Indiana University Health Ball Memorial Hospital, Inc.

Medical Staff Documents

Bylaws
Organizational Plan
Credentialing Policy

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(A) Medical Staff Bylaws
(A) 1. Article 1 -- Preamble to the Medical Staff Bylaws

Indiana University Health Ball Memorial Hospital, Inc.’s goal is simple: we are here to help and serve our patients. To successfully accomplish this goal requires that the medical staff commit itself to these tenets. Working in a spirit of cooperation,

- We will provide the best possible treatment for our patients. This will require that we continuously seek out opportunities to refine our technical skills.
- We will treat our patients with respect at all times, bearing in mind that each patient is an individual with a unique set of physical, cultural, and emotional characteristics.
- We will foster and protect the patient’s dignity.
- We will communicate thoroughly and patiently information required both by the patient and the patient’s family.

The Medical Staff understands, moreover, that the way we treat our patients is often reflected by the way we treat each other. Meeting this goal, therefore, also requires that we diligently apply the same tenets to our colleagues and to the Hospital Staff. To this end,

- We must promote an atmosphere of cooperation to ensure the best treatment for our patients and the best opportunity for each of us to use our skills fully.
- We shall treat each other with genuine collegial respect. We must remember that as individuals we of the Medical Staff bring different strengths to the treatment of our patients. These individual strengths should be recognized and nurtured.
- Regardless of position or professional standing, all members of the medical and hospital staff must be treated with equal dignity.
(A) 2. Article 2 -- Statement of Authority

Indiana University Health Ball Memorial Hospital, Inc. is an acute care hospital organized under applicable laws and regulations and accredited by the Joint Committee on the Accreditation of Healthcare Organizations.

The Hospital’s Board of Directors has established the Medical Staff which shall consist of physicians and certain other health professionals who have been appointed and granted the right to exercise clinical privileges in the delivery of medical and other clinical services for persons who avail themselves of the Hospital’s services.

The Medical Staff shall provide competent and professional advice to the Board of Directors concerning the organization and function of the Hospital and the Medical Staff, the credentialing of Medical Staff members and the quality of the Hospital’s medical and other clinical services, and shall accept and discharge all responsibilities in accordance with these Medical Staff Bylaws and applicable laws and regulations and subject to the ultimate authority of the Hospital’s Board of Directors.

The Hospital and Medical Staff qualify as professional review bodies, as defined by the Health Care Quality Improvement Act, 42 U.S.C. 11151 (11) and the regulations promulgated, and as peer review committees, as defined by Indiana’s laws governing health care provider peer review committees, as defined by Indiana’s laws governing health care provider peer review committees, I.C. 34-30-15-1 et seq., and hereby claim all privileges and immunities afforded them thereunder.
(A) 3. Article 3 -- Medical Staff Bill of Rights

(A) 3.A. Medical Staff Bylaws and Related Medical Staff Documents
It is hereby acknowledged and agreed that these Medical Staff Bylaws shall constitute an integral part of the relationship between the Hospital and each individual member of the Medical Staff (the other parts of this relationship shall include the Credentialing Policy, the Medical Staff Rules and Regulations, the Medical Staff Organization and Functions Manual, the Medical Staff application forms, and those Medical Staff and Board policies governing the relationship between members of the Medical Staff and the Hospital (hereafter referred to collectively as "Related Medical Staff Documents"). These Bylaws may be amended only as provided in Article 15 herein and may not be unilaterally amended by any action of the Board or Medical Staff.

(A) 3.B. Credentials and Quality Files
The Medical Staff Bylaws and Related Medical Staff Documents specifically encourage the use of collegial and educational efforts to address questions or concerns with an Appointee. Consistent with this, an Appointee shall be given an opportunity to review and to respond in writing to any written communication concerning the Appointee's practice that is prepared by a Medical Staff leader or a member of Hospital management and included in the Appointee's credentials and/or quality file. The Appointee's response shall be maintained in the Appointee's credentials and/or quality file along with the original communication. An Appointee's access to his or her formal credentials and/or quality file shall be accomplished in accordance with the Policy on Confidentiality of Medical Staff Records.

(A) 3.C. Right To Question
Each Appointee of the Active Staff has the right to challenge any rule, regulation, policy, recommendation, or action (except a professional review action as defined in these Bylaws that relates to another Appointee) through a supporting petition signed by fifteen percent (15%) of the Active Staff Appointees. Upon receipt of such a petition, the Chair of the Executive Committee shall place it on the agenda of the next regular Executive Committee meeting and invite the representative(s) of the petitioning Appointees to discuss the issue or schedule a special meeting of the Executive Committee to discuss the issue with the representative(s) of the petitioning Appointees.
(A) 3.D. Freedom of Assembly

Each Appointee of the Active Staff may attend and observe any meeting of the Executive Committee, except for executive sessions. Any Appointee may address the Executive Committee at one of its regular meetings for the purpose of discussing a specific issue, provided a written request to be placed on the agenda is timely received by the Chair at least one week in advance of such meeting. Each Appointee of the Active Staff may call a special meeting of the Medical Staff or said Appointee's department through a proposed agenda signed by fifteen percent (15%) of the Active Staff Appointees or Active Staff Department Appointees, respectively, submitted to the Chair or Department Chairman, respectively. Special meetings shall require five (5) days written notice, shall be deemed held only if a quorum has been established and shall adhere to the proposed agenda.

(A) 3.E. Prerogatives of The Medical Staff

Each Appointee of the Active Staff may review the minutes of any and all standing committees redacting only those portions which must remain confidential to preserve the legal protection from discovery afforded the Hospital and Medical Staff by applicable law and/or the confidentiality or privacy of the individual(s) discussed therein. However, this privilege does not apply to minutes recorded while a committee is in executive session or minutes that relate to topics designated by the Chair as restricted.

(A) 3.F. Prerogatives of Departments

Actions, resolutions, or recommendations of a department addressed to the Executive Committee shall constitute duly seconded motions at the next regular meeting of the Executive Committee.

(A) 3.G. Authority of This Article

Where conflict or inconsistency exists, the provisions of this Article 3 ("Medical Staff Bill of Rights") supersede all other provisions of these Bylaws and the Related Medical Staff Documents.
(A) 4. Article 4 -- General

(A) 4.A. Definitions

The following definitions shall apply to terms used in the Related Medical Staff Documents:

"ALLIED HEALTH PROFESSIONALS" ("AHPs") means individuals other than staff appointees who are authorized by law to provide patient care services, whose scope of practice is defined in the Policy on Allied Health Professionals.

"APPOINTEE" means physicians, dentists and podiatrists who have been granted medical staff appointment and clinical privileges by the Board to practice at the Hospital.

"BOARD" means the Board of Directors of the Hospital which has the overall responsibility for the Hospital or its designated committee.

"BOARD CERTIFICATION" means the process whereby a physician, dentist or podiatrist has passed an examination by the appropriate specialty Board in the applicant's area of practice, of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA"), the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable.

"CHAIR" means the Chair of the Executive Committee, who shall be the member of the Executive Committee serving his or her fifth year on the Committee.

"CHIEF NURSING OFFICER" ("CNO") means the individual appointed by the Board to act on its behalf for the overall management of hospital nursing services.

"CLINICAL PRIVILEGES means the authorization granted by the Board to render specific patient care services.

"CREDENTIALING POLICY" means the Hospital's Medical Staff Credentialing Policy.

"CREDENTIALING OFFICE" means the location where administrative support for the credentialing function is provided.

"DAYS" means calendar days.

"DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

"DEPENDENT PRACTITIONER" means a licensed or certified health care practitioner, or other practitioner, not appointed to the Medical Staff who has been...
approved by the President and permitted to function under the direction of a Supervising Physician pursuant to a written scope of practice.

"EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff which is also referred to as the Medical Executive Committee.

“EXECUTIVE VICE PRESIDENT-CLINICAL DEVELOPMENT” means the individual appointed by the Board to provide administrative oversight to the credentialing function.

“FEDERAL HEALTH PROGRAM” means Medicare, Medicaid, or any other federal or state program providing health care benefits which is funded directly or indirectly by the United States Government.

“GOOD STANDING” means that the Medical Staff appointee who is not under suspension or any restriction regarding staff appointment or admitting or clinical privileges at this Hospital and/or at any other health care facility or organization.

"HOSPITAL" means Indiana University Health Ball Memorial Hospital, Inc..

"INDEPENDENT PRACTITIONER" means a licensed or certified practitioner not appointed to the Medical Staff, who has been approved by the Board and granted clinical privileges to provide care to patients, whose state licensure does not require physician supervision and/or collaboration.

"MEDICAL STAFF means all physicians, dentists and podiatrists who have been appointed to the Medical Staff by the Board.

"NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, hand delivery, or posting in the physicians’ lounge.

"PATIENT CONTACTS" includes any admission, consultation, procedure, response to emergency call, evaluation, treatment or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities.

"PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

"PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

"PRESIDENT" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

“PROFESSIONAL REVIEW ACTION” means an action or recommendation of a professional peer review body which is taken or made in the conduct of professional peer review activity, which is based on the competence or
professional conduct of a staff appointee, and which affects or may affect adversely the clinical privileges or appointment of the staff appointee.

“PROFESSIONAL REVIEW ACTIVITY” means a peer review activity of the Hospital with respect to an individual Medical Staff applicant or appointee (a) to determine whether the Medical Staff applicant or appointee may have clinical privileges with respect to his/her appointment; (b) to determine the scope or conditions of those clinical privileges and appointment; and (c) to change or modify such privileges and/or appointment.

“PROFESSIONAL REVIEW BODY” means the Board of the Hospital or any Board committee which conducts professional peer review activity, and includes any committee of the Medical Staff when assisting the Board in a professional peer review activity.

"PSYCHOLOGIST" means an individual with a doctoral degree in clinical psychology.

"SCOPE OF PRACTICE" means the authorization granted by the President to perform certain clinical activities and functions under the direction of a Supervising Physician.

“SELF GOVERNMENT” means the duty of the officers, committees and departments of the Medical Staff to initiate and carry out the functions delegated by the Board and to fulfill the obligations provided for in these documents.

"SPECIAL NOTICE" means hand delivery, certified mail, return receipt requested or overnight delivery service providing receipt.

"SUPERVISING PHYSICIAN" means a Physician member of the Medical Staff with clinical privileges, who has agreed in writing to supervise the Dependent Practitioner and to accept full responsibility for the actions of the Dependent Practitioner while he or she is practicing in the Hospital.

“SUPERVISION” in regards to members of the Medical Staff, means the general oversight of a practitioner’s performance usually performed by the department chair. It does not require the constant physical presence of the supervisor, but rather, is an ongoing evaluation of the qualifications of, and quality of care being provider by, the practitioner.

"SUPERVISION" in regards to AHPs means, except as provided by law, the supervision of a Dependent Practitioner by a Physician, that does not require the actual presence of the Physician, but that does require that the Physician be readily available for consultation.
"UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment who does not have an attending physician; or whose attending physician or designated alternate is unavailable to attend the patient; or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

“VOLUNTARY” or “AUTOMATIC RELINQUISHMENT” of medical staff appointment and/or clinical privileges means a lapse in appointment and/or clinical privileges deemed to automatically occur as a result of stated conditions.

(A) 4.B. Syntax and Captions

Words used in these documents shall be read as the masculine or feminine gender, and as the singular or plural, as the context requires. The captions or heading are for convenience only and are not intended to limit or define the scope or effect of any provision in these documents.

(A) 4.C. Time Limits

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

(A) 4.D. Delegation of Functions

When a function is to be carried out by a person or committee, the person, or the committee through its chair, may delegate performance of the function to one or more qualified designees or in accordance with applicable laws. However, except as specifically stated herein, the Medical Executive Committee and Board may not delegate decisions regarding the granting of appointment and clinical privileges, or modification of same, with respect to an individual applicant.

(A) 4.E. Medical Staff Dues

(a) Annual Medical Staff dues shall be as recommended by the Executive Committee and may vary by category.

(b) Dues shall be payable annually upon request. Failure to pay dues shall result in ineligibility to apply for medical staff reappointment.
(c) Signatories to the Hospital's Medical Staff account shall be the Chair, Vice Chair, and Secretary-Treasurer. A valid transaction on the account requires two of those individuals' signatures.

(A) 5. Article 5 -- Categories of the Medical Staff

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentialing Policy are eligible to apply for appointment to one of the following categories:

(A) 5.A. Active Staff

(1) Qualifications

Appointees to the Active Staff must meet all criteria and qualifications outlined in Section 2.A. of the Credentialing Policy. They must also:

(a) be involved in the minimum number of patient contacts annually; and
(b) actively participate in Medical Staff activities and responsibilities, such as committee assignments; and
(c) be located sufficiently close to the hospital to be able to provide continuous care to patients, as may be more specifically defined by the departments and, if applicable, the national organizations setting standards for the relevant specialty.

(2) Prerogatives

Active Staff appointees

(a) may vote in all general and special meetings of the Medical Staff, and applicable department and committee meetings;
(b) may hold office, serve as Department Chairs and serve on committees; and
(c) are entitled to priority scheduling for non-emergency/elective patients for the operating room and outpatient services.

(3) Responsibilities

(a) Active Staff appointees must:

(i) assume all the responsibilities of membership on the Active Medical Staff, including committee service, emergency call, care for unassigned patients and evaluation of appointees during the provisional period;
(ii) actively participate in the peer review and performance improvement process;
(iii) accept consultations where applicable;
(iv) attend applicable meetings;
(v) pay application fees, dues and assessments; and
(vi) perform assigned duties.

(b) If the sum of an Active Staff appointee's age and years of service equals 85 or more, he or she shall not be obligated to take emergency call, satisfy meeting attendance requirements.

(A) 5.B. Consulting Staff

(1) Qualifications
The Consulting Staff shall consist of practitioners of recognized professional ability and expertise who provide a service that is not available on the Active Staff, and who are appointed to the Active Staff at another hospital where they are currently practicing.

(2) Prerogatives and Responsibilities
Consulting Staff appointees:
(a) may treat (but not admit) patients in conjunction with another physician on the Active Staff;
(b) may attend meetings of the Medical Staff and applicable department meetings (without vote) and applicable committee meetings (with vote);
(c) may not hold office or serve as department chairs or committee chairs; and
(d) shall pay application fees, dues and assessments.

(A) 5.C. Affiliate Staff

(1) Qualifications
The Affiliate Staff shall consist of those appointees who desire to be associated with, but who do not intend to establish a practice at this Hospital. The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff members for admission and care.
(2) **Prerogatives and Responsibilities**

(a) Affiliate Staff appointees:

(i) may visit their hospitalized patients and review their Hospital medical records, but may not admit patients, attend patients, exercise any clinical privileges, write orders or progress notes, make notations in the medical record, or actively participate in the provision or management of care to patients at the Hospital;

(ii) may attend educational activities and meetings of the Medical Staff and the Hospital;

(iii) may not vote, hold office, serve as a Department Chair or serve on Medical Staff committees;

(b) The grant of Affiliate Staff appointment to physicians is a courtesy only, which may be terminated by the Board upon recommendation of the Executive Committee. Termination from the Affiliate Staff does not give rise to hearing and appeal rights.

(c) Affiliate Staff appointees shall not be required to pay dues but will pay applicable fees.

(A) 5.D. **Honorary Staff**

(1) **Qualifications**

The Honorary Staff shall consist of practitioners who are recognized for outstanding or noteworthy contributions to the medical sciences, or have a record of previous long-standing service to the Hospital, and have retired from the active practice of medicine.

(2) **Prerogatives and Responsibilities**

Honorary Staff appointees:

(a) may not consult, admit or attend to patients;

(b) may attend staff and department meetings when invited to do so (without vote);

(c) may be appointed to special committees (with vote);

(d) may not vote, hold office, or serve on a standing Medical Staff committee or serve as a Department Chair; and

(e) will not pay application fees, dues or assessments.
(A) 6. Article 6 -- Medical Executive Committee & Medical Staff Officers

(A) 6.A. Composition

(a) The Executive Committee shall be composed of seven (7) Active Staff appointees elected by the voting staff,
   (i) one (1) each year to serve a (5) year term and
   (ii) one (1) each year to serve a two (2) year term.

(b) To ensure the Executive Committee can represent the diverse interests of the Medical Staff,
   the members serving five (5) year terms may not be from the same specialty or same economic group;
   (i) the members serving two (2) year terms may not be from the same specialty or same economic group; and
   (ii) there may not be more than two (2) members from the same department composing the entire seven (7) members of the Executive Committee.

(c) The member who is serving his or her fifth year on the Committee shall be the Chair; the member serving his or her fourth year shall be the Vice-Chair; and the member serving his or her third year shall be the Secretary-Treasurer. The Chair, Vice-Chair and Secretary-Treasurer of the Executive Committee shall constitute the Chair, Vice-Chair, and Secretary-Treasurer of the Medical Staff (i.e., the Medical Staff officers).

(d) The President, the Executive Vice President-Clinical Development and the Chief Nursing Officer shall be ex officio members of the Executive Committee, without vote.

(e) Members of the Board may attend meetings of the Executive Committee and participate in the discussions, but without vote.

(A) 6.B. Eligibility Criteria

Only those appointees to the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve on the Executive Committee and as an officer of the Medical Staff. They must:

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(a) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least five (5) years;
(b) have no pending adverse recommendations concerning medical staff appointment or clinical privileges;
(c) be willing to faithfully discharge the duties and responsibilities of the position;
(d) have experience in a leadership position, or other involvement in performance improvement functions for at least two (2) years;
(e) be willing to attend continuing education relating to medical staff leadership and/or credentialing functions prior to or during the term of the office;
(f) have demonstrated an ability to work well with others; and
(g) declare any financial relationship (as defined in the Policy on Financial Conflicts of Interest) with an entity that competes with the Hospital or any affiliate.

(A) 6.C. Removal

(a) Removal of a Medical Staff officer and/or member of the Executive Committee may be effectuated by any of the following, two-thirds (2/3) vote of the Executive Committee, two-thirds (2/3) vote of the Medical Staff, or by the Board, for:
   (i) failure to comply with applicable policies, Bylaws, or Rules and Regulations;
   (ii) failure to perform the duties of the position held;
   (iii) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or
   (iv) an infirmity that renders the individual incapable of fulfilling the duties of that office.
(b) At least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Executive Committee or the Board prior to a vote on removal.
(c) If the Chair, Vice-Chair, or Secretary-Treasurer is removed from the Executive Committee, such removal shall automatically result in his
or her removal from the position of Chair, Vice-Chair, or Secretary-Treasurer of the Medical Staff.

(A) 6.D. Vacancies

A vacancy in any office shall be filled by the member who would normally next serve in that office; that member shall serve until the end of the unexpired term and his/her normal term (up to 2 years). Vacancies on the committee may be filled by a special election of the Medical Staff, at the discretion of the Executive Committee. A newly elected 5 year member will have the lowest seniority; i.e., he/she will not assume the position of the member who was replaced.

(A) 6.E. Duties

(1) Executive Committee

The Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with clinical privileges. The Executive Committee is responsible for the following:

(a) recommending directly to the Board on at least the following:
   (i) the Medical Staff’s structure;
   (ii) the mechanism used to review credentials and to delineate individual clinical privileges;
   (iii) recommendations of individuals for medical staff appointment;
   (iv) recommendations for delineated clinical privileges for each eligible individual;
   (v) participation of the Medical Staff in Hospital performance improvement activities;
   (vi) the mechanism by which medical staff appointment may be terminated; and
   (vii) hearing procedures;

(b) consulting with administration on quality related aspects of contracts for patient care services with entities outside the Hospital;

(c) receiving and acting on reports and recommendations from medical staff committees, departments, and other groups as appropriate;
(d) reviewing, at least every three years, the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable;

(e) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the Chair and Vice-Chair are empowered to act in urgent situations between Executive Committee meetings);

(f) performing such other functions as are assigned to it by these Bylaws, the Credentialing Policy or other applicable policies; and

(g) supporting the collegial efforts of Medical Staff leaders.

(2) **Chair**

In addition to chairing the Executive Committee, the Chair shall:

(a) act in coordination and cooperation with Hospital management in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies and needs, and report on the activities, of the Medical Staff to the President and the Board;

(c) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the Executive Committee;

(d) appoint all committee chairs and committee members, in consultation with the Executive Committee;

(e) be a member of all other Medical Staff committees, *ex officio*, without vote;

(f) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the Policies and Procedures of the Hospital;
(g) recommend Medical Staff representatives to Hospital committees; and  
(h) perform all functions authorized in all applicable policies, including collegial intervention in the Credentialing Policy.

(3) **Vice-Chair**  
In addition to serving on the Executive Committee, the Vice-Chair shall:  
(a) assume all duties of the Chair and act with full authority as Chair in his or her absence;  
(b) assume all such additional duties as are assigned to him or her by the Chair or the Executive Committee; and  
(c) become Chair upon completion of his/her term.

(4) **Secretary-Treasurer**  
In addition to serving on the Executive Committee, the Secretary-Treasurer shall:  
(a) be responsible for providing notices as specified in these Bylaws;  
(b) be responsible for the collection of, accounting for, and disbursements of any funds collected, donated, or otherwise assessed and present in the Medical Staff Fund and report to the Medical Staff.

(5) **Immediate Past Chair**  
The Immediate Past Chair shall:  
(a) chair the Nominating Committee;  
(b) serve as an advisor to other Medical Staff leaders;  
(c) assume all duties assigned by the Chair or the Executive Committee; and  
(d) serve a three (3) year term on the Credentials Committee.
(A) 6.F. Meetings
The Executive Committee shall meet as often as necessary, but at least quarterly, to fulfill its responsibilities and shall maintain a permanent record of its proceedings and actions.

(A) 7. Article 7 -- The Credentials Committee

(1) Composition
   (a) The Credentials Committee shall consist of:
      (i) the three (3) most recent Past Chairs who are still appointees to the Active Staff and
      (ii) three (3) individuals who have been members of the Active Staff for at least five (5) years who shall be elected by the staff as vacancies occur.
   (b) The chairperson shall be the past-Chair of the Executive Committee with the greatest seniority on the committee. Service on this committee shall be considered as the primary Medical Staff obligation of each member of the committee and other Medical Staff duties shall not interfere.
   (c) If at any time the continued workability of the committee is threatened by the inability or unwillingness of any members to serve, the Chair of the Medical Executive Committee shall appoint up to five (5) additional members to the committee, for terms of one (1) year each, to fill the vacancies.
   (d) Members of the Credentials Committee shall serve for three (3) years with staggered terms, and may serve a maximum of two (2) consecutive terms (six (6) years). Any member who has served the maximum term shall not be eligible for reappointment to the committee for a period of one (1) year.
   (e) The President and the Executive Vice President-Clinical Development shall be ex officio members of the Credentials Committee, without vote.

(2) Duties
The duties of the Credentials Committee shall be:
(a) to review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations;

(b) to review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and, as a result of such review, to make a written report of its findings and recommendations;

(c) to review and recommend to the Medical Executive Committee, as questions arise, criteria for new clinical privileges and for privileges that involve different specialties and, upon request from Administration, recommend whether new procedures or services should be offered to patients at the Hospital; and

(d) to develop professional criteria that are uniformly applied to all applicants for Medical Staff appointment and the granting of clinical privileges.

(3) **Meetings, Reports and Recommendations**

The Credentials Committee shall meet quarterly or more often if necessary to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Executive Committee, the President and the Board. The Chairperson of the Credentials Committee shall be available to meet with the Board or its committee on all recommendations that the Credentials Committee may make.
(A) 8. Article 8 -- Nominations and Elections

(A) 8.A. Nominations

(a) Nominees for membership on the Credentials Committee and Executive Committee shall be selected by the Nominating Committee or by written petition of appointees to the Medical Staff in accordance with (3)(b) of this Section.

(b) Composition of the Nominating Committee:

(c) The Nominating Committee shall consist of three (3) members, two (2) of whom shall be Appointees to the Active Staff selected by the Chair. The third member shall be the Immediate Past Chair of the Executive Committee, who shall act as the Chair of the Nominating Committee.

(d) Procedure for Nominating a Candidate:

(i) The Committee shall be appointed for all general and special elections. The Committee shall convene at least forty-five (45) days prior to the election and shall submit to the Chair the names of at least one (1) qualified nominee, and preferably more qualified nominees, for each of the open seats on the Credentials Committee and Executive Committee. Notice of the nominees shall be provided to the Medical Staff at least thirty (30) days prior to the election.

(ii) Nominations may also be submitted in writing by petition signed by at least five (5) Active Staff appointees at least ten (10) days prior to the election. Therefore, nominations from the floor shall not be accepted.

(iii) In order for a nomination to be placed on the ballot, a candidate for the Credentials Committee must meet the qualifications set forth in Section 7.1., and a candidate for the Executive Committee must meet the qualifications in Section 6.B., in the judgment of the Nominating Committee, and be willing to serve.
(A) 8.B. **Elections**

The general election shall be held annually at the April Medical Staff meeting. The candidate receiving a majority of written votes cast shall be elected and, once approved by the Board, shall be eligible to assume his or her position on the Credentials Committee or Executive Committee. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two (2) candidates receiving the highest number of votes.
(A) 9. Article 9 -- Performance Improvement & Medical Staff Committees

(A) 9.A. Performance Improvement Functions

(a) The performance improvement functions are the way the Medical Staff works to improve the clinical and non-clinical processes that require medical staff leadership or participation. These functions shall be performed by such committees, departments and individuals as may be designated by the Executive Committee in consultation with the President. When the performance of a process is dependent primarily on the activities of individuals with clinical privileges, the Medical Staff shall provide leadership for and participate in process measurement, assessment, and improvement, including, but not limited to:

(i) medical assessment and treatment of patients;
(ii) use of medications;
(iii) use of blood and blood components;
(iv) use of operative and other procedures;
(v) efficiency of clinical practice patterns; and
(vi) significant departures from established patterns of clinical practice.

(b) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Organization and Functions Manual.

(A) 9.B. Patient Care Process Improvement Functions

The Medical Staff shall also participate in the measurement, assessment, and improvement of other patient care processes. These include, though are not limited to:

education of patients and families;

(a) coordination of care with other practitioners and Hospital personnel, as relevant to the care of an individual patient; and

(b) accurate, timely, and legible completion of patients' medical records.
(A) 9.C.  Credentialing and Peer Review Functions
Mechanisms for appointment, reappointment, delineation of clinical
privileges, collegial and educational efforts, investigations, hearings and
appeals that apply to medical staff appointees shall be contained in the
Credentialing Policy.

(A) 9.D.  Responsibilities and Related Documents
Medical Staff appointees shall fulfill all applicable responsibilities contained
in these Bylaws, the Credentialing Policy, Organization and Functions
Manual, the Hospital's Code of Conduct, Medical Staff Rules and
Regulations and other applicable Bylaws, policies and Rules and
Regulations and abide by same when performing all responsibilities.

(A) 9.E.  Appointment of Committee Chairs and Members
(a) All committee chairs and members shall be appointed by the Chair,
in consultation with the Executive Committee. Committee chairs
shall be selected based on the criteria set forth in Section 6.B of
these Bylaws.
(b) Committee chairs and members shall be appointed for initial terms
of one year, but may be reappointed for additional terms.
(c) The Chair, President, and Executive Vice President of Clinical
Development (or their respective designees) shall be members, ex
officio, without vote, on all committees.

(A) 9.F.  Creation of Standing Committees
In accordance with the amendment provisions in the Organization and
Functions Manual, the Executive Committee may, by resolution and upon
approval of the Board and without amendment of these Bylaws, establish
additional committees to perform one or more staff functions. In the same
manner, the Executive Committee may dissolve or rearrange committee
structure, duties, or composition as needed to better accomplish Medical
Staff functions. Any function required to be performed by these Bylaws
which is not assigned to an individual, a standing committee, or a special
task force shall be performed by the Executive Committee.
(A) 9.G. Special Task Forces

Special task forces shall be created and their members and chairs shall be appointed by the Chair. Such task forces shall confine their activities to the purpose for which they were appointed and shall report to the Executive Committee.

(A) 10. Article 10 -- Staff Departments

(A) 10.A. Organization

The Medical Staff shall be organized into departments as listed in the Organization and Functions Manual.

(A) 10.B. Assignment To Department

(a) Upon initial appointment to the Medical Staff, each appointee shall be assigned to at least one clinical department by the Credentials Committee. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.

(b) An individual may request a change in department assignment or assignment to an additional department to reflect a change in the individual's clinical practice, by submitting a written request to the Credentials Committee, along with justifications for the request.

(A) 10.C. Functions of Departments

(a) The departments are responsible to the Executive Committee to perform the functions described and shall be organized for the purpose of implementing processes

(i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments, and

(ii) to monitor the practice of all those with clinical privileges in a given department.

(b) Each department shall assure emergency call coverage for all patients.

(A) 10.D. Qualifications of Department Chairs

Each department chair shall:

(a) be an Active Staff Appointee;
(b) be certified by an appropriate specialty Board; and
(c) satisfy the eligibility criteria in Section 6.B.
(A) 10.E. **Appointment and Removal of Department Chairs**

(a) Department chairs shall be elected by the department. Members of the department shall nominate qualified candidate(s). The election may be by ballot. Ballots may be returned in person, by mail or by facsimile. All ballots, if used, must be received in the Medical Staff Office by the day of the election. Elections may also be conducted in person. Those who receive a majority of the votes cast shall be elected and, once approved by the Board, are eligible to assume the duties of their elected positions. Prior to assuming those duties, however, newly elected department chairs shall attend an orientation meeting with the Executive Committee, where the roles and responsibilities of department chairs, among other topics, will be discussed.

(b) Any department chair may be removed by any of the following, a two-thirds (2/3) vote of the department members, by a two-thirds (2/3) vote of the Executive Committee, or by the Board, after reasonable notice and opportunity to be heard. Grounds for removal shall be:

(i) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(ii) failure to perform the duties of the position held;

(iii) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(iv) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(c) Prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be taken at least ten (10) days prior to the date of the meeting. The individual shall be afforded an opportunity to speak to the department or Executive Committee or the Board, as applicable, prior to a vote on such removal.

(d) Department chairs shall be elected in April and serve a term of two (2) years.
(A) 10.F. **Duties of Department Chairs**

Each department chair is accountable for the following:

(a) all clinically related activities of the department;

(b) all administratively related activities of the department, unless otherwise provided for by the Hospital;

(c) continuing supervision of the professional performance of all individuals in the department who have delineated clinical privileges;

(d) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(e) evaluating requests for clinical privileges for each member of the department;

(f) assessing and recommending off-site sources for needed patient care services not provided by the department or the Hospital;

(g) the integration of the department into the primary functions of the Hospital;

(h) the coordination and integration of interdepartmental and intradepartmental services;

(i) the development and implementation of policies and procedures that guide and support the provision of services;

(j) recommendations for a sufficient number of qualified and competent persons to provide care or service;

(k) determination of the qualifications and competence of department personnel who provide patient care services;

(l) continuous assessment and improvement of the quality of care and services provided;

(m) maintenance of quality monitoring programs, as appropriate;

(n) the orientation and continuing education of all persons in the department;

(o) recommendations for space and other resources needed by the department;

(p) being sensitive to and working to resolve conflicts among members of the department and between members of the department and other personnel;
(q) performing all functions authorized in the Credentialing Policy, including collegial intervention; and
(r) appointing one or more Vice-Chairs as deemed necessary, subject to approval of the Executive Committee and Board.

(A) 11. Article 11 -- Meetings

(A) 11.A. Medical Staff Year

The Medical Staff year begins on July 1.

(A) 11.B. Medical Staff Meetings

(1) Regular Meetings

The Medical Staff shall meet at least twice a year.

(2) Special Meetings

Special meetings of the Medical Staff may be called by the Chair, the Executive Committee or the Board, or by a petition signed by not less than ten percent (10%) of the Active Staff.

(A) 11.C. Department and Committee Meetings

(1) Regular Meetings

Except as otherwise provided in these Bylaws or in the Medical Staff Organization and Functions Manual, each department and committee shall meet at least quarterly, at times set by the presiding officer.

(2) Special Meetings

A special meeting of any department or committee may be called by or at the request of the presiding officer, the Chair, or by a petition signed by not less than one-fourth (1/4) of the Active Staff members of the department or committee, but not by fewer than two (2) members.

(A) 11.D. Provisions Common To All Meetings

(1) Notice of Meetings

(a) Medical Staff appointees shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments and committees at least seven (7) days in advance of the meetings. Notice may also be provided by posting in a designated location at least seven (7) days prior to the meetings. All notices shall state the
date, time, and place of the meetings. Posting shall constitute adequate notification for routine meetings.

(b) When a special meeting of the Medical Staff, a department and/or a committee is called, all of the provisions in paragraph (a) shall apply except that the notice period shall be reduced to forty-eight (48) hours (i.e., must be given at least forty-eight (48) hours prior to the special meeting). Posting may not be the sole mechanism used for providing notice if the posting is made less than seven (7) days in advance of the meeting.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

(2) **Quorum and Voting**

(a) For any regular or special meeting of the Medical Staff, department or committee, those voting members present shall constitute a quorum, but in no event shall a quorum be fewer than two (2).

(b) Recommendations and actions of the Medical Staff, departments and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present. To be considered "present" at a meeting, an individual must be physically present (for an in-person meeting) or actually participating via telephone (for a meeting held via telephone conference). Substitutes will not be permitted to act on behalf of a member at a meeting, nor will they be counted in determining a quorum. Similarly, proxy voting shall not be permitted.

(c) Any matter may be presented by notice and votes returned to the Presiding Officer by the method designated in the notice. A quorum shall be the number of ballots returned. The question raised shall be determined in the affirmative if a majority of the ballots returned have so indicated.

(d) Meetings may be conducted by telephone conference.

(3) **Agenda**

The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department or committee.
(4) **Rules of Order**
The latest edition of Robert's Rules of Order Revised may be used for reference at all meetings and elections, but shall not be binding. Specific provisions of these Bylaws, and Medical Staff, department, or committee custom shall prevail at all meetings, and the Department Chair or Committee Chair shall have the authority to rule definitively on all matters of procedure.

(5) **Minutes, Reports, and Recommendations**
(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments and committees shall be transmitted to the Executive Committee and President. The Board shall be kept apprised of the relevant recommendations of the Medical Staff and its departments and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

(A) **11.E. Confidentiality**
Members of the Medical Staff who have access to credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes. A breach of confidentiality may result in the imposition of disciplinary action.

(A) **11.F. Attendance Requirements**
(a) Each Active Staff member is expected to attend and participate in all medical staff meetings and applicable department and committee meetings each year.

(b) At a minimum, however, each Active Staff member is required to attend fifty (50) percent of applicable Medical Staff and department meetings each year. It is not necessary to prepare excuses for missed
meetings because excuses shall not be considered when compliance with attendance requirements is considered. Failure to meet this attendance requirement shall not constitute grounds for denying reappointment to the staff. Failure to meet attendance requirements shall result in the member’s automatic relinquishment of voting rights for the ensuing year.
(A) 12. Article 12 -- Questions Involving Medical Staff Appointees

(A) 12.A. Collegial Intervention

(a) These Bylaws encourage collegial and educational efforts by Medical Staff members and leaders and Hospital administration to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(b) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

(c) All collegial intervention efforts by Medical Staff leaders and Hospital administration are part of the Hospital's performance improvement and professional and peer review activities.

(d) The department chair, Chair of the Credentials Committee, or Chair of the Executive Committee shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

(e) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

(f) The Chair in conjunction with the Executive Vice President-Clinical Development or President shall determine whether to direct that a matter be handled in accordance with another policy, such as a policy on physician health and well being or a code of conduct policy, or to direct it to the Executive Committee for further determination.
(A) 12.B. Investigations

(1) Initial Review

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:

(i) the clinical competence or clinical practice of any appointee to the Medical Staff, including the care, treatment or management of a patient or patients;

(ii) the known or suspected violation by any appointee to the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; and/or

(iii) conduct by any appointee to the Medical Staff that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others, the matter may be referred to the Chair, the chair of the department, the chair of a standing committee, the President, or the Chair of the Board.

(b) The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the Executive Committee.

(c) No action taken pursuant to this Section shall constitute an investigation.

(2) Initiation of Investigation

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Executive Committee, the Executive Committee shall review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to a policy on physician health and well being or a code of conduct policy. In making this determination, the Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Executive Committee to do so.
(b) The Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

(c) The Board may also determine to commence an investigation and may delegate the investigation to the Executive Committee, a subcommittee of the Board, or an ad hoc committee.

(d) The Chair shall keep the President fully informed of all action taken in connection with an investigation.

(3) Investigative Procedure

(a) Once a determination has been made to begin an investigation, the Executive Committee shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation. An ad hoc committee shall not include individuals who are in direct economic competition, partners, associates, or immediate family members of the individual being investigated, but may include individuals not on the Medical Staff. Whenever the question raised concerns the clinical competence of the individual under review, the ad hoc committee shall include an appointee of the Medical Staff, or, if an appointee is unavailable, a peer colleague of the individual (e.g., physician, dentist).

(b) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that:

(i) the clinical expertise needed to conduct the review is not available on the Medical Staff; or

(ii) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or
(iii) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

(c) The investigating committee may require a physical and/or mental examination of the individual by qualified health care professional(s) mutually acceptable to the individual and investigating committee. If they cannot agree, then the individual and investigating committee shall each submit two (2) proposed qualified health care professionals for the Chair of the Executive Committee to render a decision. The results of such examination shall be made available for consideration by the investigating committee.

(d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting but, with the permission of the committee, may be accompanied by a colleague who is not a lawyer and who will not participate in the discussion.

(e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within thirty (30) days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within thirty (30) days of receiving the results of the outside review, and within a total of ninety (90) to one hundred twenty (120) days of the commencement of the investigation. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time.
periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

(f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions, interview summary (if any), and recommendations to the Executive Committee.

(g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committees may consider:

(i) relevant literature and clinical practice guidelines, as appropriate;

(ii) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);

(iii) any information or explanations provided by the individual under review.

(4) **Recommendation**

(a) The Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Executive Committee may:

(i) determine that no action is justified;

(ii) issue a letter of guidance, warning, or reprimand;

(iii) impose conditions for continued appointment;

(iv) impose a requirement for monitoring or consultation;

(v) recommend additional training or education;

(vi) recommend reduction of clinical privileges;

(vii) recommend suspension of clinical privileges for a term;

(viii) recommend revocation of appointment and/or clinical privileges; or
(ix) make any other recommendation that it deems necessary or appropriate.

(b) A recommendation by the Executive Committee that would entitle the individual to request a hearing shall be forwarded to the President, who shall promptly inform the individual by special notice and inform the Board at its next regularly scheduled meeting. The President shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) If the Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately by notice to the individual and be reported to the Board at its next regularly scheduled meeting. The recommendation shall remain in effect unless modified by the Board.

(d) In the event the Board considers a modification to the recommendation of the Executive Committee that would entitle the individual to request a hearing, the President shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

(A) 12.C. Precautionary Suspension of Clinical Privileges

(1) Grounds for Precautionary Suspension

(a) Any combination of two (2) of the following: the Chair, the chair of a clinical department, or the President, or their designees, shall have the authority to suspend all or any portion of an individual's clinical privileges whenever failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation.
(b) Precautionary suspension is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.

(c) A precautionary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the President and the Chair of the Executive Committee, and shall remain in effect unless it is modified by the Executive Committee.

2) Executive Committee Procedure

(a) The Executive Committee shall review the matter resulting in a precautionary suspension within a reasonable period, not to exceed seven (7) days, and determine whether there is sufficient information to warrant a recommendation, or proceed under the investigative procedure.

(b) The suspended individual may request, and if requested it shall be granted, a meeting with the Executive Committee to discuss the circumstances leading to the suspension.

3) Care of Suspended Individual's Patients

(a) Immediately upon the imposition of a precautionary suspension, the department chair, or in his or her absence, the Chair of the Executive Committee, shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician. Caution should be exercised such that only those with a need to know are advised as to the precautionary suspension.

(b) All appointees to the Medical Staff have a duty to cooperate with the Chair, the department chair, the Executive Committee, and the President in enforcing suspensions.

(A) 12.D. Automatic Relinquishment

1) Failure to Complete Medical Records

Failure to complete medical records shall be handled in accordance with Article IX, Medical Records, Part J: Chart Completion Policy,
of the Medical Staff Rules and Regulations, which to complete medical records can result in automatic relinquishment of an individual’s clinical privileges until the matter is resolved.

(2) **Action by Government Agency or Insurer**

(a) Automatic relinquishment or restriction, for the reasons described below, shall take effect immediately and continue until the matter is resolved, if applicable, and a request for reinstatement of privileges has been acted upon by the Credentials Committee, the Executive Committee, and the Board.

(b) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below must be promptly reported to the President.

(c) An individual's clinical privileges shall be automatically relinquished (or restricted as stated) if any of the following occur:

(i) **Licensure:** Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's license.

(ii) **Controlled Substance Authorization:** Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization.

(iii) **Insurance Coverage:** Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part, unless after careful consideration an exception is granted by the Board upon recommendation of the Credentials Committee.

(iv) **Medicare and Medicaid Participation:** Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(v) **Criminal Activity:** Indictment, conviction, or a plea of guilty or *nolo contendere* pertaining to any felony, or any
misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance fraud or abuse; or (iv) violence against another.

(3) **Failure to Provide Requested Information**

Failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the Executive Committee, the President, or any other committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges until the information is provided.

(4) **Failure to Attend Special Conference**

(a) Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the department chair or the Chair may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff. This section shall be interpreted to require, among other things, attendance at departmental peer review upon request.

(b) The notice to the individual regarding this conference shall be given by special notice at least three (3) days prior to the conference and shall inform the individual that attendance at the conference is mandatory.

(c) Failure of the individual to attend the conference shall be reported to the Executive Committee. Unless excused by the Executive Committee upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

(5) **Failure to Use Legible Handwriting in the Medical Record**

(a) Failure to use legible handwriting in the medical record shall be handled in accordance with Article IX, Medical Records, Part K: Legible Handwriting Policy, of the Medical Staff Rules and Regulations, which failure to use legible handwriting in the medical record can result in automatic relinquishment of an individual’s clinical privileges until the matter is resolved.
(A) 12.E. Leaves of Absence

(a) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the Credentials Committee Chair. The request must state the beginning and ending dates of the leave, which shall not exceed one (1) year, and the reasons for the leave. Any absence from medical staff and/or from patient care responsibilities for longer than thirty (30) days shall require an individual to request a leave of absence.

(b) The Credentials Committee Chair will determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the Credentials Committee Chair may consult with the Chair, relevant department chair, and/or the full Credentials Committee.

(c) During the leave of absence, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all medical staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

(d) The individual shall request reinstatement by providing to the Credentials Committee Chair a written summary of activities during the leave of absence. The individual bears the burden of providing information sufficient to demonstrate current competence and all other applicable qualifications. If the leave of absence exceeds 60 days, then the request must be made no later than thirty (30) days prior to the conclusion of the leave of absence.

(e) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

a. The Credentials Committee may recommend to the Executive Committee reinstatement to the same or different staff category and/or may recommend limits on or modification of the individual’s clinical privileges. The Credentials Committee Chair may act on
behalf of the full Committee if, in his/her judgment, the request is purely routine.

(f) The Executive Committee shall make a recommendation to the board and the board shall take final action on the request for reinstatement.

(g) If the Executive Committee or the Board recommends actions that would entitle the individual to request a hearing, the President shall give special notice to the individual.

(h) Absence for longer than one (1) year shall result in automatic relinquishment of medical staff appointment and clinical privileges unless an extension is granted. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(i) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.

(j) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

(A) 13. Article 13 -- Hearing and Appeal Procedures

(A) 13.A. Initiation of Hearing

(1) Grounds for Hearing

(a) An individual is entitled to request a hearing whenever the Executive Committee or, in the absence of an adverse Executive Committee recommendation, the Board makes one of the following recommendations:

(i) denial of initial appointment to the Medical Staff;
(ii) denial of reappointment to the Medical Staff;
(iii) revocation of appointment to the Medical Staff;
(iv) denial of requested clinical privileges;
(v) revocation of clinical privileges;
(vi) suspension of clinical privileges for more than thirty (30) days; or
(vii) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance).

(b) No other recommendations shall entitle the individual to a hearing.
(c) The hearing shall be conducted in as informal a manner as possible.
(d) The individual may request a hearing before the Board takes final action, if the Board makes any of these recommendations without a prior adverse Executive Committee recommendation. In this instance, all references in this Article to the Executive Committee shall mean the Board.

(2) **Actions Not Grounds for Hearing**

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

(a) issuance of a letter of guidance, warning, or reprimand;
(b) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
(c) termination of temporary privileges;
(d) automatic relinquishment of appointment or privileges;
(e) imposition of a requirement for additional training or continuing education;
(f) precautionary suspension;
(g) denial of a request for leave of absence, or for an extension of a leave;
(h) determination that an application is incomplete;
(i) determination that an application will not be processed due to a misstatement or omission;
(j) determination of ineligibility based on a failure to meet threshold criteria, a lack of need or resources or because of an exclusive contract; or
(A) 13.B. The Hearing

(1) Notice of Recommendation
The President shall promptly give special notice to the affected individual of a recommendation which entitles an individual to request a hearing. This notice shall contain:

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

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

(3) Notice of Hearing and Statement of Reasons
The President shall schedule the hearing and provide, by special notice, the following:

(i) the time, place, and date of the hearing;
(ii) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;
(iii) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to thirty (30) days, to review and rebut the additional information.
(b) The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

(4) **Witness List**

At least fifteen (15) days before the pre-hearing conference described in Section 13.C, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(a) The witness list shall include a brief summary of the anticipated testimony.

(b) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

(5) **Hearing Panel and Presiding Officer**

(a) Hearing Panel:

(i) The President, after consulting with the Chair, shall appoint a Hearing Panel composed of not less than three (3) members, one (1) of whom shall be designated as chair. The Hearing Panel shall be composed of appointees to the Medical Staff who did not actively participate in the matter at any previous level, physicians or laypersons not connected with the Hospital or a combination thereof. At least fifty percent (50%) of the members of the panel shall be appointees to the Medical Staff. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. Employment by, or a contract with, the Hospital or an affiliate shall not preclude any individual from serving on the Hearing Panel.

(ii) The Hearing Panel shall not include anyone who is in direct economic competition with, professionally associated with or related to, or involved in a referral relationship with, the individual requesting the hearing.

(b) Presiding Officer:

(i) In lieu of a Hearing Panel Chair, the President may appoint a Presiding Officer who may be an attorney and preferably
shall be an individual with specific understanding of the legal and administrative issues raised by medical staff hearings. The Presiding Officer shall not act as an advocate for either side at the hearing.

(ii) If no Presiding Officer has been appointed, the Chair of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one (1) vote.

(iii) The Presiding Officer shall:
1. allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
2. prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
3. maintain decorum throughout the hearing;
4. determine the order of procedure;
5. rule on all matters of procedure and the admissibility of evidence;
6. conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(iv) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

(v) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it but, if the Presiding Officer is not the Chair of the Hearing Panel, he or she shall not be entitled to vote on its recommendations.
(c) Objections:
Any objection to any member of the Hearing Panel or the Presiding Officer shall be made in writing to the President, within ten (10) days of receipt of notice, who shall resolve the objection.

(A) 13.C. Pre-Hearing and Hearing Procedure

(1) Provision of Relevant Information

(a) The individual requesting the hearing is entitled to the following, subject to the condition that all documents and information be maintained as confidential and not disclosed or used for any purpose outside of the hearing:

(i) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
(ii) reports of experts relied upon by the Executive Committee;
(iii) redacted copies of relevant minutes; and
(iv) copies of any other documents relied upon by the Executive Committee. The provision of this information is not intended to waive any privilege under the state peer review protection statute.

(b) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners.

(c) Prior to the hearing, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

(e) Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual shall contact Hospital employees.
appearing on the Executive Committee's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

(2) **Pre-Hearing Conference**
The Presiding Officer shall require the individual and/or a representative (who may be counsel) for the individual, as well as a representative for the Executive Committee, to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness's testimony and cross-examination.

(3) **Failure to Appear**
Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

(4) **Record of Hearing**
A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

(5) **Rights of Both Sides and the Hearing Panel at the Hearing**
(a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

   (i) to call and examine witnesses, to the extent they are available and willing to testify;

   (ii) to introduce exhibits;

   (iii) to cross-examine any witness on any matter relevant to the issues;

   (iv) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and

   (v) to submit a written statement at the close of the hearing.

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.
(6) **Admissibility of Evidence**
The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contain information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

(7) **Post-Hearing Statement**
Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

(8) **Persons to be Present**
The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the President or the Chair.

(9) **Postponements and Extensions**
Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the President on a showing of good cause.

(10) **Presence of Hearing Panel Members**
A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

**(A) 13.D. Hearing Conclusion, Deliberations, and Recommendations**

(1) **Order of Presentation**
The Executive Committee shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.
(2) **Basis of Hearing Panel Recommendation**
Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the Executive Committee unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

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

(4) **Disposition of Hearing Panel Report**
The Hearing Panel shall deliver its report to the President within a reasonable time after conclusion of deliberations. The President shall send by special notice a copy of the report to the individual who requested the hearing. The President shall also provide a copy of the report to the Executive Committee.

(A) **13.E. Appeal Procedure**

(1) **Time for Appeal**
Within fifteen (15) days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the President either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within fifteen (15) days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.
(2) **Grounds for Appeal**

The grounds for appeal shall be limited to the following:

(a) there was substantial failure to comply with these Bylaws, the Bylaws of the Hospital, or the Credentialing Policy during or prior to the hearing, so as to deny a fair hearing; and/or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

(3) **Time, Place and Notice**

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board shall, within ten (10) days of receipt of the request, schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held no less than twenty (20), nor more than forty (40), days after receipt of the request. If the party requesting the appeal is under a suspension that is currently in effect, the appellate review will be scheduled as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved, but not more than fourteen (14) days from the receipt of the request for an appeal.

(4) **Nature of Appellate Review**

(a) The Chair of the Board shall appoint a Review Panel composed of not less than three (3) persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made, or the Board may consider the appeal as a whole body.

(b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten (10) days to respond. In its sole discretion, the Review Panel (or Board) may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes.

(c) The Review Panel (or Board) may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the
party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel (or Board).

(d) The Review Panel shall recommend final action to the Board.

(5) **Final Decision of the Board**

Within sixty (60) days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons, and shall send special notice thereof to the individual. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges. A copy shall also be provided to the Executive Committee for its information.

(6) **Further Review**

Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall not exceed thirty (30) days, except as the parties otherwise stipulate.

(7) **Right to One Hearing and One Appeal Only**

No applicant or appointee of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current appointee to the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five (5) years unless the Board provides otherwise.
(A) 14. Article 14 -- Conflict of Interest

(A) 14.A. Purpose

This Conflict of Interest Policy protects the interests of all Decision-Makers who are contemplating a particular Action and the rights of any Practitioner whose interests may be affected by the Action. This Policy requires the following:

(a) The disclosure of any and all Business Interests on the part of the Hospital, Hospital Representatives and Practitioners that may influence their contemplation of a particular Action;

(b) An orderly procedure that is to be used to address a conflict of interest or a violation of this Policy; and

(c) A mechanism to properly document and report any such proceedings.

This Policy is intended to supplement but not replace any other laws or regulations applicable to the Hospital, Hospital Representatives and Practitioners.

(A) 14.B. Definitions

(a) The term “Action” shall mean any contemplated professional review action or recommendation of the Medical Staff or the Hospital that may adversely affect an individual Practitioner’s appointment or re-appointment to the Medical Staff or the scope or conditions of the Practitioner’s clinical privileges.

(b) The term “Business Interest” shall mean any direct or indirect interest that a Decision-Maker has by virtue of a (a) an Ownership or Investment Interest, (b) a Compensation Arrangement, or (c) an appointed or elected Office or Position.

(c) The term “Medical Staff” shall mean all Practitioners who are subject to the Bylaws of the Medical Staff.

(d) The term “Compensation Arrangement” shall mean any employment, payment, economic incentive, gift, gratuity, discount, forgiveness of debt or other benefit made directly or indirectly, overtly or covertly, in cash or in kind, which is substantial in nature.
(e) The term “Decision-Maker” means any Hospital Representative or Practitioner who is contemplating an Action and their Immediate Family Members.

(f) The term “Designated Chair” means that person appointed to direct and oversee the Decision-Makers and the process resulting in the contemplated Action.

(g) The term “Hospital” shall mean Indiana University Health Ball Memorial Hospital, Inc., Inc. and any parent, subsidiary or affiliate of the Hospital.

(h) The term “Hospital Representative” shall mean any person acting for or on behalf of the Hospital, including but not limited to the Hospital’s directors, officers, employees, contractors, and agents.

(i) The term “Immediate Family Member” means a spouse, child, parent (natural or adoptive), sibling, grandparent, grandchild, spouse of grandparent or grandchild, stepparent, stepchild, stepbrother, stepsister, and any in-laws (father, mother, son, daughter, brother, sister).

(j) The term “Interested Decision-Maker” shall mean any Decision-Maker who maintains a Business Interest that may influence their contemplation of a particular Action.

(k) The term “Office or Position” means any elected or appointed post with a third party that (a) permits access to non-public financial or strategic information of the third party; (b) requires a duty of loyalty to the third party; or (c) both.

(l) The term “Ownership or Investment Interest” means any holding of five percent (5%) or more of the stock, investments, partnership shares, membership or other interest in a business through debt, equity, or other means.

(m) The term “Practitioner” shall apply to all licensed health care practitioners who qualify as either Medical Staff or Allied Health Professionals under the Medical Staff Bylaws and whose interests may be affected by a particular Action.
(A) 14.C. Policy and Procedure

(1) Duty to Disclose.
(a) Prior to the contemplation of any Action, all Decision-Makers shall be asked to review the Business Interest Questionnaire, attached hereto as Exhibit A, and disclose to the Designated Chair and other Decision-Makers:
   (i) Any affirmative Questionnaire responses; and
   (ii) All information requested by the Decision-Makers regarding the particular Business Interest(s) that may cause him/her to qualify as an Interested Decision-Maker.
(b) All such disclosures shall be recorded in or as part of the Decision-Maker’s meeting minutes.
(c) Unless a particular Decision-Maker’s disclosure results in a decision under 14.C.2 below, the Decision-Maker shall participate without further review.

(2) Determining Whether a Conflict of Interest Exists.
(a) Following any such disclosure and necessary explanations, the Interested Decision-Maker shall leave the room and the other Decision-Makers shall review the matter and decide by majority vote
   (i) whether a conflict of interest exists,
   (ii) whether an existing conflict could be remediated under specified conditions (e.g., confidentiality/nondisclosure agreement, etc.); and
   (iii) whether the Interested Decision-Maker may participate, in any capacity, in the Action and if so, the specified conditions.
(b) The Designated Chair for the Decision-Makers shall notify the Interested Decision-Maker of the decision and if necessary,
   (i) dismiss the Interested Decision-Maker from any further proceedings,
   (ii) remediate the conflict as appropriate, or
   (iii) ask the Interested Decision-Maker to withdraw from the Business Interest that has created the conflict, as appropriate.
   The Interested Decision-Maker shall act accordingly.
(c) If the Interested Decision-Maker is dismissed, the other Decision-Makers shall decide, after exercising due diligence, whether an alternative approach, the appointment of another disinterested Decision-Maker, or both, would result in an Action that would not give rise to a conflict of interest.

(d) If such an Action (that would not give rise to a conflict of interest) is not reasonably attainable, the Decision-Makers shall decide by a majority vote whether the Action and related proceedings are fair and reasonable, in the best interest of the Hospital and the Medical staff and whether the Action should proceed accordingly.

(e) If it is decided that an Action should proceed, the Designated Chair shall poll all Decisions-Makers to confirm and resolve, if necessary, any remaining conflicts, objections, or questions that may exist before further contemplation of the Action occurs.

(3) Violations.

(a) Any Decision-Maker who has reasonable cause to believe that a Decision-Maker has failed to disclose an actual or potential conflict of interest shall report same to the Designated Chair who shall inform the Decision-Maker of the basis for such belief and afford him/her an opportunity to explain the alleged failure to all other Decision-Makers.

(b) If, after hearing the Decision-Maker’s explanation and conducting any further due diligence, the other Decision-Makers determine by a majority vote that an actual or potential conflict has not been properly disclosed, the Decision-Makers shall take all steps set forth in Section (3) above.

(c) The Designated Chair shall report the Interested Decision-Maker’s failure to disclose the conflict to the Chair of the Medical Staff (in the case of Practitioners) or the President (in the case of a Hospital Representative) for further disciplinary and corrective action as appropriate.

(4) Records.

The Designated Chair (or designee) shall create a record of any proceedings that concern an actual or potential conflict of interest which includes the following:

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Hard copy is uncontrolled. Check DMS for current version.
(a) The name of the Interested Decision-Maker(s) who disclosed, or otherwise was found to have a Business Interest that created an actual or potential conflict of interest;
(b) The nature of the Business Interest;
(c) Any action taken by the Decision-Makers to determine whether a conflict of interest existed;
(d) All actions taken by the Decision-Makers if a conflict of interest existed; and

The names of all Decision-Makers who were present for the discussion and votes relating to the contemplated Action, the content of any discussion, including any alternatives to the contemplated Action, and a record of any votes taken in connection therewith.
INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL, INC., INC.
MEDICAL STAFF

CONFLICT OF INTEREST POLICY

(A) 14.D. Exhibit A -- Financial Interest Questionnaire

NAME OF DECISION-MAKER
COMPLETING THIS QUESTIONNAIRE:______________________________

NATURE OF PENDING ACTION:_____________________________________ 

NAME(S) OF PRACTITIONER(S) WHOSE INTERESTS MAY BE AFFECTED
BY THIS ACTION:__________________________________________________

________________________________________________________________

INSTRUCTIONS: Please complete this Questionnaire and return it to the Designated Chair named above prior to the contemplation of the above-referenced Action.

The purpose of this Questionnaire is to assist you, the Decision-Maker, in recalling any actual or potential Business Interests that may affect (1) your independent contemplation of the pending Action and (2) the rights of the above-referenced Practitioner, as follows:

BUSINESS RELATIONSHIPS. Are you a party to any joint venture, partnership or other business relationships with any outside person or entity that you reasonably believe (a) secures or may secure goods or services from the Practitioner; (b) competes, directly or indirectly, with this Practitioner; (c) is involved, or is likely to become involved, in any litigation or adversarial proceeding with this Practitioner; or (d) may otherwise affect your independent review and contemplation of this pending Action?

______  YES  ______  NO
**ECONOMIC INTERESTS.** Do you maintain any economic interests wherein you hold an equivalent position or a financial interest of five percent (5%) in any outside business that you reasonably believe (a) secures or may secure goods or services from this Practitioner; (b) competes, directly or indirectly, with this Practitioner; (c) is involved, or is likely to become involved, in any litigation or adversarial proceeding with this Practitioner; or (d) may otherwise affect your independent review and contemplation of this pending Action?

_____ YES  _____ NO

**OWNERSHIP OR INVESTMENT INTERESTS.** Do you maintain any holdings of five percent (5%) or more of the capital stock, investments, or profits in any business that you reasonably believe (a) secures or may secure goods or services from this Practitioner; (b) competes, directly or indirectly, with the Practitioner; (c) is involved, or is likely to become involved, in any litigation or adversarial proceeding with this Practitioner; or (d) may otherwise affect your independent review and contemplation of the pending Action?

_____ YES  _____ NO

**EMPLOYMENT OR OTHER COMPENSATION ARRANGEMENTS.** Do (or will) you accept or enter into any part-time, full-time, or “as needed” employment or other compensation arrangements from an outside person or entity that you reasonably believe (a) secures or may secure goods or services from this Practitioner; (b) competes, directly or indirectly, with this Practitioner; (c) is involved, or is likely to become involved, in any litigation or adversarial proceeding with this Practitioner; or (d) may otherwise affect your independent review and contemplation of the pending Action?

_____ YES  _____ NO

**APPOINTED OR ELECTED OFFICE OR POSITION.** Do you hold any appointed or elected office of position with an outside entity, whether or not you are compensated, that you reasonably believe (a) secures or may secure goods or services from this Practitioner; (b) competes, directly or indirectly, with this Practitioner; or (c) is involved, or is likely to become involved, in any litigation or adversarial proceeding with this Practitioner; (d) permits you access to certain non-public information related

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to this contemplated Action or this Practitioner; or (e) may affect your independent review and contemplation of the pending Action?

_____ YES  _____ NO

OUTSIDE ACTIVITIES. List and describe any managerial, consulting, expert witness, patent or other outside activities that you reasonably believe (a) secures or may secure goods or services from this Practitioner; (b) competes, directly or indirectly, with this Practitioner; (c) is involved, or is likely to become involved, in any litigation or adversarial proceeding with this Practitioner; or (d) may affect your independent review and contemplation of the pending Action?

_____ YES  _____ NO

GIFTS, GRATUITIES AND ENTERTAINMENT. Indicate whether you have accepted any substantial gifts, gratuities, entertainment or favors any outside person or company that you reasonably believe (a) secures or may secure goods or services from the Hospital; (b) competes, directly or indirectly, with the Hospital or any of its subsidiaries or affiliates; (c) is involved, or is likely to become involved, in any litigation or adversarial proceeding with the Hospital; or (d) may compromise your duty of loyalty the Hospital and its Medical Staff.

_____ YES  _____ NO

I hereby affirm that to the best of my knowledge the above responses are accurate and complete at this time.

SIGNATURE OF DECISION-MAKER
COMPLETING THIS QUESTIONNAIRE: __________________________

DATE:      ____________________, 20__
(A) 15. Article 15 -- Amendments

(a) All proposed amendments must be reviewed by the Executive Committee prior to a vote by the Medical Staff. The Executive Committee shall provide notice by reporting on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least fourteen (14) days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(b) The Executive Committee may present proposed amendments to the voting staff by mail ballot. Along with the proposed amendments, the Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by at least fifty percent (50%) of the staff eligible to vote.

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

(d) All amendments shall be effective only after approval by the Board.

(e) If the Board has determined not to accept a recommendation submitted to it by the Executive Committee or the Medical Staff, the Executive Committee may request a conference with the officers of the Board, for the purpose of permitting the Board to communicate its rationale for its contemplated action and permitting the Executive Committee to discuss the rationale for the recommendation. Such a conference will be scheduled by the President within two (2) weeks after receipt of a request for same submitted by the Chair.

(A) 16. Article 16 -- Rules and Regulations of The Medical
Staff

(a) Medical Staff Rules and Regulations, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws, shall be adopted in accordance with this Article. Rules and Regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and Regulations shall have the same force and effect as the Bylaws.

(b) Rules and Regulations may be adopted, amended, repealed, or added by the Executive Committee, provided that the proposed Rules and Regulations are posted in the Medical Staff lounge for fourteen (14) days prior to their adoption, amendment, repeal, or addition.

(c) Rules and Regulations may also be adopted, amended, repealed, or added by the Medical Staff at a regular meeting or special meeting called for that purpose provided that the procedure used in amending the Medical Staff Bylaws is followed.

(d) Adoption of and changes to the Rules and Regulations shall become effective only when approved by the Board.

(e) The present Rules and Regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent they are inconsistent, they are of no force and effect.
(A) 17. Article 17 -- Board Confirmation and Indemnification

All Medical Staff officers, department chairs, committee chairs, committee members, and individual staff appointees who act for and on behalf of the Hospital in discharging their responsibilities and professional review activities pursuant to these Bylaws, the Credentialing Policy, the Medical Staff Organization and Functions Manual, and/or the Policy on Other Health Professionals, shall be indemnified when acting in those capacities, to the fullest extent permitted by law, provided that the Board has confirmed the appointment and/or election of the individual to the position in question.

(A) 18. Article 18 -- Peer Review

In performing responsibilities hereunder, the Departments and Committees of the Medical Staff, the Board of Directors and any other committees of the Board are intended to constitute a “peer review committee” within the meaning of the federal Health Care Quality Improvement Act and the Indiana State Peer Review Act. All proceedings of a peer review committee are confidential. All communications to a peer review committee are privileged communications. Neither the personnel of a peer review committee nor any participant in a committee proceeding shall reveal any content of communications to, the records of, or the determination of a peer review committee outside the peer review committee unless otherwise provided by law.
(A) 19. Article 19 -- Adoption

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

Adopted by the Medical Staff on:

Date: __________________________

____________________________________
Chair

Approved by the Board:

Date: __________________________

____________________________________
Chair, Board of Directors
(B) Medical Staff Organization and Functions Manual
(B) 1. Article 1 -- Definitions

(B) 1.A. Definitions
The definitions listed in the Medical Staff Bylaws apply to terms used in this Policy.

(B) 2. Article 2 -- Medical Staff Organizational Plan

(B) 2.A. Development and Annual Review of Plan
Each year, the Executive Committee shall review the structure of the Medical Staff as set forth in this manual with reference to appropriate legal guidelines and accrediting agency standards. This plan shall describe the organization of the Medical Staff and specify the functions of each Medical Staff standing committee. A special or ad hoc committee may be created by the Executive Committee from time to time to assist with the development of an organizational plan.
(B) 3. Article 3 -- Clinical Departments

(B) 3.A. List of Departments

The following clinical departments are established. In the event sections are formed, minutes of and attendance at meetings of the sections or divisions shall be recorded.

- Anesthesiology Department
- Cardiology Department
- Emergency Department
- Family Medicine Department
- Medical Department
- Orthopedic Department
- Obstetrics and Gynecology Department
- Pathology Department
- Pediatric Department
- Psychiatry Department
- Radiology Department
- Surgery Department

(B) 3.B. Creation of Additional Departments

Additional departments may be established pursuant to the following process:

Ten or more members of the Medical Staff with similar practices may petition the Executive Committee to become a "department applicant."

With approval of the Executive Committee, the "department applicant" shall function as a provisional department for three (3) years, during which time the "department applicant" shall keep minutes of its meetings, establish peer review, and otherwise function as a department as set forth in 3.C., herein.

After three (3) years, the "department applicant" may petition the Executive Committee to become a department. The Executive Committee shall consider the matter and make a recommendation to the Board, which shall make the determination of whether to create the department.
(B) 3.C. Functions and Responsibilities of Departments

The functions and responsibilities of clinical departments and clinical department chairs, including medical directors of clinical sections or divisions, shall be those set forth in Article 10 of the Medical Staff Bylaws, which are herein incorporated by reference.

(B) 4. Article 4 -- Medical Staff Committees and Functions

This article shall outline those Medical Staff committees responsible for the performance of quality assessment/evaluation or other review functions delegated to the Medical Staff by the Board.

(B) 4.A. General Information

Committee Chairs

All committee chairs, unless otherwise provided for in Articles 6 and 7 of the Medical Staff Bylaws and/or this manual shall be recommended by the Chair and appointed by the Executive Committee for an initial term of two (2) years beginning on July 1 and ending on June 30. All committee chairs shall be appointed based on the criteria set forth in Section 6.B. of the Medical Staff Bylaws. Such appointments shall become effective when approved by the Board. After serving an initial term, a chair may be reappointed by the Board from year to year for a maximum of three (3) additional two(2) year terms upon recommendation from the Chair and the President.

Members

Except as otherwise provided for in the Medical Staff Bylaws or this manual, members of each committee shall be appointed yearly by the Chair, in consultation with the Executive Committee and the President, not more than thirty (30) days after the annual meeting of the Medical Staff, and there shall be no limitation in the number of terms they may serve. All appointed members may be removed and vacancies filled at the discretion of the Chair.

The Chair and the President, the Executive Vice President-Clinical Development or their respective designees shall be members, ex officio, without vote, on all committees.

Unless otherwise provided in this manual, the secretary of each committee shall be appointed by the chair of the committee.
Committee Meetings

All Medical Staff committees shall meet at least quarterly, unless otherwise specified in this manual, at a time set by the chair of the committee. The agenda for the meeting and its general conduct shall be set by the chair.

All committee chairs shall have the authority to convene their committees for special meetings as needed, in addition to those regular meetings required by this manual. The notice requirements set forth in the Medical Staff Bylaws, Article 11.C. through D. shall apply.

Quorum for Committee Meetings

No quorum shall be required to convene a regular or special meeting of a committee, but in no event shall a meeting be convened with less than two (2) members including the chair.

Attendance by Medical Staff Appointees

Active Staff appointees may attend any staff committee meetings, except for portions of such meetings during which confidential credentialing and/or peer review matters are discussed.

(B) 4.B. Executive Committee

The composition and functions of the Executive Committee are set forth in Article 4 of the Medical Staff Bylaws, the provisions of which are incorporated herein by reference.

(B) 4.C. Credentials Committee

The composition and functions of the Credentials Committee are set forth in Article 7 of the Medical Staff Bylaws, the provisions of which are incorporated herein by reference.

(B) 4.D. Board Joint Conference Committee

The Board Joint Conference Committee is a Board and Clinical Staff Committee, the composition and functions of which are set forth in full in the Corporate Bylaws. Essentially, the Committee consists of representatives from the Medical Staff leadership as well as the Board, and is responsible for the discussion of hospital policies, as well as peer review. Any change in the Corporate Bylaws will automatically change the description of the Joint Conference Committee set forth herein.

(B) 4.E. Operating Room Committee

Composition

The Operating Room Committee will be composed of the following persons: the Medical Director of the Hospital Operating Room, five (5) physicians
appointed by the Executive Committee who are all Active members of the Medical Staff, the Hospital Senior Administrative Director of Surgical Services, the Hospital Manager of the Operating Room and the Hospital Assistant Manager(s) of the Operating Room. The Hospital Chief Medical Officer and the President may attend as ex-officio members of the committee.

Duties
The purpose of the Operating Room Committee will be to provide a source of assistance for efficient operation of the Hospital Operating Rooms. The committee will focus its efforts on development of block schedules and monitoring of surgical site markings, time out compliance, start times, late case starts, cancelled cases, turnover times and scheduling of unconfirmed cases (e.g. scheduling prior to confirming that patient can be scheduled for the procedure). In addition, the committee will assist in development of policies related to the Hospital Operating Rooms, evaluate quality data and make recommendations concerning surgical services.

Meetings, Reports and Recommendations
The Operating Room Committee shall meet as often as necessary to transact its business, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the Executive Committee. The committee may from time to time adopt written rules, regulations, policies or protocols for the discharge of its duties. Such written rules, regulations, policies or protocols shall become effective upon approval by the Executive Committee and publication to all members of the Medical Staff and House Staff. The committee shall serve as a peer review committee as set forth in Article 18 of the Bylaws of the Medical Staff.

(B) 4.F. Physician Health and Well Being Committee

Purpose
The purpose of the Physician Health and Well Being Committee is to provide a source of assistance to members of the Medical Staff and House Staff whose health and well being may be in jeopardy; by the reason of emotional difficulties or problems caused by alcohol or other drug abuse, or other health problems.
Composition

The Physician Health and Well Being Committee will be composed of five (5) persons appointed by the Executive Committee which shall consider the following in making its appointments:

All members shall have been members of the Active Medical Staff for, at least, five (5) years and, preferably, have a broad exposure to leadership positions.

All members shall be appointed for their demonstrated expertise and/or experience in the areas of physician health, chemical and alcohol dependence, and willingness to serve on the committee.

No more than one (1) shall be appointed from any department.

One (1) member shall have a specialty related to psychiatry.

The members of the committee shall be appointed to serve a three (3) year term. Initially, one (1) member shall be appointed serve a (1) year term; two (2) members shall be appointed to serve two (2) years; and two (2) members shall be appointed to serve three (3) year terms.

The Executive Committee shall designate one of the members the chair.

Since experience is beneficial, reappointment of members, who have provided valuable service and are willing to continue to serve, is encouraged.

No member, during his term as member, shall also serve on the Executive Committee, Credentials Committee, Board of Directors, or as a Department Chair.

There shall be no ex-officio members of the committee.

Duties

The committee shall provide education to its members and to members of the Medical Staff and House Staff concerning physician health, well being and impairment; appropriate responses to different levels and kinds of distress and impairment; and appropriate resources for prevention, treatment and rehabilitation.

The committee shall accept referrals when requested from the Executive Committee or the Credentials Committee to investigate, monitor or council with a member of the Medical Staff:
who is subject to an investigation or disciplinary action or
who is subject of concerns from either committee about his/her health and/or well being.

The committee shall
not provide treatment but shall council with members of the Medical Staff and House Staff and recommend or refer members to sources for treatment.

be the identified point within the Hospital to receive information from and concerning any member of the Medical Staff or House Staff being monitored by the committee.

shall have no authority to take disciplinary actions.

assist in the monitoring or supervising such member’s recovery.

keep all information received by the committee, together with its source, confidential.

serve as a peer review committee as set forth in Article 16 of the Bylaws of the Medical Staff.

The chair of the committee will keep the Chair informed about the general aspects of any of its intervention with members that may affect patient care and will specifically notify the Chair of any member referred to it who refuses to cooperate with the committee or deviates significantly from an agreed upon plan.

The committee may from time to time adopt written rules, regulations, polices or protocols for the discharge of its duties. Such written rules, regulations, policies, or protocols shall become effective upon approval of the Executive Committee and publication to all members of the Medical Staff and House Staff.

The committee shall meet at the call of its chair as frequently as is required to fulfill its duties.

(B) 4.G. Pharmacy and Therapeutics Committee

Composition

The Pharmacy and Therapeutics Committee shall consist of an adequate number of Active Medical Staff members to well represent the various departments and specialties of the Medical Staff. One physician shall be selected as the Chairperson of the Committee. The Director of Pharmacy Services and appointed pharmacists overseeing clinical or distributive pharmacy services shall also serve as committee members. The Director of the Pharmacy Services or designee shall act as Secretary for the Committee. The committee may also consist of ex officio members, without vote, such as
a representative from Hospital Administration, Nursing Services, or other departments as deemed necessary.

**Duties**

The duties of the Pharmacy and Therapeutics Committee shall be to examine and survey all drug utilization policies and practices within the hospital in order to assure optimum clinical results and a minimum potential for hazard. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety and all other matters relating to drugs in the Hospital. It shall also perform the following specific functions:

- Evaluate clinical data concerning new drugs requested for use in the hospital, in order to develop a comprehensive formulary while preventing unnecessary duplication. The formulary should be continuously reviewed.
- Review drug usage in the hospital, primarily through means of Drug Usage Evaluations.
- Develop and maintain policies and procedures related to drug use.
- Educate the Medical Staff and other health care professionals on appropriate drug use as necessary.
- Review all reported cases of suspected adverse drug reactions and medication errors.
- Make recommendations concerning drugs to be stocked on the nursing units and by other services.
- Serve as an advisory group to the Medical Staff and Pharmacists on matters pertaining to the choice of available drugs.
- Serve as a peer review committee.
- Provide consultation with the Institutional Review board in establishing standards in the use of investigational drugs.

**Meetings, Reports and Recommendations**

The Pharmacy and Therapeutics Committee shall meet as often as necessary to transact its business, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the Executive Committee and the Chief Executive Officers.

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The Committee shall report (with or without recommendation) to the Credentials Committee for its consideration and appropriate action any situation involving questions of the clinical competency, patient care and treatment or case management of any individual appointed to the Medical Staff.

The Committee shall report (with or without recommendation) to the Executive Committee for its consideration and appropriate action any situation involving questions of professional ethics, infraction of Hospital or Medical Staff Bylaws or rules or unacceptable conduct on the part of any individual appointed to the Medical Staff.

(B) 4.H. Infection Control Committee

Composition

The Infection Control Committee shall consist of:
one (1) representative from each clinical department,
one (1) representative of the Department of Pathology,
and at least one (1) each from the Nursing Service and Hospital Management,
and
the Hospital Epidemiologist.

Duties

The Infection Control Committee shall be responsible for the surveillance of inadvertent Hospital infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities, and may include:
operating rooms, delivery rooms, recovery rooms, and special care units;
sterilization procedures by heat, chemicals or otherwise;
isolation procedures;
prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;
testing of Hospital personnel for carrier status;
disposal of infectious material;
required cultures of personnel or of the environment;
antimicrobial susceptibility or resistance trend studies;
the relation of infection to length of stay;
Meetings, Reports and Recommendations

The Infection Control Committee shall meet at least bi-monthly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a monthly report to the Executive Committee, the Chief Executive Officer and the Director of Nursing Services.

(B) 4.I. Bylaws Committee

Composition

The Bylaws Committee shall consist of five persons appointed from the Active Staff.

Duties

The Bylaws Committee shall review the Bylaws of the Medical Staff and the related Medical Staff documents at least annually and recommend amendments thereto to the Executive Committee. In addition the Committee shall receive and consider all recommendations for changes by the Board, the Board Joint Conference Committee, the Executive Committee of the Medical Staff, the departments, the Chair, the President, committees of the Medical Staff and any individual appointed to the Medical Staff.

Meetings, Reports and Recommendations

The Bylaws Committee shall meet as often as necessary to fulfill its duties, shall maintain a permanent record of its activities, and shall report its recommendations to the Executive Committee and the President.

(B) 4.J. Professional Standards Committee

Composition

The Professional Standards Committee will be composed of five (5) persons appointed by the Executive Committee who are all Active members of the Medical Staff and who have at least five (5) years of Active Medical Staff experience. There will also be ad hoc members, one (1) from each
Department, from time to time to assist. The ad hoc members will be called upon to review specific cases as determined by the five (5) permanent members of the Professional Standards Committee. The Executive Committee will consider the following in making its appointments to the Professionals Standards Committee:

Members should have a broad experience in leadership positions. Members should have experience with physician behavior review. Each should have demonstrated a capacity to keep peer review protected information confidential. It is preferable that a majority of the five (5) permanent members be past Executive Committee Chairs.

**Duties**

The Professional Standards Committee will have three primary duties. They will first develop and update (approximately every two years) a code of conduct for appropriate professional behavior. Secondly, they will develop and implement a tool to measure physician communication skills. Finally, they will review all reports of unprofessional conduct by physicians referred to the Professional Standards Committee and when applicable, investigate, monitor or council with a member of the Medical Staff and House Staff and recommend or refer members to sources for assistance. The Professional Standards Committee shall have no authority to take disciplinary actions and shall serve as a peer review committee as set forth in Article 16 of the Bylaws of the Medical Staff. The chair of the Professional Standards Committee will keep the Chair informed about the general aspects of any of its intervention with members referred to it who refuses to cooperate with the committee or deviates significantly from an agreed upon plan. The Professional Standards Committee shall meet at the call its chair as frequently is required to fulfill its duties.

(B) 4.K.  **Transfer Quality Committee**

**Composition**

The Transfer Quality Committee will be composed of the following persons: a member of the Executive Committee, the Hospital Chief Medical Officer, an Emergency Department physician member of the Medical Staff, a Surgery Department member and a Hospitalist physician member of the Medical Staff. The Hospital Senior Administrative Director of Critical Care and the ‘Just
Call Ball’ Registered Nurse may attend as ex-officio members of the Committee.

**Duties**

The purpose of the Transfer Quality Committee will be to evaluate the appropriateness of external patient acceptance or transfer to a receiving facility based on the patient care rendered or capable of being rendered, the activities of the provider incident to the acceptance or transfer and whether same affects or could affect adversely the health or welfare of a patient or patients. The committee will focus its efforts on review of the ‘Just Call Ball’ quality assurance records and evaluation of other quality data.

**Meetings, Reports and Recommendations**

The Transfer Quality Committee shall meet as often as necessary to transact its business, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the Executive Committee. The committee may from time to time adopt written rules, regulations, policies or protocols for the discharge of its duties. Such written rules, regulations, policies, or protocols shall become effective upon approval by the Executive Committee and publication to all members of the Medical Staff and House Staff. The Transfer Quality Committee shall have no authority to take disciplinary actions and shall serve as a peer review committee as set forth in Article 18 of the Bylaws of the Medical Staff.
(B) 5. Article 5 -- Amendments

This Medical Staff Organization and Functions Manual may be amended or repealed by vote of the Executive Committee at any regular or special meeting, provided that copies of the proposed amendments, additions or repeals are posted on the Medical Staff bulletin board and/or electronic information system, and/or delivered, either in person or by mail, to each Medical Staff appointee and made available to all members of the Executive Committee at least fourteen (14) days before being voted upon, and further provided that all written comments on the proposed changes by persons holding current appointments to the Medical Staff are brought to the attention of the Executive Committee before the change is voted upon.

When notice of proposed amendments, additions or repeals are mailed to Executive Committee members, they shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to the members at their addresses as they appear on the records of the Hospital. Such posting and mailing shall be deemed to constitute actual notice to the persons concerned.

Adoption of and changes to this Medical Staff Organization and Functions Manual shall become effective when approved by the Board.
(B) 6. Article 6 -- Adoption

This Medical Staff Organization and Functions Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff bylaws and policies pertaining to the subject matter herein, and henceforth all department and committee activities of the Medical Staff and of each individual serving as a member of a department or staff committee shall be undertaken pursuant to the requirements of this manual.

Adopted by the Medical Staff:

By:

(Date)

Approved by the Board of Directors:

By:

(Date)
(C) Credentialing Policy
(C) 1. Article 1 -- General

(C) 1.A. Definitions
The definitions listed in the Medical Staff Bylaws apply to terms used in this Policy.

(C) 1.B. Time Limits
Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

(C) 1.C. Delegation of Functions
When a function is to be carried out by a person or committee, the person, or the committee through its chair, may delegate performance of the function to one or more qualified designees. However, except as specifically stated herein, the Medical Executive Committee and Board may not delegate decisions regarding the granting of appointment and clinical privileges, or modification of same, with respect to an individual applicant.
(C) 2. Article 2 -- Qualifications, Conditions and Responsibilities

(C) 2.A. Qualifications

(1) Eligibility Criteria
To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists and podiatrists must:

(a) have a current unrestricted license to practice in this state and have never had a license to practice revoked or suspended by any state licensing agency;

(b) where applicable to their practice, have a current, unrestricted DEA registration and state controlled substance license;

(c) be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill their medical staff responsibilities and to provide timely and continuous care for their patients in the Hospital;

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

(e) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;

(f) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health care program;

(g) have never had medical staff appointment or clinical privileges denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(h) have never been convicted of any felony, or of any misdemeanor relating to controlled substances, illegal drugs, insurance fraud or abuse or violence;

(i) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the AOA in a specialty in which the applicant seeks clinical privileges,
or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association (This requirement is applicable only to those individuals who apply for initial staff appointment on or after January 1, 2005);

(j) be certified by the appropriate specialty board of the ABMS, the AOA, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency training within the last five (5) years shall be eligible for medical staff appointment. However, in order to remain eligible, those applicants must achieve board certification within five (5) years from the date of completion of their residency training. (This requirement is applicable only to those individuals who apply for initial staff appointment on or after January 1, 2005, and shall thereafter apply to those individuals at reappointment. All individuals appointed previously shall be governed by the board certification requirements in effect at the time of their appointments); and

(k) qualify as a "health care provider" under the Indiana Medical Malpractice Act.

(2) Waiver of Criteria

(a) Any individual who does not satisfy a criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, Executive Committee, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.
(c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.

(d) A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

(3) **Factors for Evaluation**

Only those individuals who can document that they are highly qualified in all regards will be appointed to the Medical Staff. The following factors will be evaluated as part of the appointment and reappointment processes:

(a) relevant training, experience, demonstrated current competence and judgment;
(b) adherence to the ethics of their profession;
(c) good reputation and character;
(d) ability to perform, safely and competently, the clinical privileges requested; and
(e) ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by them will receive quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner.

(4) **No Entitlement to Appointment**

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

(a) is licensed to practice a profession in this 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;
(d) resides in the geographic service area of the Hospital; or
(e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

(5) **Nondiscrimination**

No individual shall be denied appointment on the basis of gender, age, ancestry, race, color, creed, sex, marital status, or national origin.
(C) 2.B. General Conditions of Appointment and Reappointment

(1) Basic Responsibilities and Requirements

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every applicant and appointee specifically agrees to the following:

(a) to provide for the continuous and timely care to all patients for whom the individual has responsibility;

(b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed;

(c) to accept committee assignments, emergency service call obligations, and such other reasonable duties and responsibilities as assigned;

(d) to provide, with or without request, new or updated information to the President as it occurs, pertinent to any question on the application form;

(e) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable Bylaws, Rules and Regulations and agrees to be bound by them;

(f) to appear for personal interviews in regard to an application for initial appointment or reappointment;

(g) to use the Hospital sufficiently to allow continuing assessment of current competence;

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

(i) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(j) to refrain from deceiving patients as to the identity of any individual providing treatment or services;

(k) to seek consultation whenever necessary;

(l) to participate in monitoring and evaluation activities of himself/herself and peers;

(m) to complete in a timely manner all medical and other required records, containing all information required by the Hospital;
(n) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
(o) to promptly pay any applicable dues and assessments;
(p) to satisfy continuing medical education requirements;
(q) to be involved annually in the minimum number of patient contacts established by the Credentials Committee; and
(r) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal.

(2) Burden of Providing Information

(a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

(b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information requiring primary source verification has been received. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

(d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.
(C) 2.C. Application

(1) Information

(a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.

(b) In addition to other information, the applications shall seek the following:

(i) information as to whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged;

(ii) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(iii) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the Executive Committee, or the Board may request;

(iv) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and

(v) information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital,
clinical information from the individual's private office practice, peer references, and/or a quality profile from a managed care organization).

(c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

(2) **Grant of Immunity and Authorization to Obtain/Release Information**

By applying for appointment, reappointment, or clinical privileges, the applicant expressly accepts the following conditions during the processing and consideration of the application, whether or not appointment or clinical privileges are granted, and throughout the term of any appointment or reappointment.

(a) **Immunity**

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, the Medical Staff, their authorized representatives, and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Hospital, its authorized agents, or appropriate third parties.

(b) **Authorization to Obtain Information from Third Parties**

The individual specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request.

(c) **Authorization to Release Information to Third Parties**
As required by law, the individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility. Otherwise, such information will be disclosed only pursuant to a written, signed release.

(d) **Hearing and Appeal Procedures**

The individual agrees that the hearing and appeal procedures set forth in the Medical Staff Bylaws shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) **Legal Actions**

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Hospital and any appointee to the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

(f) **Authorization to Share Information among Components of the System**

The individual specifically authorizes the Hospital and its component system to share credentialing and peer review information within the system for applicable credentials, quality management, utilization and risk management review pertaining to the individual’s clinical competence and/or professional conduct.
(C) 3. **Article 3 -- Procedure For Initial Appointment To The Medical Staff**

(1) **Procedure For Initial Appointment**
   (a) Applications for appointment shall be in writing and shall be on forms approved by the Board upon recommendation by the Executive Committee and Credentials Committee.
   (b) An individual seeking initial appointment shall be sent a letter that outlines the eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form.

(2) **Initial Review of Application**
   (a) A completed application form with copies of all required documents must be returned to the Credentialing Office within 60 days after receipt. The application must be accompanied by the application fee.
   (b) As a preliminary step, the application will be reviewed by the credentialing coordinator to determine that all questions have been answered and that the individual satisfies all threshold criteria. Incomplete applications will not be processed. Individuals who fail to return completed applications or fail to meet the threshold criteria will be notified that their application will not be processed.
   (c) The Credentialing Office shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.
   (d) The names of applicants shall be posted so that appointees to the Medical Staff may submit, in writing, information bearing on the applicant's qualifications for appointment or clinical privileges.

(3) **Steps to Be Followed for All Initial Applicants**
   (a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chiefs at other health care entities, residency training director, and others who may have knowledge
about the applicant's education, training, experience, and ability to work with others.

(b) An interview with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by any of the following individuals: the department chair, a Credentials Committee representative, the Credentials Committee, and/or the Chair.

(4) **Department Chair Procedure**

(a) The Credentialing Office shall transmit the complete application and all supporting materials to the chair of the department in which the applicant seeks clinical privileges. The department chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.

(b) The department chair shall be available to the Credentials Committee, Executive Committee or the Board to answer any questions that may be raised with respect to that chair's report and findings.

(5) **Credentials Committee Procedure**

(a) The Credentials Committee shall review and consider the report prepared by the relevant department chair and shall make a recommendation.

(b) The Credentials Committee may use the expertise of the department chair, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) The Credentials Committee may determine that an applicant is otherwise qualified for appointment and privileges.

(i) After making such a determination, the Credentials Committee shall review the applicant's Confirmation of Ability to Perform Privileges Requested to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment.
(ii) If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration.

(iii) Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

(d) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

(e) The Credentials Committee may determine that an applicant is not otherwise qualified for appointment and clinical privileges. In such cases, the Credentials Committee need not review the applicant's Confirmation of Ability to Perform Privileges Requested. Rather, the Committee may forward its recommendation directly to the Executive Committee.

(f) If the recommendation of the Credentials Committee is delayed longer than 60 days, the Chair of the Credentials Committee shall send a letter to the applicant, with a copy to the Executive Committee and the President, explaining the reasons for the delay.

(6) **Executive Committee Procedure**

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Executive Committee shall:

(i) adopt the findings and recommendation of the Credentials Committee as its own; or

(ii) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by
the Executive Committee prior to its final recommendation; or

(iii) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(b) If the recommendation of the Executive Committee is to appoint, the recommendation shall be forwarded to the Board through the President. These recommendations can be in the form of an Executive Committee report to the Board.

(c) If the recommendation of the Executive Committee would entitle the applicant to request a hearing, the Executive Committee shall forward its recommendation to the President, who shall promptly send special notice to the applicant. The President shall then hold the application until after the applicant has completed or waived a hearing and appeal.

(7) **Board Action**

(a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Executive Committee and there is no evidence of any of the following:

(i) a current or previously successful challenge to any license or registration;

(ii) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or

(iii) a final adverse judgment in a professional liability action.

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

(b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(i) appoint the applicant and grant clinical privileges as recommended; or
(ii) refer the matter back to the Credentials Committee or Executive Committee or to another source inside or outside the Hospital for additional research or information; or
(iii) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chairs of the Credentials Committee and Executive Committee. If the Board's determination remains unfavorable to the applicant, the President shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

(8) **Time Periods for Processing**

Once an application is deemed complete, it is expected to be processed in less than 90 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

(C) 3.B. **Provisional Status**

(1) **Duration of Provisional Period**

(a) All initial appointments to the Medical Staff (regardless of the category of the staff) and all initial clinical privileges shall be provisional for a period of 12 months or longer, up to a maximum of 24 months, if recommended by the Credentials Committee.

(b) All grants of increased clinical privileges are also provisional. The duration and/or terms of this provisional period will be recommended by the Credentials Committee, after consulting with the department chair, and approved by the Board.

(c) During the provisional period, the individual shall be evaluated by the chair of the department in which the individual has clinical privileges and by the relevant committees as to the individual's clinical competence and general behavior and conduct in the Hospital.

(2) **Duties of Provisional Appointees**

(a) The provisional appointee must arrange, or cooperate in the arrangement of, the required numbers and types of cases to be
reviewed/observed by the department chair and/or designated observers.

(b) If the provisional appointee fails to:
   (i) admit or treat the number of patients established by the Credentials Committee (sufficient to permit observation and assessment), or
   (ii) fulfill requirements of appointment relating to completion of medical records,

then at the expiration of provisional appointment, all clinical privileges shall be automatically relinquished. The individual may reapply for initial appointment in the future. Whenever provisional appointment or provisional clinical privileges are terminated, revoked, or restricted for other reasons, the individual shall be entitled to a hearing and appeal.

(c) Notwithstanding the foregoing, if a provisional appointee fails to demonstrate competence in a part, but not in all areas of practice, and the privileges can be distinctly separated, then after extensive peer review all privileges may not be relinquished within the discretion of the Credentials Committee and the approval of the Board.
(C) 4. Article 4 -- Clinical Privileges

(C) 4.A. Clinical Privileges

(1) General

(a) Appointment or reappointment shall not confer any clinical privileges or right to practice at the Hospital.

(b) Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.

(c) The granting of the right to exercise clinical privileges includes responsibility for emergency service call established to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act (EMTALA) and/or other applicable requirements or standards.

(d) Clinical privileges may be voluntarily relinquished only in a manner that provides for the orderly transfer of applicable obligations and does not compromise the provision of emergency service call.

(e) In order for a request for privileges to be processed, the applicant must satisfy any applicable eligibility criteria.

(f) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with applicable contracts.

(g) The clinical privileges recommended to the Board shall be based upon consideration of the following:

(i) the applicant's education, training, experience, demonstrated current competence and judgment, references, utilization patterns, and ability to perform the privileges requested competently and safely;

(ii) availability of qualified staff appointees to provide coverage in case of the applicant's illness or unavailability;

(iii) adequate professional liability insurance coverage for the clinical privileges requested;

(iv) the Hospital's available resources and personnel;
(v) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(vi) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital; and

(vii) other relevant information, including a written report and findings by the chair of each of the clinical departments in which privileges are sought.

(h) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.

(i) The report of the chair of the clinical department in which privileges are sought shall be forwarded to the Credentials Committee and processed as a part of the initial application for staff appointment.

(j) During the term of appointment, an appointee may request increased privileges by applying in writing. The request shall state the specific additional clinical privileges requested and information sufficient to establish eligibility, as specified in applicable criteria. If the individual is eligible and the application is complete, it shall be processed in the same manner as an application for initial clinical privileges.

(k) If an application is deemed incomplete, then the applicant does not have any appeal rights for an incomplete application on which no action has been taken.

(2) Clinical Privileges for New Procedures

(a) Requests for clinical privileges to perform a significant procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure "new procedure") will not be processed until:

(i) a determination has been made that the procedure will be offered by the Hospital and until

(ii) criteria to be eligible to request those clinical privileges have been established.
The Credentials Committee shall be responsible to determine whether a service is "new," and thus requires approval under this Part.

(b) The Credentials Committee and the Executive Committee shall make a preliminary recommendation as to whether the new procedure should be offered, considering whether the Hospital has the capabilities, including support services, to perform the new procedure.

(c) If it is recommended that the new procedure be offered, the Credentials Committee shall conduct research and consult with experts, including appropriate chairs of the clinical departments, other appointees to the Medical Staff, and those outside the Hospital, and develop recommendations regarding:
   (i) the minimum education, training, and experience necessary to perform the new procedure, and
   (ii) the extent of monitoring and supervision that should occur if the privileges are granted.

(d) The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

(3) Clinical Privileges That Cross Specialty Lines

(a) Requests for clinical privileges that traditionally at the Hospital have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

(b) If the privileges requested are not developed then upon reasonable request the Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff (e.g., department chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
(c) If the Credentials Committee elects it shall develop new criteria regarding:
   (i) the minimum education, training, and experience necessary to perform the clinical privileges in question, and
   (ii) the extent of monitoring and supervision that should occur.

(d) The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

(4) **Clinical Privileges After Age 70**

(a) Individuals who desire to exercise clinical privileges after the age of 70 must apply for appointment/reappointment on a yearly basis.

(b) The Credentials Committee shall first assess the applicant's professional qualifications based on the reappointment factors. If the Credentials Committee determines that the individual appears to be professionally qualified for reappointment and continued privileges, it shall make a conditional recommendation to that effect and the individual shall then be required to undergo a physical and mental health assessment.

(c) The examining physician, mutually acceptable to the applicant and the Credentials Committee, shall provide a written report, addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff membership, or work cooperatively in a hospital setting. The report shall be provided directly to the Committee. The examining physician shall be available to discuss any questions or concerns that the Committee may have.

(d) The examining physician shall identify any accommodations that would be necessary to permit safe practice, discharge of responsibilities and effective functioning. The Credentials Committee and Executive Committee, in conjunction with Hospital management, will determine whether the accommodation(s) would be reasonable based on all of the circumstances.
(e) In the event that an accommodation would not be reasonable, the individual will be notified that he/she is ineligible for renewed clinical privileges.

(5) **Clinical Privileges for Dentists, Oral and Maxillofacial Surgeons, and Podiatrists**

(a) The scope and extent of surgical procedures that a dentist, an oral and maxillofacial surgeon or a podiatrist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

(b) Surgical procedures performed by dentists, oral and maxillofacial surgeons, and podiatrists shall be under the overall supervision of the Chair of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician who is an appointee to the medical staff before dental surgery shall be performed (with the exception of (c) below), and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) Oral and maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee and Executive Committee.

(d) The dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. The podiatrist may be allowed to complete a medical history and podiatric physical examination for ASA Class 1 and 2 patients if they are deemed qualified to do so by the Credentials Committee and Executive Committee based on their training, competence and experience. For non-ASA Class 1 and 2 patients, the medical history and physical examination is to be completed by a physician who is an appointee to the Medical Staff, and the podiatrist is responsible for completion of the podiatric history and physical examination, as well as all appropriate elements of the patient's record. Dentists, oral and maxillofacial surgeons, and
podiatrists may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws and this Policy.

(6) **Physicians in Training**

(a) Physicians in training at Indiana University Health Ball Memorial Hospital, Inc. shall not hold appointments to the Medical Staff and shall not be granted specific privileges. The program director, clinical faculty and/or attending staff appointees shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements and/or training protocols approved by the Vice President of Medical Education or his or her designee. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

(b) These provisions do not apply to individuals who may be residents, but who are employed by, or are performing some other service for, the hospital not in conjunction with a training program.

(C) 4.B. **Temporary Clinical Privileges**

(1) **Eligibility to Request Temporary Clinical Privileges**

(a) Temporary privileges may be granted by the President or Executive Vice President-Clinical Development or their designee only:

(i) when there is an important patient care need that requires immediate authorization to practice. Specifically, temporary privileges may be granted for:

1. the care of a specific patient;
2. an individual serving as a locum tenens for members of the Medical Staff; or
3. the purpose of proctoring or teaching; or
4. to meet an important patient care need; or
(ii) when an applicant for initial appointment is awaiting review by the Executive Committee and Board, following a favorable recommendation of the Credentials Committee and:

1. the application is complete,
2. the credentialing process is complete, including verification of current licensure, relevant training and experience and evaluation of current competence, ability to exercise the privileges requested, compliance with criteria for the privileges requested, and information from the Data Bank,
3. has no current or previously successful challenges to his or her licensure or registration and
4. has not been subject to involuntary termination of medical staff membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility.

(b) Prior to temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

(c) Temporary privileges may be granted only after the President or Executive Vice President-Clinical Development has consulted with the Chair of the Credentials Committee after a favorable recommendation from the department chair.

(d) Temporary privileges shall be granted for a specific period of time as warranted by the situation. In no situation should the initial grant of temporary privileges be for a period exceeding 120 days.

(2) **Supervision Requirements**

In exercising temporary privileges, the individual shall act under the supervision of the department chair. Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges. "Supervision," as that term is used in this section, does not require the constant physical presence of the supervisor, but rather, an
ongoing evaluation of the qualifications of, and quality of care being provided by, the individual with temporary privileges.

(3) **Termination of Temporary Clinical Privileges**

(a) The President may, at any time after consulting with the Chair, the Chair of the Credentials Committee, or the department chair, terminate temporary admitting privileges. Clinical privileges shall be terminated when the individual's inpatients are discharged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the President, the department chair, or the Chair may immediately terminate all temporary privileges. The department chair or the Chair shall assign to another appointee to the Medical Staff responsibility for the care of such individual's patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

(c) The granting of temporary privileges is a courtesy and may be terminated for any reason.

(d) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal.

(4) **Emergency Situations**

(a) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(b) In an emergency situation, an appointee to the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.
(c) If the emergency management plan has been activated, the President, or his or her designee, the Executive Vice President-Clinical Development, or the Chair of the Executive Committee may grant emergency privileges to any licensed independent practitioner as detailed in the *Temporary Credentialing of Practitioners in the Event of Emergency Management Plan Activation* policy.
(C) 5. Article 5 -- Procedure For Reappointment

(C) 5.A. Procedure For Reappointment

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

(1) Eligibility for Reappointment

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

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

(2) Factors for Evaluation

The following factors will be evaluated as part of the reappointment process:

(a) current clinical competence, judgment and technical skill in the treatment of patients;
(b) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;
(c) participation in medical staff duties, including committee assignments and emergency call;
behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of the Hospital, and ability to work with others;

use of the Hospital's facilities for patients, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty; provided that, other practitioners shall not be identified;

current ability to safely and competently exercise the clinical privileges requested and perform the responsibilities of staff appointment;

capacity to satisfactorily treat patients as indicated by the results of the Hospital's performance improvement and professional and peer review activities;

appropriate resolution of any verified complaints received from patients and/or staff; and

other reasonable indicators of continuing qualifications.

Reappointment Application

An application for reappointment shall be furnished to appointees at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Credentialing Office within 30 days.

Failure to return a completed application within this time frame will result in the assessment of a reappointment processing fee. In addition, failure to submit an application at least two months prior to the expiration of the appointee's current term shall result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment, and the individual may not practice until an application is processed.

Reappointment, if granted, shall be for a period of not more than two years.

If an application for reappointment is submitted timely, but the Board has not acted on it prior to the expiration of the current term, the President or the Executive Vice President-Clinical Development shall have the authority to grant the individual temporary appointment and clinical privileges until such time as the Board can
act on the application. Temporary appointment and privileges shall be granted only if the President, the Executive Vice President-Clinical Development or designee, determines, after consulting with the chair of the applicable department, the Chair of the Credentials Committee and the Chair, that there is an important patient care need that mandates an immediate authorization to practice, including but not limited to an inability to meet on-call coverage requirements, or denying the community access to needed medical services. The temporary appointment and clinical privileges shall be only for a period not to exceed 120 days.

(e) In the event the applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

(f) The application will be reviewed by the Credentialing Office to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment and for the clinical privileges requested.

(g) The Credentialing Office shall oversee the process of gathering and verifying relevant information. The Credentialing Office shall also be responsible for confirming that all relevant information has been received.

(4) **Processing Applications for Reappointment**

(a) The Credentialing Office shall forward the application to the relevant department chair and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.

(b) If it becomes apparent to the Credentials Committee or the Executive Committee that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the chair of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation.
contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

(5) **Time Periods for Processing**

Once an application is deemed complete, it is expected to be processed within 90 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.
(C) 6. Article 6 -- Confidentiality and Peer Review Protection

(C) 6.A. Confidentiality

Actions taken and recommendations made pursuant to this Policy and related Medical Staff documents shall be strictly confidential. Individuals participating in peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

(a) when the disclosures are to another authorized appointee of the Medical Staff or authorized Hospital employee and are for the purpose of conducting legitimate peer review activities; or

(b) when the disclosures are authorized, in writing, by the President or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

(C) 6.B. Peer Review Committee

(a) All peer review activities pursuant to this Policy and related Medical Staff documents shall be performed by peer review committees in accordance with applicable state law. Peer review committees include, but are not limited to:

(i) all committees;
(ii) all departments;
(iii) the Board and its committees; and
(iv) any individual acting for or on behalf of any such entity, including but not limited to department chairs, committee chairs and members, officers of the Medical Staff, the Executive Vice President-Clinical Development and experts or consultants retained to assist in peer review activities.

(b) All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable state law.

(c) All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. ' 11101 et seq.
(C) 6.C. Reporting

The Hospital will report all professional review actions regarding applicants and Medical Staff members as is required by law. This specifically includes all required reports to the Indiana Medical Licensing Board and the National Practitioner Data Bank. Additionally, the Hospital will report any discovery that a practitioner fails to satisfy the state licensing requirements set forth in the Indiana Code.

(C) 7. Article 7 -- Amendments

(a) When changes to this Policy are necessitated by changes in the law or accreditation standards, this Policy may be amended by a majority vote of the members of the Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Executive Committee. Notice of all proposed amendments shall be posted on the Medical Staff bulletin board at least 14 days prior to the Executive Committee meeting and any appointee to the Medical Staff may submit written comments to the Executive Committee. No amendment shall be effective unless and until it has been approved by the Board.

(b) In all other circumstances:

(i) All proposed amendments must be reviewed by the Executive Committee prior to a vote by the Medical Staff. The Executive Committee shall provide notice by reporting on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least fourteen (14) days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(ii) The Executive Committee may present proposed amendments to the voting staff by mail ballot. Along with the proposed
amendments, the Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by at least fifty percent (50%) of the staff eligible to vote.

(iii) The Executive Committee shall have the power to adopt such amendments to this policy which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

(iv) All amendments shall be effective only after approval by the Board.

(v) If the Board has determined not to accept a recommendation submitted to it by the Executive Committee or the Medical Staff, the Executive Committee may request a conference with the officers of the Board, for the purpose of permitting the Board to communicate its rationale for its contemplated action and permitting the Executive Committee to discuss the rationale for the recommendation. Such a conference will be scheduled by the President within two (2) weeks after receipt of a request for same submitted by the Chair.
(C) 8. Article 8 -- Adoption

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:        April 26, 2005
Approved by the Board:              May 20, 2005
Effective Date:                     July 1, 2005
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