorization to Obtain Information

The Applicant or Member specifically authorizes the Hospital and its authorized representatives to consult or inquire with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, background, ethics, behavior or any other matter reasonably having a bearing on the Applicant's or Member's satisfaction of the criteria for initial and continued appointment to the Medical Staff and Clinical Privileges. This authorization also covers the right to inspect or obtain all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. Applicants and Members also specifically authorize such third parties to release any relevant information to the Medical Staff and Hospital and their authorized representatives upon request.

3.4-3 Authorization to Release Information

All Applicants, Members and AHPs specifically authorize the Medical Staff and Hospital and their authorized representatives to release such information to other hospitals, health care facilities, and their agents, who solicit such information for the purposes of evaluating the Applicant's, Member's or AHP’s professional qualifications pursuant to a request for appointment and/or Clinical Privileges. All Applicants, Members and AHPs agree to execute any written authorization and release that is requested by the Medical Staff or Hospital for the purpose of sharing information as set forth herein.

## 3.5 Procedure for Appointment

 3.5-1 Request for an Application

An Applicant expressing interest in joining the Medical Staff or in possessing Clinical Privileges shall contact the Medical Staff Office to request an application.

 3.5-2 Submission of Application

(a) The application for Medical Staff appointment shall be signed and submitted by the Applicant to the Medical Staff Office. It must be accompanied by payment of such processing fees as shall be determined from time to time by the President. After reviewing an application to determine that all questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with the primary sources, the Medical Staff Office shall transmit the application and all supporting materials to the MEC, as well as the appropriate Clinical Service Chair (if not a member of the MEC).

(b) An application shall be deemed complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information verified, and when it is apparent from such information and documentation that the Applicant meets the threshold qualifications for appointment that are set forth in Article II, Section 2.1-1(a) through (d) of this Credentialing Manual,. The Hospital shall perform primary source verification as required by applicable accreditation, licensure, and other applicable bodies including, but not necessarily limited to, educational background, licensure, National Practitioner Data Bank, board certification status, status with the Office of Inspector General (OIG) as an excluded individual/entity and will obtain a criminal background check.

(c) An application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation process. Any application that continues to be incomplete forty-five (45) days after the Applicant has been notified of the additional information required shall be deemed withdrawn by the Applicant. It is the responsibility of each Applicant to provide a complete application, including adequate responses from references. Incomplete applications will not be processed.

 3.5-3 Medical Executive Committee Procedure

(a) The MEC shall examine the application and evidence of the Applicant's character, professional competence, qualifications, prior behavior and ethical standing 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 satisfied all of the necessary qualifications for appointment and for the Clinical Privileges requested. The MEC shall evaluate the Applicant’s competence, education, training, experience, background and conduct and make inquiries with respect to the same to the Applicant’s past or current section, department and chief(s) of service, residency training director, and others who may have knowledge about such matters. In conducting this evaluation, the MEC shall provide the application and supporting information to the appropriate Clinical Service Chairperson or Chairpersons (whether or not such individuals serve as voting members of the MEC), and shall consider any recommendations or conclusions reached by such Chairperson regarding the Applicant's request for Membership and Clinical Privileges.

(b) As part of the process in making a recommendation, the MEC shall have the right to meet with and/or interview the Applicant to discuss any aspect of the Applicant's application, qualifications or Clinical Privileges requested. The MEC may also consult and utilize the expertise of any other Member of the Medical Staff or an outside consultant, if additional information is required regarding the Applicant's qualifications.

(c) Unless for good cause, no later than sixty (60) days after receipt of the completed application and supporting documentation from the Medical Staff Office, the MEC shall send its recommendation, along with all supporting documentation and the completed application, to the Board of Directors.

(d) All recommendations for appointment must specifically recommend the Clinical Privileges to be granted, which may be qualified by probationary or other conditions or restrictions as deemed appropriate by the MEC (in addition to FPPE). All unfavorable recommendations must state the specific reasons for the unfavorable recommendation.

(e) If the recommendation of the MEC entitles the Applicant to request a hearing pursuant to the Corrective Action and Fair Hearing Plan, the recommendation shall be forwarded to the President who will promptly notify the Applicant of such recommendation by Special Notice as more fully described in the Corrective Action and Fair Hearing Plan. The President shall then hold the application until after the Applicant has exercised or waived the right to a hearing, after which the President shall forward the recommendation of the MEC, together with the completed application and all supporting documentation to the Board for consideration and further action.

3.5-5 Board Procedure

 Unless a fair hearing is requested or for other good cause, the Board shall approve or deny the application not later than sixty (60) days after receiving the MEC's recommendation. During such time, the Board may request further review or input as it deems appropriate before acting upon the application, as necessary.

# **ARTICLE IV REAPPOINTMENT**

## 4.1 Procedure for Reappointment

Unless otherwise specified, all terms, conditions and procedures relating to initial appointment shall apply to reappointment.

 4.1-1 Application

(a) Each Member who is eligible for reappointment to the Medical Staff shall be responsible for completing a reappointment application. The completed reappointment application must be submitted to the Medical Staff Office no later than one-hundred twenty (120) days before expiration of his or her then current term. If the Member should fail to return a completed application in a timely manner that allows for processing and review and approvals as required by these Bylaws and the Board, the Member will be informed by Special Notice that his or her Membership and Clinical Privileges will automatically expire at the end of the Member's current term.

(b) Reappointment, if granted by the Board, shall be for a period of not more than two (2) years with reappointments staggered in a manner as determined by the President. If an application for reappointment is timely submitted, processed and approved by the MEC, however, the Board has not acted on the application prior to the expiration of the Member's current term of appointment, the Member shall be granted Temporary Privileges consistent with the Member's then existing/approved privileges pursuant to the process set forth in this Credentialing Manual and said Temporary Privileges shall continue in effect until such time as the Board acts on the reappointment application, but not longer than the time limits for Temporary Privileges set forth in this Credentialing Manual or the Bylaws.

(c) Members of the Medical Staff who were appointed to the Medical Staff prior to August 1, 2012 and who have maintained continuous, uninterrupted Membership since such date are not required to achieve board certification as otherwise required by Section 2.1-1(d) of the Credentialing Manual.

 4.1-2 Factors to be Considered

(a) Each recommendation concerning reappointment of a Member on the Medical Staff shall be based upon such Member's:

1) Patient contacts or volume at the Hospital during the previous appointment term for purposes of determining competency;

2) Ethical behavior, compliance with the Board’s Code of Conduct, clinical competence and clinical judgment in the treatment of patients;

3) Compliance with the Hospital Bylaws, Medical Staff Bylaws and Related Manuals, and relevant policies;

4) Behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of this Hospital, and general attitude toward patients, the Hospital, and its personnel, including volunteers and contract staff;

5) Use of the Hospital's facilities for patients, taking into consideration the individual's comparative utilization patterns;

6) Current physical, mental, and emotional health;

7) Capacity to treat patients in a satisfactory manner as indicated by the results of the Hospital's performance improvement activities, FPPE, OPPE, or other ongoing professional practice evaluation and reasonable indicators of continuing competency;

8) Current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments, and settlements;

9) Current licensure, including currently pending challenges to any license or registration;

10) Results of the National Practitioner Data Bank query;

11) Voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction or loss of Clinical Privileges at another hospital or other health care facility;

12) Relevant findings from the Hospital's performance improvement activities; and

13) Other reasonable indicators of continuing qualification.

 The Hospital shall perform primary source verification as required by applicable accreditation, licensure, and other applicable bodies including, but not necessarily limited to, licensure, National Practitioner Data Bank, board certification status, status with the Office of Inspector General (OIG) as an excluded individual/entity and will obtain a criminal background check.

(b) To be eligible to apply for renewal of Clinical Privileges, a Member must have performed a sufficient number of procedures, treatments or therapies in the previous appointment term to enable the Clinical Service Chair and MEC to assess the Member's clinical competence. The MEC may recommend renewal of existing Clinical Privileges of a Member where Clinical Privileges may not have been exercised due to the infrequent need by patients.

(c) Consistent with the Hospital's policy for Ongoing Professional Practice Evaluation ("OPPE"), a Member with low volume or no patient care activity at the Hospital will be requested to provide evidence of clinical competency by submitting documentation of activity at a primary facility where the Member holds Clinical Privileges or a current delineation of Clinical Privileges form approved by the primary facility along with an attestation statement from the facility to confirm the Clinical Privileges being requested. Where procedures or patient care activity is performed in private clinics or physician offices, the Member will make medical records available to the Clinical Service Chair, MEC and Board for their respective review, if such records are needed for credentialing at the Hospital.

(d) To the extent a Member is requesting new or additional Clinical Privileges, and such Clinical Privileges are granted, the Member shall undergo a period of Focused Professional Practice Evaluation in accordance with the Hospital's policy for FPPE.

## 4.2 Medical Executive Committee Procedure

 The MEC shall follow the process described in Section 3.5-4 of this Credentialing Manual.

## 4.3 Board Procedure

 The Board shall follow the process described in Section 3.5-5 of this Credentialing Manual.

# **ARTICLE VCLINICAL PRIVILEGES**

## 5.1 Exercise of Clinical Privileges for Physicians

5.1-1 Membership on the Medical Staff does not confer or automatically grant Clinical Privileges or the right to practice medicine at the Hospital.

5.1-2 Each member of the Medical Staff shall be entitled to exercise only those Clinical Privileges specifically granted by the Board.

5.1-3 The granting of Clinical Privileges shall carry with it acceptance of the obligations of such Clinical Privileges, including compliances with the Hospital's processes for OPPE and FPPE, emergency service and other rotational or coverage obligations established by the Board, Hospital Administration, MEC, and the Member’s assigned Service in order to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Labor Act and/or other applicable requirements or standards.

5.1-4 The Clinical Privileges recommended by the MEC to and granted by the Board shall be based upon consideration of the following:

(a) The Applicant's or Member’s education, training, experience, background, demonstrated current competence and judgment, professional conduct, references, utilization patterns, and health status;

(b) The Applicant's or Member’s ability to meet all current criteria for the requested Clinical Privileges;

(c) Availability of qualified Members to provide medical coverage for the Applicant or Member in case of his/her illness or unavailability;

(d) Adequate levels of professional liability insurance coverage (participation in the Indiana Patient Compensation Fund) with respect to the Clinical Privileges requested;

(e) The Hospital's available resources and personnel, including whether the President as a member of the Board has determined that the service related to the Clinical Privileges being requested is appropriate and necessary to be performed at the Hospital;

(f) Any previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration;

(g) Any information concerning professional review actions, voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary relinquishment limitation, reduction or loss of Clinical Privileges at the Hospital or at another hospital of health care facility; and

(h) Other relevant information, including a written report and findings by the Credentials Committee or designee and the findings of any focused professional practice evaluation or similar evaluation.

5.1-5 The Applicant or Member shall have the burden of establishing qualifications for and competence to exercise the Clinical Privileges requested. All grants of Clinical Privileges by the Board shall be subject to Focused Professional Practice Evaluation in accordance with the Hospital's policy for FPPE.

## 5.2 Telemedicine Clinical Privileges

5.2-1 If the Hospital has a clinical need for telemedicine services, including telehealth consultations, and a Physician or Allied Health Professional can supply such services via a telemedicine link, the Hospital may evaluate the use of telemedicine clinical privileges for such providers as addressed in Paragraph 5.2-2, below. In such cases, the Physician or Allied Health Professional must be credentialed and privileged to provide telemedicine services in accordance with Hospital standards and procedures applicable to the approved telemedicine services; provided, however, while Allied Health Professionals may be granted Clinical Privileges for telemedicine services, Allied Health Professionals will not be permitted to enter orders (e.g. medication, testing) for patients receiving telemedicine services. The MEC recommends those clinical services that may be appropriately delivered through telemedicine services and such services must be consistent with commonly accepted quality standards.

5.2-2 Clinical Privileges may be granted for providing telemedicine services as described in this Section. The period of time shall be for a duration determined by the Medical Staff and not to exceed two (2) years, unless otherwise renewed. In order to reliably assess the quality and performance of a telemedicine practice, a Physician or Allied Health Professional who has been granted Clinical Privileges to provide telemedicine services must provide such telemedicine services at a sufficient volume and repetition to maintain such Clinical Privileges. If a Physician or Allied Health Professional who has been granted Clinical Privileges to provide telemedicine services at the Hospital fails to utilize such Clinical Privileges or otherwise provide telemedicine services to Hospital patients at a satisfactory volume as determined by the MEC, such Clinical Privileges shall administratively cease following the date such Physician or Allied Health Professional, as applicable, is notified by the MEC. The administrative expiration or cessation of such Clinical Privileges for telemedicine services does not give rise to the hearing rights referenced in the Corrective Action and Fair Hearing Manual.

5.2-3 Any Admitting Practitioner may provide services and care for patients in the Hospital via telemedicine link, subject to applicable Hospital policies and law, and shall not be required to request nor be granted telemedicine services Clinical Privileges, which is intended for providers who routinely or totally provide health care services via telemedicine link.

## 5.3 Temporary Clinical Privileges

 5.3-1 Temporary Clinical Privileges

(a) Temporary Clinical Privileges are not routinely granted to Applicants or Members. Temporary Clinical Privileges may be granted to Physicians and AHPs after receiving a recommendation by the Chief of Service. Such Temporary Privileges shall then be granted by the President or his/her designee, in the following four (4) circumstances:

 1) To fulfill an important patient care need;

2) When an Applicant, including AHP Applicants, with a complete clean application for Membership and/or Clinical Privileges is awaiting review and approval by the Board, and the recommendation for approval of the Applicant's application by the MEC has been issued;

3) To address locum tenens needs;

4) For emergency or disaster reasons as set forth in Section 5.4.

5.3-2 Important Patient Care Need

 Whenever a patient is in need of the particular skills or experience of a particular Physician or AHP, Temporary Clinical Privileges may be granted for a limited period of time, not to exceed one hundred twenty (120) days on a case by case basis upon the recommendation of the appropriate Clinical Service Chair or designee, Medical Staff President or designee, and approval of the President. Prior to review and recommendation, the Applicant or Member must:

1) Submit a complete application;

2) Have no pending or previous denial, restriction, or limitation to Indiana licensure or certification;

3) Have not been subject to involuntary termination of medical staff, Membership at the Hospital or at another hospital or health care organization;

4) Have not been subject to involuntary limitation, reduction, denial or loss of Clinical Privileges; and

5) Submit a specific statement of the reason for requesting Temporary Clinical Privileges.

 The following information must be verified prior to the granting of Temporary Clinical Privileges:

1) Current unlimited professional licensure;

2) Relevant training and experience;

3)Current professional liability/malpractice insurance coverage and qualified health care provider status under the Indiana Medical Malpractice Act;

4) Current, unrestricted DEA/CSR registration, if applicable;

5) Ability to perform Clinical Privileges requested;

6) Results of the National Practitioner Data Bank query;

7) Verification of clear history from the Office of the Inspector General pursuant to Medicare/Medicaid sanction or reinstatement; and

8) At minimum, one reference from a previous hospital.

5.3-4 Locum Tenens

 Temporary Clinical Privileges may be granted to Applicants seeking to provide patient care on a locum tenens basis, not to exceed one hundred twenty (120) days upon the recommendation of the applicable Clinical Service Chair or designee, Medical Staff President or designee, and the President. Prior to review and recommendation, the Applicant must:

1) Submit a complete application;

2) Have no pending or previous denial, restriction, or limitation to Indiana licensure or certification;

3) Have not been subject to involuntary termination of medical staff, Membership at the Hospital or at another hospital or health care organization;

4) Have not been subject to involuntary limitation, reduction, denial or loss of Clinical Privileges; and

5) Submit a specific statement of the reason for requesting temporary Clinical Privileges, if appropriate.

 The following information must be verified prior to the granting of Temporary Clinical Privileges:

1) Current unlimited professional licensure;

2) Relevant training and experience;

3)Current professional liability/malpractice insurance coverage and qualified health care provider status under the Indiana Medical malpractice Act;

4) Current, unrestricted DEA/CSR registration, if applicable;

5) Ability to perform Clinical Privileges requested;

6) Results of the National Practitioner Data Bank query;

7) Verification of clear history from the Office of the Inspector General pursuant to Medicare/Medicaid sanction or reinstatement; and

8) At minimum, one reference from a previous hospital.

 5.3-5 Special Requirements

Special requirements of supervision and reporting may be imposed by the Medical Staff President, in consultations with the appropriate Clinical Service Chair, on any individual granted Temporary Clinical Privileges. Temporary Clinical Privileges shall be immediately terminated by the President or his/her designee upon notice of any failure by the individual to comply with such special conditions.

 5.3-6 Termination of Temporary Clinical Privileges

(a) The President may, at any time after consulting with the Medical Staff President, and the Clinical Service Chair, terminate Temporary Clinical Privileges. In taking such action, the President, the Medical Staff President, and the Clinical Service Chair shall be acting as a peer review committee. In addition, the MEC may take action to revoke Temporary Privileges. If the Applicant has inpatients in the Hospital at the time Temporary Clinical Privileges are terminated, the Medical Staff President or his/her designee will assign the inpatients to another Member of the Medical Staff, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

(b) The granting of any Temporary Clinical Privileges is a courtesy on the part of the Hospital and any or all may be terminated if a clinical question or concern has been raised. Neither the granting, denial nor termination of such Clinical Privileges shall entitle the individual concerned to any of the procedural rights provided in the Corrective Action and Fair Hearing Manual.

(c) Temporary Clinical Privileges shall be automatically terminated at such time as the MEC recommends not appointing the Applicant or AHP to the Medical Staff or otherwise recommends a denial of requested Clinical Privileges.

(d) Temporary Clinical Privileges shall be automatically modified to conform to the recommendation of the MEC that the Applicant or AHP be granted Clinical Privileges different from those Temporary Clinical Privileges granted by the President.

## 5.4 Emergency/Disaster Clinical Privileges

5.4-1 Scope

(a) In a declared emergency or disaster (together referred to as “emergency”), non-member of the Medical Staff or allied health professional who has not been granted Clinical Privileges by the Board; but, who is a duly licensed or certified practitioner may be granted certain Emergency Clinical Privileges by the President to the extent permitted by the duly licensed or certified practitioner’s license or certification. Any such privileges shall be considered as Temporary Privileges and be granted pursuant to the process set forth in this Credentialing Manual. To the extent possible, and within the time constraints of the emergency, primary source verification shall be obtained from the practitioner's hospital. However, the failure to obtain primary source verification shall not delay the granting of Temporary Privileges in a declared emergency when all necessary medical personnel are required to address the emergency.

(b) When the emergency situation no longer exists, patients will be assigned by the Medical Staff President to Members with appropriate Clinical Privileges. The wishes of a patient will be considered in the selection of a substitute.

(c) Emergency Clinical Privileges may be exercised at any Hospital facility or any temporary facility for which the Hospital has staffing responsibility under a formal or informal arrangement.

5.4-2 Declared Emergency

Emergency Clinical Privileges may be granted in the event of a declared emergency under a formal or informal arrangement in which the Hospital is a participant or as otherwise determined by the President. Upon the declaration of such an emergency, the President or designee may grant Emergency Clinical Privileges to any Physician or AHP who is a member in good standing of the medical staff or has Clinical Privileges at any hospital that is a participant in the Hospital’s formal or informal arrangement (a participating hospital) or at any other hospital or health care facility determined to be acceptable by the President or designee.

5.4-3 Procedure

(a) In order to be granted Emergency Clinical Privileges, individuals must present (1) a current professional license to practice in the State of Indiana, and (2) a hospital photo identification or other photo identification in the event the practitioner's home hospital does not issue photo identifications. Practitioners with Emergency Clinical Privileges shall use reasonable judgment in determining the type of patient care to provide during the emergency, but may provide any type of care necessary as a life-saving measure or to prevent serious harm, as long as the care provided is within the scope of the individual's licensure and practice.

(b) To the extent permitted under the circumstances of the emergency, the Medical Staff Office will attempt to verify the credentials of any practitioner granted Emergency Clinical Privileges by contacting the practitioner's hospital of record. Emergency Clinical Privileges shall terminate immediately when the emergency is declared over by an authorized public official and the President.

(c) Emergency Clinical Privileges may also be immediately terminated, with or without cause, by the President, Medical Staff President or designee of any of the above. Notwithstanding any other provision of the Hospital Bylaws and Medical Staff Bylaws and Related Manuals, any such termination shall not give rise to the hearing or appeal rights set forth in the Corrective Action and Fair Hearing Plan.

## 5.5 Procedure for Requesting Additional Clinical Privileges

 5.5-1 Application for Additional Clinical Privileges

Whenever, during the term of Membership, additional Clinical Privileges are desired, the Member requesting additional Clinical Privileges shall apply in writing to the Clinical Service Chair. The Member shall state in detail the specific additional Clinical Privileges desired and the individual's relevant recent training and experience which justify the additional Clinical Privileges. Thereafter, the Member’s request shall be processed in the same manner as an application for initial Clinical Privileges as set forth in this Credentialing Manual.

 5.5-2 Factors to be Considered

(a) In the discretion of the MEC, upon consultation with the appropriate Clinical Service Chairperson, recommendations for additional Clinical Privileges may be based upon:

1) Relevant recent training;

2) Observation of patient care provided;

3) Review of the records of patients treated in the Hospital or at other health care facilities;

4) Findings or results of FPPE, OPPE, and Hospital's Quality Assurance and/or Performance Improvement activities;

5) Member's ability to meet the qualifications and criteria for the Clinical Privileges requested;

6) Other reasonable indicators of the individual's continuing qualifications for the privileges in question; and

 7) The statements from relevant specialty societies.

(b) The recommendation for additional Clinical Privileges may carry with it such requirements for supervision or consultation, or other conditions, for such periods of time as are thought necessary. All such new or additional Clinical Privileges shall also be subject to Focused Professional Practice Evaluation in accordance with the Hospital's policy for FPPE.

(c) The Hospital's available resources and personnel, including whether the President (as a member of the Board) has determined that the service related to the Clinical Privileges being requested is appropriate and necessary to be performed at the Hospital.

**5.6 Responsibility for Maintenance of Credential File**

5.6-1 Current Copies of All Documents

In order to facilitate the Hospital obtaining primary source verification, all Members and AHPs are responsible for providing current copies of supporting documents to the Medical Staff Office, upon request, to be placed in their respective credentials file. These documents include but are not limited to the following critical items:

(1) An Indiana license to practice medicine or practice allied health as appropriate;

(2) Indiana CSR license;

(3) Federal DEA certificate; and

(4) Proof of status as a qualified health care provider under the Indiana Medical Malpractice Act and insurance coverage.

5.6-2 Automatic Suspension of Clinical Privileges-Critical Expirable Items

Failure to provide current information by the expiration date for any of the critical items listed in Section 5.6-1 above will result in automatic suspension of Clinical Privileges. Reinstatement will be automatic once the information is supplied and verified by the Medical Staff Office. Should the Member or AHP fail to provide the information within thirty (30) days from the effective date of the suspension, a letter will be sent to the Member or AHP notifying Member or AHP his/her lack of response is considered a voluntary resignation of Medical Staff Membership and privileges and that he/she must reapply as a new Applicant in the future.

5.6-3 Missing Current Documents for Non-Critical Expirable Items

The Member or AHP will be sent a letter notifying him/her that he/she has thirty (30) days to provide missing documentation. Should the Member or AHP fail to provide the information within the thirty (30) day period, a letter will be sent to the Member or AHP notifying Member or AHP his/her lack of response is considered a voluntary resignation of Medical Staff Membership and privileges and that he/she must reapply as a new Applicant in the future.

**5.7 Emergency Service Coverage Obligation**

5.7-1

As a condition of ongoing Membership, Members of the Active Staff agree to provide "on call" coverage services in the Emergency Room within the scope of their granted Clinical Privileges. The on call schedule shall be determined by the MEC, following consultation with the Clinical Service Chairs, and consistent with applicable Hospital policy. The Hospital Board shall have final oversight and authority with respect to issues concerning call coverage in order to ensure compliance will all pertinent State, Federal and Accreditation requirements. A Member's failure to timely and appropriately comply with on call responsibilities may result in corrective action being taken against that Member.

# **ARTICLE VI PRIVILEGES FOR New Procedures and New Technology**

## 6.1 Requests for Clinical Privileges for New Procedures and New Technology

For all requests for Clinical Privileges to perform procedures, utilizing a new device or a new approach for which there are no approved criteria at the Hospital, the Board must determine, following recommendation of the MEC, whether it will grant the Clinical Privileges. The Board will use the following procedure to develop criteria for its consideration whether to grant such requests. Requests for which the Board has approved no specific criteria within a reasonable period of time will be processed using the general criteria of adequate education, training, clinical experience, and references demonstrating current clinical competence.

6.1-1 Procedure for Developing Privilege Criteria

Whenever a request for Clinical Privileges arises for which there is no policy or current review criteria, the MEC will follow these steps to coordinate the development of a policy and applicable criteria upon approval of the President that the Hospital has analyzed the financial impact on the Hospital and will provide the necessary equipment, supplies, and other support for the requested Clinical Privileges:

(a) If the issue pertains to the use of new technology, a new treatment protocol, a new device or new approach, the burden is initially on the requesting Member to provide information about the device, technology or protocol. The requesting Member must provide a comprehensive briefing concerning the new technique or procedure that should include the following information concerning the development of the new technology:

1) The name of other hospitals in which it is used

2) Any evidence-based medicine demonstrating the risks and benefits of this technology;

3) Any product literature or education syllabus addressing the technology;

4) The names of any residency training directors responsible for providing training in this area; and,

5) Information regarding cost/benefit and reimbursement data, if available.

(b) Use of a non-FDA approved device should receive Institutional Review Board (IRB) review and recommendation.

(c) The MEC will review the request and will determine if the procedure or equipment should be permitted within the Hospital. When making this determination, the MEC should discuss the Hospital's current plan of care, whether or not the new technology/procedure is of proven clinical efficacy and effectiveness, if the new procedure/technology carries a greater risk than existing conventional treatment.

(d) The MEC shall complete its review within a reasonable period of time concerning the specific issue:

1) The type of basic education and, if necessary, continuing education required to exercise the privileges safely and effectively; and

2) The number of years of formal training, and in what field(s) (and, if applicable, continuing training-either didactic or hands-on).

6.1-2 The recommendations of the specialty (ties)/task force, if one is formed by the Medical Staff President, will be reviewed by the MEC. If there is general agreement concerning the proposed privileging criteria the MEC will determine if the criteria are acceptable. If the advising committee has been unable to agree on the amount of education, training or experience necessary, the MEC will draft proposed criteria. Such criteria will be submitted to the involved specialty(ies) with a request that each review and comment on the proposed criteria. Following review, the MEC will make a recommendation to the Board.

# **ARTICLE VII PROCEDURE FOR LEAVE OF ABSENCE**

## 7.1 Requests for Leave of Absence

Members may request a leave of absence by submitting a written request to the Medical Staff President. The request must state the beginning and ending dates of the leave, which shall not exceed one (1) year, and the reason(s) for the leave, such as military duty, additional training, family matters or personal health condition. Absence from the Medical Staff and patient care responsibilities for longer than sixty (60) days shall require a Member to submit a written request for a leave of absence.

## 7.2 Procedure for Review of Requests for Leave of Absence

The Board delegates to the President the authority to make determinations in connection with requests for leaves of absence, provided that the Board reserves the right to make final determinations, in its discretion. In determining whether to grant a request, the President shall consult with Medical Staff President and the appropriate Clinical Service Chair and use his or her best efforts to make a determination within thirty (30) days of the receipt of the written request based on reason(s) for request and any clarifying information requested from the Member.

## 7.3 Requests for Reinstatement

No later than thirty (30) days prior to the conclusion of the leave of absence, the Member may request reinstatement by providing the Medical Staff President a written summary of professional activities during the leave of absence. The Medical Staff President shall refer the matter to the appropriate Clinical Service Chair and MEC for a recommendation. The individual bears the burden of providing information and documentation sufficient to demonstrate current competence and all other applicable qualifications. The Member shall provide any information requested by the President, the Clinical Service Chair or the MEC, including the execution of any releases that may be necessary to cause and permit third parties, including the Member's physician, to respond to any requests by President or MEC for additional information or clarification.

7.3-1 Report of Member's Physician

If the leave of absence was for health reasons, the request of reinstatement must be accompanied by a report from the Member's physician indicating that the Member is physically and/or mentally capable of resuming a Hospital practice and safely executing the Clinical Privileges requested.

7.3-2 Approval by the President

The President, after considering the recommendations of the Clinical Service Chair and MEC, may approve reinstatement to either the same or a different Medical Staff category and may limit or modify the Clinical Privileges to be extended to the Member upon reinstatement or impose conditions for the Member's practice deemed reasonably necessary for patient safety or the effective operation of the Hospital.

## 7.4 Absence for Longer than One (1) Year

Absence for longer than one (1) year shall result in automatic relinquishment of Medical Staff appointment and Clinical Privileges unless an extension is requested in writing at least thirty (30) days prior to the end of the leave and granted by the President. Extensions will be considered only in extraordinary cases of hardship and when extension of a leave is found to be in the best interest of the Hospital. Under no circumstances will a leave of absence exceed any single term of appointment to the Medical Staff.

## 7.5 No Entitlement to Leaves of Absence or Reinstatement

Leaves of absence and reinstatement are matters of courtesy, not of right. In the event that it is determined that a Member has not demonstrated good cause for a leave of absence or where a request for extension is not granted, the determination shall be final, and shall not entitle Member to any hearing or appeal rights set forth in the Corrective Action and Fair Hearing Manual.

## 7.6 Reappointment Requirement

If leave of absence period encompasses the required date for reappointment, Member will be required to complete the reappointment process prior to returning from a leave of absence and within the required time frame for reappointment.

# **ARTICLE VIII ALLIED HEALTH PROFESSIONALS**

 Allied Health Professionals are those licensed or certified individuals who the Board has determined are eligible to apply for Clinical Privileges consistent with the minimum eligibility and qualification requirements established by the Board, which will include their recognized scope of practice, licensure, certification, education, and demonstrated competency. Only those AHPs who have been granted Clinical Privileges consistent with their scope of practice may practice their medical specialty within the Hospital. All AHPs who are eligible and granted Clinical Privileges will be classified into two (2) categories: Independent or Dependent. Clinical Privileges may be granted to AHPs for a period of time not to exceed two (2) years, unless otherwise renewed as provided for herein. Only a member of the Allied Health Staff who is an Admitting Practitioner may admit patients to the Hospital and consistent with the requirements of the Allied Health Care Provider Policy.

 Allied Health Professionals are not Members of the Medical Staff, and as such, have no prerogatives or responsibilities of Medical Staff Membership.

## 8.1 Categories of Allied Health Professionals

8.1-1 Independent AHPs

"Independent AHPs" are those individuals who exercise independent medical judgment within the scope of his/her license or certificate and are permitted by the Hospital to provide care, treatment and services without direction or supervision. Independent AHPs must be employed by a Member or the Hospital unless the President and MEC agree that an exception is warranted to fulfill a significant patient need. Independent AHPs may include dentists, podiatrists, optometrists, psychologists, licensed advanced practice nurses, licensed physical, occupational and speech therapists, dieticians, and such other individuals approved by the Board from time to time. Licensed Independent AHPs with Clinical Privileges at the Hospital shall be assigned to the appropriate Clinical Service and shall be subject to the Hospital's policies for OPPE and FPPE.

8.1-2 Dependent AHPs

"Dependent AHPs" are those individuals who do not exercise independent medical judgment within the scope of his/her license or certificate and/or are not permitted by the Hospital to provide care, treatment and services without direction or supervision. Only those Dependent AHPs employed by a Member are subject to the following Medical Staff credentialing and privileging process. Hospital employed or contracted Dependent AHPs are subject to the Hospital’s employment policies and the terms of the individual’s employment relationship. Dependent AHPs include licensed physician assistants, licensed practical nurses, surgical assistants or surgical technicians, and such other individuals approved by the Board from time to time.

## 8.2 Eligibility

 8.2-1 General Qualifications of AHP Applicants

All AHPs who apply for Clinical Privileges at the Hospital, either as an Independent or Dependent AHP, shall:

(a) Be currently licensed and/or certified to practice his or her profession, as applicable;

(b) Maintain a current collaborative or supervision agreement with a Member and/or be employed by the Hospital, as applicable;

(c) Be covered by current, valid professional liability insurance coverage in such form and amounts satisfactory to the Hospital;

(d) Have never been convicted of a felony, with the exception of a felony that in the opinion of the MEC and the Board does not adversely affect the AHP's ability to practice in a safe manner; have not engaged in criminal conduct, or similar occurrences or conduct;

(e) If the AHP is a former Hospital employee, the AHP must have an employment record free of disciplinary or corrective action; and

(f) Be able to demonstrate to the satisfaction of the Board, Hospital, and Medical Staff, his/her:

1) Background, education, relevant training, experience, and current demonstrated clinical competence:

2) Adherence to the ethics of his or her profession;

3) Good character and reputation;

4) Ability to perform the clinical functions and activities requested;

5) Ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by the individual will receive quality care and the Hospital will be able to operate in an orderly manner;

6) Immunity to Rubella and be free of active TB as evidenced by such tests as may be required by the Hospital from time to time; and

7) Current PPD/TB test records.

8.2-2 Additional Requirements/Restrictions for Particular AHPs

 (a) Independent AHP Collaboration Supervision

 1) Licensed advanced practice nurses may exercise independent medical judgment within the scope of his/her license or certificate with a proper collaboration agreement in place with a Member.

 2) Hospitalist nurse practitioners, if any, may exercise independent medical judgment within the scope of his/her license or certificate with a proper collaboration agreement, which requires stringent oversight by physician hospitalists for inpatients, in place with the Hospital’s employed physician hospitalists.

(b) Dependent AHP Supervision by Employing or Supervising Member

1) Dependent AHPs may exercise Clinical Privileges only under the direct supervision of their employing or supervising Member. Except as permitted by law or Board-approved policy, "direct supervision" shall not require the actual physical presence of the employing or supervising Member.

2) Dependent AHPs may only exercise Clinical Privileges on the condition that they remain employees of, or are directly supervised by the designated collaborative or supervising Member of the Medical Staff.

(c) Revocation or Termination of Collaborative/Supervising Member's Membership/Clinical Privileges

1) If the Membership or Clinical Privileges of the employing or collaborative/supervising Member is revoked or terminated, for any reason, the Independent and Dependent AHP's Clinical Privileges shall automatically terminate.

2) If an AHP’s employment with the Hospital terminates for any reason, the Independent and Dependent AHP’s Clinical Privileges shall automatically terminate.

(d) Responsibilities of Employing or Collaborative/Supervising Member

1) The number of Dependent AHPs acting as employees of or under the collaborative/supervision of one (1) Member, as well as the acts the AHP(s) may undertake, shall be consistent with applicable Indiana law, the Medical Staff policies or applicable policies of the Board.

2) It shall be the responsibility of the Hospital or Member employing the AHP to provide or to arrange for professional liability insurance in amounts required by the Board that covers any activities of the Dependent AHP at the Hospital and to furnish evidence of such coverage to the Hospital. The Dependent AHP shall exercise Clinical Privileges only while such coverage is in effect.

8.2-3 Assumption of Duties and Responsibilities

All AHPs shall assume such reasonable duties and responsibilities as the MEC or the Board shall require, including:

(a) Provide appropriate continuous and timely care and supervision to all patients in the Hospital for whom the individual has responsibility;

(b) Abide by all applicable provisions of the Hospital Bylaws, Medical Staff Bylaws and Related Manuals as shall be in force during the time the individual is granted permission to practice in the Hospital;

(c) Provide to the Hospital, with or without request, and, as it occurs, new or updated information that is pertinent to any question on the application form;

(d) Appear for personal interviews as requested about the application;

(e) Refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(f) Refrain from assuming responsibility for diagnoses or care of Hospitalized patients for which he or she is not qualified or without adequate supervision;

(g) Refrain from deceiving patients as to his or her status as an AHP;

(h) Seek consultation whenever appropriate or necessary;

(i) Promptly notify the President or a designee of any change in eligibility for payments by third-party payers or for participation in any government healthcare program, including any sanctions imposed or recommended by the federal Department of Health and Human Services, and/or the receipt of quality denial letter concerning alleged quality problems in patient care;

(j) Abide by generally recognized ethical principles applicable to the individual's profession;

(k) Participate in performance improvement monitoring and evaluation activities of the Hospital;

(l) Complete, in a timely manner, the medical and other required records for all patients as required by the Medical Staff Bylaws and Related Manuals and other applicable policies of the Hospital; and,

(m) Participate in applicable continuing education programs.

8.2-4 Code of Conduct

(a) Each AHP agrees to abide by the Code of Conduct approved by the Board and as may be amended from time to time by the Board in its sole discretion.

(b) AHPs who are granted Clinical Privileges are expected to relate in a positive and professional manner to other health care professionals, and to cooperate and work collegially with the Medical Staff leadership, Hospital Administration, Hospital employees, contract staff and volunteers.

(c) Professional conduct shall include, but is not limited to, each AHP's obligation to present himself or herself at the Hospital physically and mentally capable of providing safe and competent care to patients.

## 8.3 Application for Clinical Privileges

8.3-1 No Entitlement to Medical Staff Appointment

(a) AHPs applying for Clinical Privileges shall not be eligible for appointment to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Membership on the Medical Staff.

8.3-2 Hospital-Employed AHPs

(a) Hospital-employed AHPs shall be initially screened and approved by the Hospital's Human Resources Department and appropriate management personnel.

(b) Annual performance reviews and clinical competency evaluations shall be conducted by the Physician Practice Administrator in conjunction with the collaborative/supervising Member who shall ensure the AHP satisfies applicable licensure or certification requirement and continues to demonstrate current clinical competence.

(c) Annual performance reviews and clinical competency evaluations of nurse practitioner hospitalists, if any, shall be conducted by the individual serving as the Medical Director of the Hospitalist Program who shall ensure the AHP satisfies applicable licensure or certification requirement and continues to demonstrate current clinical competence.

(d) Annual performance reviews of other AHPs employed by the Hospital, not referred to above, shall be conducted by the AHP’s supervisor.

8.3-3 AHPs Requesting Clinical Privileges

(a) An application for Clinical Privileges is sent only to those Independent and Dependent AHP types or classes who have been approved by the Board, who meet the general and specific qualifications set forth in this Credentialing Manual and applicable Federal and State law. A list of approved AHP types shall be maintained in the Medical Staff Office for review. Any AHP type not listed may be approved by the Board following a recommendation of the MEC.

(b) Any AHP who requests an application for Clinical Privileges at the Hospital will initially be sent a copy of portion of the Bylaws applicable to AHPs.

 (c) An AHP Applicant will also be sent an application form which requests sufficient evidence that the Applicant meets the general qualifications outlined in this Article and as required by applicable law relating to each Applicant's area of practice.

(d) A completed application form with copies of all required documents must be returned to the Medical Staff Office within thirty (30) days after the Applicant's receipt of the application form if the Applicant desires further consideration.

8.3-4 Information to be Submitted With Applications

(a) For consideration by the MEC, AHP applications require detailed information concerning the Applicant's professional qualifications. This information will include professional references; education; work, licensure, and privileging history; medical malpractice and insurance history; health status, and such other information as deemed appropriate by the MEC and/or Board. Prior to the AHP's application file being sent to the MEC, a criminal background check, primary source verification, an National Practitioner Data Bank query, and a check to ensure the AHP is not on the Medicare/Medicaid exclusion list must be performed.

(b) Any application that does not provide the information requested on the application form will be considered incomplete and will not be considered or processed.

8.3-5 Burden of Providing Information

(a) The Applicant shall have the burden of producing information deemed adequate by the MEC for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.

(b) The Applicant shall have the burden of proving that all the statements made and information given on the application are true and correct.

(c) Any misstatement, omission and/or representation on the application, whether intentional or not, shall constitute cause for immediate cessation of the processing of the application, and no further processing shall occur.

(d) In the event that Clinical Privileges have been granted prior to discovery of such misstatement, misrepresentation or omission, such discovery shall result in automatic relinquishment of all Clinical Privileges, functions and activities, and designation as a Dependent AHP or Independent AHP. In either situation, there will be no entitlement to any grievance, hearing or appeal action.

8.3-6 Release and Immunity

By applying for Clinical Privileges at the Hospital, each Applicant agrees that no individual who is a Member, AHP, agent, or employee of the Hospital, the Medical Staff, Hospital Administration. Officer or Director or Board shall be liable for civil damages as a result of his or her acts, omissions, communications, documents, recommendations, decisions, disclosures or any other conduct of a Peer Review Committee or as a result of their participation on a Peer Review Committee or any other committee whose purpose, directly or indirectly, is performance improvement, quality assurance, credentialing, patient care, utilization review, or such similar purpose for improving patient care within the Hospital or for the purpose of professional discipline.

8.3-7 Non-Discrimination Policy

No individual shall be denied Clinical Privileges at the Hospital based on sex, race, creed, religion, color, national origin, handicap, or on the basis of any criteria unrelated to professional qualifications or to the Hospital's purposes, needs and capabilities.

## 8.4 Credentialing Procedure

8.4-1 Processing of Applications

(a) Completed applications shall be submitted to the Medical Staff Office.

(b) After reviewing the application for completeness and after verifying all references and other information provided in the application with the primary sources, the Medical Staff Office shall transmit the completed application along with all supporting materials to the MEC. The MEC shall evaluate the Applicant's competence, education, training, experience, background and conduct and make inquiries with respect to the same to the Applicant's past or current collaborative/supervising physician, directors and others who may have knowledge about the Applicant's competence, education, training, experience, background, and ability to work with others.

(c) An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied and all information verified.

(d) An application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation.

1) Any application that continues to be incomplete forty-five (45) days after the Applicant has been notified of the additional information required shall be deemed to be withdrawn.

2) It is the responsibility of the Applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

8.4-2 Review by the MEC

(a) The MEC shall evaluate the application and all supporting information to ensure that each application is reviewed consistent with the criteria and standards 8.4-1(b) above.

(b) The MEC may use the expertise of any Member on the Medical Staff or the Hospital or an outside consultant, if additional information is required regarding the Applicant's qualifications.

(c) In evaluating the application, the MEC may also meet with the Applicant and, when applicable, the collaborative/supervising Member or employer.

(d) Favorable Recommendations

1) If the MEC's recommendation is favorable to the Applicant, this recommendation will be forwarded to the Board for review and approval.

(e) Unfavorable Recommendations

1) If the MEC's initial recommendation is unfavorable to the Applicant, the Applicant and, when applicable, the collaborative/supervising Member shall be given the opportunity upon written request to meet with the MEC before a final recommendation is made to the Board.

2) This meeting will be informal and shall not be considered a hearing for purposes of the Corrective Action and Fair Hearing Plan.

3) Following this meeting, the MEC shall issue a final recommendation.

4) The MEC's final recommendation, whether favorable or unfavorable, will be forwarded to the Board for review and approval.

## 8.5 Re-Credentialing

The eligibility requirements, application requirements, and credentialing procedures outlined in this Credentialing Manual for credentialing of AHPs will be applied to the renewal of AHP Clinical Privileges. Renewal, if granted by the Board, shall be for a renewal term of not more than two (2) years. During each AHP's renewal, the MEC shall review the utilization, performance improvement, and quality assurance data compiled during the AHP's prior term.

## 8.6 Corrective Action

 Except for Dentists, who shall hereby be subject to the Corrective Action and Fair Hearing Plan, AHPs shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff's

Corrective Action and Fair Hearing Plan or any other Hospital or Medical Staff policy or document. However, in the event corrective action is requested or required for the actions of an AHP, the MEC shall conduct whatever investigation is required, including but not limited to, meeting with the AHP to obtain the AHP's perspective on the matter, and after doing so the MEC shall recommend to the President appropriate action. The President shall consider the recommendation and then take such final action as the President deems appropriate. If the MEC makes an unfavorable recommendation to the President, prior to the President taking final action, the AHP shall be entitled to submit a written statement to the President providing whatever information the AHP desires to provide. If desired, the President may elect to meet with the AHP in person to obtain additional information.

# **ARTICLE IX AMENDMENT**

**9.1** **Amendment of Credentialing Manual and Rules and Regulations**

 This Credentialing Manual may be amended or repealed, in whole or in part, pursuant to the process and procedures set forth in Article XIV of the Medical Staff Bylaws.

**ARTICLE X

ADOPTION**

This Medical Staff Credentialing Manual was adopted to be effective August 26, 2022.