Indiana University Health

Bloomington

MEDICAL STAFF BYLAWS

Part I: Governance

Revised – October 2021
Board Approved October 2021

Table of Contents Part I

Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this Medical Staff is to organize the activities of physicians and other clinical practitioners who practice at Indiana University Health Bloomington ("IU Health Bloomington") in order to provide oversight of care, treatment, and services provided by practitioners with privileges at the Hospital. The members of the Medical Staff work together as an organized body to promote a uniform standard of quality patient care, treatment, and services and to offer advice, recommendations, and input to the Hospital President and the board.

1.2 Authority

Subject to the authority and approval of the IU Health Bloomington Board of Directors, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and under the corporate bylaws of IU Health Bloomington. Henceforth, whenever the term "Hospital" is used, it shall mean IU Health Bloomington; and whenever the term "Board" is used, it shall mean the IU Health Bloomington Board of Directors.

Section 2. Medical Staff Membership

2.1 Nature of Medical Staff Membership

Membership on the Medical Staff of the Hospital is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), oromaxillofacial surgeons and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated policies of the Medical Staff and the Hospital.

2.2 Qualifications for Membership

The qualifications for Medical Staff membership are delineated in Part III of these bylaws (Credentials Procedures).

2.3 Nondiscrimination

The Hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, gender, religion, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the Medical Staff. The Board shall act on appointment and reappointment only after the Medical Staff has submitted their recommendation from the Medical Executive Committee ("MEC"). Appointment and reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months.

2.5 Medical Staff Membership and Clinical Privileges

Requests for Medical Staff membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria established by the Medical Staff and approved by the Board. Membership and/or privileges will be granted and administered as delineated in Part III (Credentials Procedures) of these bylaws**.**

2.6 Medical Staff Members Responsibilities

2.6.1 Each staff member must provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals.

2.6.2 Each staff member must, as assigned or requested, participate in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions as may be required.

2.6.3 Each staff member, consistent with his/her granted clinical privileges, must participate in the on-call coverage of the emergency department or in other Hospital coverage programs as determined by the MEC and the Board, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.

2.6.4 Each staff member must submit to any type of health evaluation as requested by the officers of the Medical Staff, Hospital President and/or Service Line Medical Executive ("SLME") when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or credentials committee as part of an evaluation of the member's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and Hospital policies addressing physician health or impairment.

2.6.5 Each staff member must abide by the Medical Staff bylaws and any other rules, regulations, policies, procedures, and standards of the Medical Staff. Each staff member must provide evidence of professional liability coverage of a type and in an amount sufficient to cover the clinical privileges granted or an amount established by the Board. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member shall notify the Hospital President or designee immediately of any and all malpractice claims threatened in writing or filed against the Medical Staff member.

2.6.6 Each staff member agrees to release from any liability, to the fullest extent permitted by law, all persons for their conduct in connection with investigating and/or evaluating the quality of care provided by the Medical Staff member within his/ her credentials.

2.6.7 Each staff member shall prepare and complete in timely fashion, according to Medical Staff and Hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the Hospital, or within its facilities, clinical services, or departments.

2.6.8 Each staff member will use confidential information only as necessary for treatment, payment, or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these bylaws, confidential information means patient information, peer review information, and the Hospital's business information designated as confidential by the Hospital or its representatives prior to disclosure.

2.6.9 Each staff member must participate in any type of competency evaluation when determined necessary by the MEC and/or Board to properly delineate that member's clinical privileges.

2.7 Medical Staff Member Rights

2.7.1 Each staff member in the active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC. In the event such practitioner is unable to resolve a matter of concern after working with his/her SLME or other appropriate Medical Staff leader(s), that practitioner may, upon written notice to the Chief of Staff at least two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

2.7.2 Each staff member in the active category has the right to initiate a recall election of an elected Medical Staff official by following the procedure outlined in Section 4.7 of these bylaws, regarding removal and resignation from office.

2.7.3 Each staff member in the active category may call a general staff meeting to discuss a matter relevant to the Medical Staff. Upon presentation of a petition signed by ten percent (10%) of the members of the active category, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

2.7.4 Each staff member in the active category may challenge any rule or policy established by the MEC. If a rule, regulation, or policy is thought to be inappropriate, any Medical Staff member may submit a petition signed by ten percent (10%) of the members of the active category. Upon presentation of such a petition, the adoption procedure outlined in Section 9.2.1 will be followed.

2.7.5 Each staff member in the active category may call for a service meeting by presenting a petition signed by ten percent (10%) of the members of the service. Upon presentation of such a petition the SLME will schedule a service meeting.

The above sections 2.7.1 – 2.7.5 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.

2.7.6 Any staff member has a right to a hearing/appeal pursuant to the conditions and procedures described in the Medical Staff's hearing and appeal plan (Part II of these bylaws).

2.8 Indemnification

2.8.1 Members of the Medical Staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the Hospital and Medical Staff.

2.8.2 Subject to applicable law, the Hospital shall indemnify against actual and necessary expenses, costs, and liabilities incurred by a Medical Staff member in connection with the defense of any pending or threatened action, suit or proceeding to which the physician is made a party by reason of having acted in an official capacity in good faith on behalf of the Hospital or Medical Staff. However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

Section 3. Categories of the Medical Staff

3.1 The Active Category

3.1.1 Qualifications: Members of this category have admitting privileges and must have served on the Medical Staff for at least one (1) year and be involved in at least one (1) patient contact per year (i.e., a patient contact is defined as an inpatient admission, consultation, or an inpatient or outpatient surgical procedure) at the Hospital or affirm involvement in the Medical Staff by attending committee meetings.

In the event that a member of the active category does not meet the qualifications for reappointment to the active category, and if the member is otherwise abiding by all bylaws, rules, regulations, and policies of the Medical Staff and Hospital, the member may be appointed to another Medical Staff category if s/he meets the eligibility requirements for such category.

3.1.2 Prerogatives: Members of this category may:

a. Attend Medical Staff/service meetings of which s/he is a member and any Medical Staff or Hospital education programs.

b. Vote on all matters presented by the Medical Staff, service, and committee(s) to which the member is assigned.

c. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff bylaws or Medical Staff policies.

3.1.3 Responsibilities: Members of this category shall:

a. Contribute to the organizational and administrative affairs of the Medical Staff.

b. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion and in the discharge of other staff functions as may be required.

c. Fulfill or comply with any applicable Medical Staff or Hospital policies or procedures.

3.2 The Associate Category

3.2.1 Qualifications: The associate category is reserved for Medical Staff members who do not meet the eligibility requirements for the active category or choose not to pursue active status. These members have admitting privileges.

3.2.2 Prerogatives: Members of this category may:

a. Attend Medical Staff/service meetings of which s/he is a member and any Medical Staff or Hospital education programs.

b. Not vote on matters before the entire Medical Staff or be an elected officer of the Medical Staff.

c. Serve on Medical Staff committees, including MEC, and may vote on matters that come before such committees.

3.2.3 Responsibilities: Members of this category shall have the same responsibilities as active category members.

Section 4. Officers of the Medical Staff

4.1 Officers of the Medical Staff

4.1.1 Chief of Staff

4.1.2 Chief of Staff - elect

4.2 Qualifications of Officers

4.2.1 Officers. The Chief of Staff is an ex-officio, non-voting member of the Board. At the Chief of Staff's direction and in coordination with the Board President, additional Medical Staff Representatives may be elected to serve as a representative to the Board, provided they are members in good standing of the active or associate category for at least three (3) years and be actively involved in patient care in the Hospital, have previously served in a significant leadership position on the Medical Staff, indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have participated in Medical Staff leadership training and/or be willing to participate in such training during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the Hospital, and have excellent administrative and communication skills. Qualifications for the positions of Chief of Staff and Chief of Staff-elect also include the degree of MD and DO. The Medical Staff nominating committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

4.2.2 Officers may not simultaneously hold a leadership position on another hospital's Medical Staff or in a facility that is directly competing with the Hospital. Noncompliance with this requirement will result in the officer being automatically removed from office unless the Board determines that allowing the officer to maintain his/her position is in the best interest of the Hospital. The Board shall have discretion to determine what constitutes a "leadership position" at another hospital.

4.2.3 Each staff member shall disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or Hospital.

4.3 Election of Chief of Staff Elect

4.3.1 The nominating committee shall offer at least one nominee for the available position. Nominations must be announced, and the names of the nominees distributed to all members of the active Medical Staff at least thirty (30) days prior to the election.

4.3.2 A petition signed by at least ten percent (10%) of the members of the active staff may also make nominations. The Medical Staff must submit such a petition to the Chief of Staff at least fourteen (14) days prior to the election for the nominee(s) to be placed on the ballot. The nominating committee must determine if the candidate meets the qualifications in section 4.2 above before he/she can be placed on the ballot.

4.3.3 Chief of Staff Elect shall be elected at least one month prior to the expiration of the term of the current officers. Only members of the active category shall be eligible to vote. The Medical Staff manager will determine the mechanisms by which votes may be cast, subject to the approval of the MEC. The mechanisms that may be considered include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the member's voting choices. No proxy voting will be permissible. The nominee(s) who receives the greatest number of votes will be elected. In the event of a tie vote, the Medical Staff support professional will make arrangements for a repeat vote(s) until one candidate receives a greater number of votes.

4.4 Term of Office

4.4.1 All officers serve a term of two (2) years. Officers shall take office in the month of January of even years.

4.5 Vacancies of Office

4.5.1 The MEC shall fill vacancies of office during the Medical Staff year, except the office of Chief of Staff. If there is a vacancy in the office of Chief of Staff, the Chief of Staff - elect shall serve the remainder of the term.

4.6 Duties of Officers

4.6.1 **Chief of staff** – The Chief of Staff shall represent the interests of the Medical Staff to the MEC and the Board. The Chief of Staff will fulfill the duties specified in Part IV of these bylaws (Organization and Functions Manual).

4.6.2 **Chief of Staff-elect** – In the absence of the Chief of Staff, the Chief of Staff-elect shall assume all the duties and have the authority of the Chief of Staff. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.

4.7 Removal and Resignation from Office

4.7.1 The Medical Staff may remove any officer if at least ten percent (10%) sign a petition advocating for such action. The petition must be followed by an affirmative vote by two thirds (2/3) of those active staff members casting ballot votes.

a. Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with policies and procedures of the Medical Staff, for conduct or statements that damage the Hospital, its goals, or programs, or an automatic or precautionary suspension of clinical privileges that lasts more than thirty days. The Board will determine if the member has failed in his/her duties after consulting with the joint conference committee (see 8.1.1).

4.7.2 Resignation: Any elected officer may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

5.1.1 The Medical Staff shall be organized as a non-departmentalized staff. The MEC may recognize any group of practitioners who wish to organize themselves into a Clinical Service. Any Clinical Service, if organized, shall not be required to hold regularly scheduled meetings, keep routine minutes, or require attendance. A written report is required only when the Clinical Service is making a formal recommendation. A Clinical Service may identify a Clinical Service Chief. Clinical Services are completely optional and shall exist to perform any of the following activities:

a. Continuing education/discussion of patient care.

b. Grand rounds.

c. Discussion of policies and procedures.

d. Discussion of equipment needs.

e. Development of recommendations for Clinical SLMEs or MEC.

f. Participation in the development of criteria for clinical privileges when requested by the credentials committee or MEC.

g. Discussion of a specific issue at the request of a Medical Staff committee or the MEC.

5.1.2 The current Clinical Services that are organized by the Medical Staff and formally recognized by the MEC shall be listed Part IV of the bylaws (Organization and Functions Manual).

5.2 Qualifications, Selection, and Removal of MEC Members

5.2.1 Each MEC member shall serve a term of three (3) years commencing on January 1st and may serve successive terms. All appointed providers must be members of the Medical Staff with relevant clinical privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process; and have completed or be willing to complete the established leadership education.

5.2.2 MEC members will be elected by majority vote of the active members of the service, subject to ratification by the MEC. Each service shall establish procedures for identifying and electing candidates and these procedures must be ratified by the MEC.

5.2.3 MEC members may be removed from office by the MEC upon receipt of a recommendation of two-thirds (2/3) of the members of the service, or, in the absence of such recommendation, the MEC may remove a chief on its own by two thirds vote if any of the following occurs:

a. The MEC member ceases to be a member in good standing of the Medical Staff

b. The MEC member suffers an involuntary loss or significant limitation of practice privileges.

c. The MEC member fails, in the opinion of the MEC, to demonstrate to the satisfaction of the MEC or the Board that he or she is effectively carrying out the responsibilities of the position.

d. If removal is required, a new election will be held according to the established service procedures.

5.2.4 MEC member shall carry out the responsibilities assigned in Part IV of these bylaws the (Organization and Functions Manual).

5.3 Assignment to Clinical Service

5.3.1 The MEC will, after consideration of the recommendations of the medical director of the appropriate clinical service, recommend clinical service assignments for all members in accordance with their qualifications. Each member will be assigned to one primary clinical service. Clinical privileges are independent of clinical service assignment.

Section 6. Committees

6.1 Designation and Substitution

6.1.1 There shall be a MEC, and such other standing and special committees as established by the MEC and enumerated in Part IV of the bylaws (Organization and Functions Manual). Those functions requiring participation of, rather than direct oversight by the Medical Staff may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions. The Chief of Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 MEC

6.2.1 Committee Membership:

a. Composition: The MEC shall be a standing committee, chaired by the Chief of Staff, consisting of the following voting members: the officers of the Medical Staff and sixteen (16) representatives as appointed by the respective Service Line Medical Executive. One representative from the Advanced Practice Provider group will participate in the committee as a non-voting member.

b. Removal from MEC: An officer, or other MEC member who is removed from his/her position in accordance with Section 4.7 [and/or Section 5.2.3] above will automatically lose his/her membership on the MEC. When the member resigns or is removed from these positions, his/her replacement will serve on the MEC. Other members of the MEC may be removed by a two-thirds (2/3) affirmative vote of MEC members. Duties: The duties of the MEC, as delegated by the Medical Staff, shall be to:

- Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff bylaws and provide oversight for all Medical Staff functions.
- Coordinate the implementation of policies adopted by the Board.
- Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, clinical service assignments, clinical privileges, and corrective action.
- Account to the Board and to the staff for the overall quality and efficiency of professional patient care services provided in the Hospital by individuals with clinical privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities.
- Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff members including collegial and educational efforts and investigations, when warranted.
- Make recommendations to the Board on medical administrative and Hospital management matters.
- Keep the Medical Staff up to date concerning the licensure and accreditation status of the Hospital.
- Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.

- Review and act on reports from Medical Staff committees, services, and other assigned activity groups.
- Formulate and recommend to the Board Medical Staff rules, policies, and procedures.
- Request evaluations of practitioners privileged through the Medical Staff process in instances in which there is question about an applicant or member's ability to perform privileges requested or currently granted.
- Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures.
- Consult with administration on the quality, timeliness, and appropriateness of aspects of contracts for patient care services provided to the Hospital by entities outside the Hospital.
- Oversee that portion of the corporate compliance plan that pertains to the Medical Staff.
- Hold Medical Staff leaders, committees, and services accountable for fulfillment of their duties and responsibilities.
- Make recommendations to the Medical Staff for changes or amendments to the Medical Staff bylaws.

6.2.2 Meetings

The MEC shall meet as often as necessary to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

7.1.1 An annual meeting and other general meetings of the Medical Staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all Medical Staff members via appropriate media and posted conspicuously.

7.1.2 Except for bylaws amendments or as otherwise specified in these bylaws, the actions of a majority of the members present and voting at a meeting of the Medical Staff is the action of the group. Action may be taken without a meeting of the Medical Staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or Internet, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.

7.1.3 Special Meetings of the Medical Staff

a. The Chief of Staff may call a special meeting of the Medical Staff at any time. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.

b. Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff at least five (5) business days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.2 Regular Meetings of Medical Staff Committees and Services

Committees and Services may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

7.3 Special Meetings of Committees and Services

A special meeting of any committee or Service may be called by the chair or the Chief of Staff.

7.4 Quorum

7.4.1 Medical Staff meetings: Those present or those eligible Medical Staff members voting on an issue.

7.4.2 MEC: A quorum will exist when 50% of the members are present. When dealing with Category 1 requests for routine appointment, reappointment, and clinical privileges (expedited credentialing) the MEC quorum will consist of at least three members.

7.4.3 Credentials Committee: A quorum will exist when three (3) members are present.

7.4.4 Medical Staff Quality Committee: A quorum will exist when four (4) members are present.

7.4.5 Service meetings or Medical Staff committees other than those listed in 7.4.2 above: Those present or those eligible Medical Staff members voting on an issue.

7.5 Attendance Requirements

7.5.1 Members of the Medical Staff are encouraged to attend meetings of the Medical Staff.

a. **MEC, Credentials Committee, and Medical Staff Quality/Peer Review Committee meetings**: Members of these committees are expected to attend at least sixty percent (60%) of the meetings held. Attendance at these committee meetings will be assessed annually and those committee members not meeting these committees' attendance requirement will be replaced on the committee.

b. Special meeting attendance requirements: Whenever there is suspected or actual non-compliance with Medical Staff or Hospital policies or suspected deviation from standard clinical or professional practice, the Chief of Staff or the applicable service line representative/committee chair may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) days prior to the meeting, including the date, time, place, a statement of the issue involved, and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting after two notices, unless excused by the MEC upon showing good cause, will result in an automatic termination of membership and privileges. Such termination will not give rise to a fair hearing but will automatically be rescinded upon the practitioner's participation in the previously referenced meeting.

c. Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of clinical privileges as outlined in Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.6 Participation by the Hospital President

The Hospital President or his/her designee may attend any general, committee or service meetings of the Medical Staff. This will not preclude any committee or general Medical Staff meeting from going into executive session without any members other than the Medical Staff.

7.7 Parliamentary Procedure

Medical staff and committee meetings shall be run in a manner determined by the individual who is the chair of the meeting. When parliamentary procedure is needed, as determined by the chair, or evidenced by a majority vote of those attending the meeting, the latest edition of Standard Code of Parliamentary Procedure will be followed.

7.8 Notice of Meetings

Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the service or committee not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.9 Action of Committee or Clinical Section

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or clinical service. Such recommendation will then be forwarded to the MEC for action.

7.10 Rights of Ex officio Members

Except as otherwise provided in these bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members thereof, except that they shall not vote or be counted in determining the existence of a quorum.

7.11 Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding chair shall authenticate the minutes and copies thereof shall be submitted to the MEC or another designated committee. A permanent file of the minutes of each meeting shall be maintained.

Section 8. Conflict Resolution

8.1 Conflict Resolution

8.1.1 In the event the Board acts in a manner contrary to a recommendation by the MEC the matter may (at the request of the MEC) be submitted to a joint conference committee composed of the officers of the Medical Staff and an equal number of members of the Board for review and recommendation to the full Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

8.1.2 The chair of the Board or the Chief of Staff may call for a joint conference as described above at any time and for any reason to seek direct input from the Medical Staff leaders, clarify any issue, or relay information directly to Medical Staff leaders.

Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

9.1.1 The Medical Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any Medical Staff bylaws, rules, regulations, policies, procedures, and amendments as needed, which shall be effective when approved by the Board. The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.

9.2 Methods of Adoption and Amendment to these bylaws

9.2.1 Proposed amendments to these bylaws may be originated by the MEC or by a petition signed by twenty percent (20 %) of the members of the active category.

Each active member of the Medical Staff will be eligible to vote on the proposed amendment to these bylaws via printed or secure electronic ballot in a manner determined by the MEC. All active members of the Medical Staff shall receive at least thirty (30) days advance notice of the proposed changes. To be adopted, such changes must receive a simple majority of the votes cast by those active members eligible to vote whenever a quorum of fifty percent (50%) is present.

Amendments so adopted shall be effective when approved by the Board.

9.3 Methods of Adoption and Amendment to any Medical Staff rules, regulations, and policies.

9.3.1 The Medical Staff may adopt additional rules, regulations, and policies as necessary to carry out its functions and meet its responsibilities under these bylaws. A Rules and Regulations and Policies Manual may be utilized to organize these additional documents.

9.3.2 Proposed amendments to the rules, regulations and policy manual may be originated by the MEC.

9.3.3 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, any of these documents may be adopted, amended, or repealed, in whole or in part and such changes shall be effective when approved by the Board.

9.3.4 In addition to the process described in 9.3.3 above, the organized Medical Staff itself may recommend directly to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by twenty percent (20%) of the members of the active category. Upon presentation of such petition, the adoption process outlined in 9.2.1 above will be followed.

9.4 The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering or those needed due to punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the Hospital President. Neither the organized Medical Staff nor the Board may unilaterally amend the Medical Staff bylaws or rules and regulations**.**

Indiana University Health

Bloomington

MEDICAL STAFF BYLAWS

Part II: Investigations, Corrective Actions, Hearing and Appeal Plan

Revised – October 2021
Board Approved October 2021

Table of Contents Part II

Section 1. Collegial, Educational, and/or Informal Proceedings

1.1 Criteria for initiation: These bylaws encourage the use of progressive steps by Medical Staff leaders and Hospital administration, beginning with collegial and education efforts, 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. All collegial intervention efforts by Medical Staff leaders and Hospital administration shall be considered confidential and part of the Hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Hospital administration. When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the Medical Staff and Hospital. Collegial intervention efforts may include but are not limited to the following**:**

a. Educating and advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records.

b. Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance.

c. Sharing summary comparative quality, utilization, and other relevant information to assist individual(s) to conform their practices to appropriate norms.

Following efforts at collegial intervention, if it appears that the practitioner's performance places patients in danger or the quality of care is compromised, or in cases where it appears that patients may be placed in harm's way while collegial interventions are undertaken, the MEC will consider whether a recommendation to restrict or revoke membership and/or privileges should be made to the Board. Before issuing such a recommendation the MEC will authorize an investigation to determine whether sufficient evidence exists to support such a recommendation.

Section 2. Investigations

2.1 Initiation

A request for an investigation must be submitted by a Medical Staff officer, committee chair, service line representative, Hospital President, or Board chair to the MEC and supported by reference to the specific activities or conduct of concern. If the MEC initiates the request, it shall make an appropriate record of its reasons.

2.2 Investigation

If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the Medical Staff.

If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation in a prompt manner and shall forward a written report of its findings, conclusions, and recommendations to the MEC as soon as practicable. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant necessary and such use is approved by the MEC and the Hospital President. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams. The practitioner of concern shall be notified that the investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. This meeting (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as that term is used in the hearing and appeals sections of these bylaws, nor shall the procedural rules with respect to hearings or appeals apply. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the Medical Staff to engage external consultation. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process, or other action.

2.2.1 An external peer review consultant should be considered when:

a. Litigation seems likely.

b. The Hospital is faced with ambiguous or conflicting recommendations from Medical Staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the MEC or the Board to retain an objective external reviewer.

c. There is no one on the Medical Staff with expertise in the subject under review, or when the only physicians on the Medical Staff with appropriate expertise are direct competitors, partners, or associates of the physician under review.

2.3 MEC Action

As soon as practicable after the conclusion of the investigation the MEC shall take action that may include, without limitation:

a. Determining no corrective action is taken, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the member's file.

b. Deferring action for a reasonable time when circumstances warrant.

c. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee chairs/section chiefs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner's quality file.

d. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring.

e. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges.

f. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care.

g. Recommending suspension, revocation, or probation of Medical Staff membership.

h. Taking other actions deemed appropriate under the circumstances.

2.4 Subsequent Action

If the MEC recommends any termination or restriction of the practitioner's membership or privileges, that recommendation shall be transmitted in writing to the Board. The recommendation of the MEC shall become final unless the member requests a hearing, in which case the final decision shall be determined as set forth in this Hearing and Appeal plan.

2.5 MEC Deliberation:

As soon as practicable after action is taken or warranted as described in Sections 2.1 through Section 2.3, the MEC shall convene to review and consider the facts and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in the Section 2.4 above.

Section 3. Corrective Action

3.1 Automatic Relinquishment/Voluntary Resignation

In the following instances, the practitioner's privileges and/or membership will be considered relinquished, or limited as described, which action shall be final without a right to hearing. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as practicable. Unless a shorter timeframe is stated below, the Chief of Staff may reinstate the practitioner's privileges or membership if s/he determines the triggering circumstances have been rectified or are no longer present within sixty days of the relinquishment. Unless a shorter timeframe is stated below, after sixty days the practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these bylaws whenever any of the following actions occur:

3.1.1 Licensure

a. Revocation and suspension: Whenever a practitioner's license or other legal credential authorizing practice in this or another state is revoked, suspended, expired, or voluntarily relinquished, Medical Staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.

b. Restriction: Whenever a practitioner's license or other legal credential authorizing practice in this or another state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this Hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. Probation: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

d. Medicare, Medicaid, Tricare (a managed-care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs: Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or other federal programs, Medical Staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

3.1.2 Controlled substances

a. DEA certificate/Indiana CSR: Whenever a practitioner's United States Drug Enforcement Agency (DEA) or Indiana Controlled Substances Registration (CSR) certificate is revoked, limited, or suspended, the practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

b. Probation: Whenever a practitioner's DEA or Indiana CSR certificate is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

3.1.3 Medical record completion requirements: A practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever s/he fails to complete medical records within time frames established by the MEC. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

3.1.4 Professional liability insurance: Failure of a practitioner to maintain professional liability insurance in the amount required by state regulations, Medical Staff, and Board policies and sufficient to cover the clinical privileges granted shall result in immediate, automatic relinquishment of a practitioner's clinical privileges. If within 60 calendar days of the relinquishment the practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical Staff. The practitioner must notify the Medical Staff office immediately of any change in professional liability insurance carrier or coverage.

3.1.5 Medical Staff special assessments or fines: Failure to promptly pay any special assessment or fine shall be considered an automatic relinquishment of a practitioner's appointment. If within 60 calendar days after written warning of the delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership on the Medical Staff.

3.1.6 Felony/misdemeanor or conviction: A practitioner who has been convicted of or pled "guilty" or "no contest" or its equivalent to a felony or to a misdemeanor involving a charge of moral turpitude in any jurisdiction (this excludes routine traffic violations) shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately upon such indictment, conviction, or plea, regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.

3.1.7 Failure to satisfy the special appearance requirement: A practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these bylaws shall be considered to have automatically relinquished all clinical privileges except for emergencies and imminent deliveries. These privileges will be restored upon compliance with the special appearance requirement. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.8 Failure to participate in an evaluation: A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically relinquished all privileges. These privileges will be restored upon compliance with the requirement for an evaluation. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.9 Failure to become board certified or failure to maintain board certification: A practitioner who fails to become board certified or maintain board certification in compliance with these bylaws or Medical Staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her Medical Staff appointment and clinical privileges unless an exception is granted by the Board upon recommendation from the MEC. Physician may request a 1 cycle (approximately 1 year) extension. Further extensions, under rare circumstances, may be granted by Board, upon recommendation from MEC.

3.1.10 Failure to Execute Release and/or Provide Documents: A practitioner who fails to execute a general or specific release and/or provide documents, including but not limited to documentation showing evidence of any immunization, vaccinations and/or screening tests required by Medical Staff or Hospital policies, when requested by the Chief of Staff or designee in order to evaluate the competency and credentialing/privileging qualifications of the practitioner to assure patient safety shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within thirty calendar days of notice of the automatic relinquishment, the practitioner may be reinstated. Thereafter, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

3.2 Precautionary Restriction or Suspension

3.2.1 Criteria for Initiation: Whenever a practitioner's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when Medical Staff leaders and/or the Hospital President determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to affect patient or employee safety or the effective operation of the institution, or to impair the reputation of the Medical Staff or Hospital, then any one of the following (Hospital President or designee, Chief of Staff or designee, or the MEC) may restrict or suspend the Medical Staff membership or clinical privileges of such practitioner as a precaution. A suspension of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a precautionary suspension of all or any of the practitioner's clinical privileges at this Hospital.

Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the practitioner, the MEC, the Hospital President, and the Board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The precautionary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.

Unless otherwise indicated by the terms of the precautionary restriction or suspension, the practitioner's patients shall be promptly assigned to another Medical Staff member by the Chief of Staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

3.2.2 MEC action: As soon as practicable and within 14 calendar days after such precautionary suspension has been imposed, a meeting of the MEC shall be convened to review and consider the action and if necessary, begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event, it shall furnish the practitioner with notice of its decision.

3.2.3 Procedural rights: Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation described in Section 2.2, the member shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days.

3.3 Administrative Time Out

The MEC may, with approval of the Hospital President and the Board chair, institute one or more administrative time outs for a practitioner for a cumulative period not to exceed fourteen (14) consecutive calendar days in a calendar year. During an administrative time out, the practitioner may not exercise any clinical privileges except in an emergency or to address an imminent delivery. An administrative time out may be instituted only under the following circumstances:

a. When the action that has given rise to the time out relates to one of the following policies of the Medical Staff: Completion of medical records, practitioner behavior (or disruptive practitioner policy) or requirements for emergency department coverage.

b. When the action(s) have been reviewed by the MEC and only when the MEC has determined that one or more of the above policies have been violated.

c. When the practitioner has received at least two written warnings within the last twelve (12) months regarding the conduct in question. Such warnings must state the conduct or behavior that is questioned and specify or refer to the applicable policy and state the consequence of repeat violation of the policy.

d. When the affected practitioner has been offered an opportunity to meet with the MEC prior to the imposition of the administrative time out. Failure on the part of the practitioner to accept the MEC offer of a meeting will constitute a violation of the Medical Staff bylaws regarding special meetings and will not prevent the MEC from issuing the administrative time out.

An administrative time out will take effect after the practitioner has been given an opportunity to either arrange for his/her patients currently at the Hospital to be cared for by another qualified practitioner or until s/he has had an opportunity to provide needed care prior to discharge. During this period, the practitioner will not be permitted to schedule any elective admissions, surgeries, or procedures. The Chief of Staff or designee will determine details of the extent to which the practitioner may continue to be involved with hospitalized patients prior to the effective date of the administrative time out.

Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any practitioner eligible for Medical Staff appointment shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following actions when the basis for such action is related to clinical competence or professional conduct:

a. Denial of Medical Staff appointment or reappointment.

b. Revocation of Medical Staff appointment.

c. Denial or restriction of requested clinical privileges.

d. Involuntary reduction or revocation of clinical privileges.

e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual Medical Staff member and is imposed for more than fourteen (14) calendar days.

f. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

4.2 Hearings Will Not Be Triggered by the Following Actions

a. Issuance of a letter of guidance, warning, or reprimand.

b. Imposition of a requirement for proctoring (i.e., observation of the practitioner's performance by a peer to provide information to a Medical Staff peer review committee) with no restriction on privileges.

c. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege.

d. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee.

e. Requirement to appear for a special meeting under the provisions of these bylaws.

f. Automatic relinquishment or voluntary resignation of appointment or privileges.

g. Imposition of a precautionary suspension or administrative time out that does not exceed 14 calendar days.

h. Denial of a request for leave of absence, or for an extension of a leave.

i. Determination that an application is incomplete or untimely.

j. Determination that an application will not be processed due to misstatement or omission.

k. Decision not to expedite an application.

l. Termination or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct.

m. Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership.

n. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a Medical Staff development plan or covered under an exclusive provider agreement.

o. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted.

p. Termination of any contract with or employment by Hospital and/or any related entities.

q. Proctoring, monitoring, and any other performance monitoring requirements imposed to fulfill any Joint Commission standards on focused professional practice evaluation.

r. Any recommendation voluntarily accepted by the member.

s. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period.

t. Change in assigned staff category.

u. Refusal of the credentials committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request.

v. Removal or limitations of emergency department call obligations.

w. Any requirement to complete an educational assessment.

x. Retrospective chart review.

y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws.

z. Grant of conditional appointment or appointment for a limited duration.

aa. Failure to fulfill the obligations of conditions of a conditional appointment.

bb. Appointment or reappointment for duration of less than 24 months.

4.3 Notice of Recommendation

When a precautionary suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which, according to this plan entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall promptly (but no longer than five (5) calendar days) be given written notice by the Hospital President delivered either in person or by certified mail, return receipt requested. This notice shall contain:

a. A statement of the recommendation made and the general reasons for it (Statement of Reasons).

b. Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation.

c. Notice that the recommendation, if finally adopted by the board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank.

d. The individual shall receive a copy of Section 5, Hearing Panel & Presiding Officer or Hearing Officer of Part II of these bylaws outlining procedural rights with regard to the hearing.

4.4 Request for Hearing

Such individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the Hospital President or designee. In the event the affected individual does not request a hearing within the time and in the manner required by this policy, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made, and such recommended action shall thereupon become effective immediately upon final board action.

4.5 Notice of Hearing and Statement of Reasons

The Hospital President shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

a. The time, place, and date of the hearing.

b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence in support of the MEC, (or the Board), at the hearing.

c. The names of the hearing panel members and presiding officer or hearing officer, if known.

d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as practicable, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

4.6 Witness List

At least fifteen (15) calendar days before the hearing, the individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on the affected individual's behalf. The list of witnesses who will testify in support of the recommendation of the MEC or the Board will include a summary of the nature of the anticipated testimony. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the hearing, provided that notice of the change is given to the other party. The presiding officer shall have the authority to limit the number of witnesses.

Section 5. Hearing Panel and Presiding Officer or Hearing Officer

5.1 Hearing Panel

a. When a hearing is requested, the Hospital President, acting for the Board and after considering the recommendations of the Chief of Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination), shall appoint a hearing panel that shall be composed of not fewer than three individuals. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere 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. Hearing panel members need not be members of the Hospital Medical Staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.

b. The hearing panel shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is professionally associated with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or the presiding officer.

c. The Hospital President or designee shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the Hospital President, who shall determine whether a replacement panel member should be identified. While the practitioner who is the subject of the hearing may object to a panel member, s/he is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the Hospital President.

5.2 Hearing Panel Chairperson or Presiding Officer

5.2.1 In lieu of a hearing panel chair, the Hospital President, acting for the Board and after considering the recommendations of the Chief of Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may appoint an attorney at law or other individual experienced in legal proceedings as presiding officer. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it but shall not be entitled to vote on its recommendation.

5.2.2 If no presiding officer has been appointed, a chair of the hearing panel shall be appointed by the Hospital President to serve as the presiding officer and shall be entitled to one vote.

5.2.3 The presiding officer (or hearing panel chair) shall do the following:

a. Act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than fifteen hours.

c. Maintain decorum throughout the hearing.

d. Determine the order of procedure throughout the hearing.

e. Have the authority and discretion, in accordance with this policy, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.

f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations.

g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel.

h. Seek legal counsel when s/he feels it is appropriate. Legal counsel to the Hospital may advise the presiding officer or panel chair.

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

6.1.1 There is no right to formal "discovery" in connection with the hearing. The presiding officer, hearing panel chair, or hearing officer shall rule on any dispute regarding discovery and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and assure a reasonable and fair hearing. In general, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties and the individual's counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:

a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense.

b. Reports of experts relied upon by the MEC.

c. Copies of redacted relevant committee minutes.

d. Copies of any other documents relied upon by the MEC or the Board.

e. No information regarding other practitioners shall be requested, provided, or considered.

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

6.1.2 Prior to the hearing, on dates set by the presiding officer or agreed upon by counsel for both sides, each party shall provide the other party with all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing in advance of the hearing. The presiding officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

6.1.3 Prior to the hearing, on dates set by the presiding officer, the individual requesting the hearing shall, upon specific request, provide the credentials committee or MEC (or the Board) copies of any expert reports or other documents upon which the individual will rely at the hearing.

6.1.4 There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the Hospital's witness list concerning the subject matter of the hearing; nor shall there be contact by the Hospital with individuals appearing on the affected individual's witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his/her counsel.

6.2 Pre-Hearing Conference

The presiding officer may require a representative for the individual and for the MEC (or the Board) 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 determine the time to be allotted to each witness's testimony and cross-examination.

6.3 Failure to Appear

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Board for final action. Good cause for failure to appear will be determined by the presiding officer, chair of the hearing panel, or hearing officer.

6.4 Record of Hearing

The hearing panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The hearing panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Indiana.

6.5 Rights of Both Sides

6.5.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the presiding officer:

a. To call and examine witnesses to the extent available.

b. To introduce exhibits.

c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence.

d. To have representation by counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may call, examine, cross-examine witnesses, and present the case. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing.

e. To submit a written statement at the close of the hearing.

6.5.2 Any individuals requesting a hearing who do not testify in their own behalf may be called and examined as if under cross-examination.

6.5.3 The hearing panel may question the witnesses, call additional witnesses, or request additional documentary evidence.

6.6 Admissibility of Evidence

The hearing shall not be conducted according to legal rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute legal hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to relying in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

6.7 Burden of Proof

The hearing panel shall recommend in favor of the MEC (or the Board) unless it finds that the individual who requested the hearing has proved with a preponderance of the evidence that the recommendation which prompted the hearing was arbitrary, capricious, or appears to be unfounded or not supported by credible evidence. It is the burden of the practitioner under review to demonstrate that s/he satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all Medical Staff and Hospital policies

6.8 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum, and the hearing panel may request such a memorandum to be filed, following the close of the hearing.

6.9 Official Notice

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

6.10 Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the presiding officer or the Hospital President on a showing of good cause.

6.11 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 Chief of Staff or Hospital President.

6.12 Order of Presentation

The Board or the MEC, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

6.13 Basis of Recommendation

The hearing panel shall recommend in favor of the MEC (or the Board) 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.

6.14 Adjournment and Conclusion

The presiding officer may adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and questions by the hearing panel, the hearing shall be closed.

6.15 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation.

6.16 Disposition of Hearing Panel Report

The hearing panel shall deliver its report and recommendation to the Hospital President who shall forward it, along with all supporting documentation, to the Board for further action. The Hospital President shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the MEC for information and comment.

Section 7. Appeal to the Hospital Board

7.1 Time for Appeal

Within ten (10) calendar days after notice of the hearing panel's recommendation, either the practitioner subject to the hearing or the MEC may appeal the recommendation. The request for appellate review shall be in writing and shall be delivered to the Hospital President or designee either in person or by certified mail and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days as provided herein, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the Board.

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

a. There was substantial failure to comply with the Medical Staff bylaws prior to or during the hearing so as to deny a fair hearing; or

b. The recommendation of the hearing panel was made arbitrarily, capriciously or with prejudice; or

c. The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

7.3 Time, Place and Notice

Whenever an appeal is requested as set forth in the preceding sections, the chair of the Board shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected individual shall be given notice of the time, place, and date of the appellate review. The chair of the Board may extend the time for appellate review for good cause.

7.4 Nature of Appellate Review

a. The chair of the Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.

b. The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied.

c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. The review panel shall recommend final action to the Board.

d. 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.

7.5 Final Decision of the Hospital Board

Within thirty (30) calendar days after receipt of the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairs of the credentials committee and MEC, in person or by certified mail, return receipt requested.

7.6 Right to One Appeal Only

No applicant or Medical Staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current member, that individual may not apply within five (5) years for Medical Staff appointment or for those clinical privileges at this Hospital unless the Board provides otherwise.

7.7 Fair Hearing and Appeal Process for Privileged Non-Members

For those practitioners who have privileges without membership, excluding locum tenens physicians and telemedicine physicians, the fair hearing and appeal process will differ from that of the Medical Staff. The fair hearing will be an appearance before the service line and the Appeal will be before the Medical Executive Committee. Neither side will be represented by lawyers during the proceedings. In all other regards, except as noted above, the process and timeframes will be similar to that as for the Medical Staff.

Indiana University Health

Bloomington

MEDICAL STAFF BYLAWS

Part III: Credentials Procedures

Revised – October 2021
Board Approved October 2021

Table of Contents Part III

Section 1. Hospitals Regional Medical Staff Credentials Committee

1.1 Composition

Medical Staff members from IU Health Bloomington, IU Health Bedford and IU Health Paoli Hospitals will make up the membership of the IU Health South Central Region Credentials Committee. The committee shall consist of at least six (6) members of the active Medical Staff from Hospital who are experienced leaders; one Medical Staff representative from IU Health Bedford Hospital and one Medical Staff representative from IU Health Paoli Hospital, both who are experienced leaders; and two members of the advanced practice provider (Nurse Practitioners and Physician Assistants) staff who are experienced leaders. The chair will be appointed by the IU Health South Central Region Chief Medical Officer. The Chief of Staff and appointed chairperson will appoint the other members. The Chief of Staff/President of the Bedford and Paoli Medical Staff will appoint representation from the members of their Medical Staff. Members will be appointed for two (2) year terms with the initial terms staggered such that approximately one half of the members will be appointed each year. The members may be reappointed for additional terms without limit. Any member, including the chair, may be relieved of his/her committee membership by a two-thirds (2/3) vote of the Hospital's MEC's. The committee may also invite ex officio members such as representatives from Hospital administration and the Board.

1.2 Meetings

The Medical Staff credentials committee shall meet on call of the chair or the Chief of Staff.

1.3 Responsibilities

1.3.1 To review and recommend action on all applications and reapplications for membership on the Medical Staff including assignments of Medical Staff category.

1.3.2 To review and recommend action on all requests regarding privileges from eligible practitioners.

1.3.3 To recommend eligibility criteria for the granting of Medical Staff membership and privileges.

1.3.4 To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities.

1.3.5 Grant Medical Staff committees, Medical Staff, or Hospital leaders.

1.3.6 To perform such other functions as requested by the MEC.

1.4 Confidentiality

This committee shall function as a peer review committee consistent with federal and state law. All members of the committee shall, consistent with the Medical Staff and Hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.

1.4.1 The credentials file is the property of the Hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the Hospital in locked file cabinets or in secure electronic format. Medical staff and administrative leaders may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the Hospital President or designee.

1.4.2 Individual practitioners may review their credentials file under the following circumstances:

Only upon written request approved by the Chief of Staff, Hospital President, or credentials chair. Review of such files will be conducted in the presence of the Medical Staff service professional, Medical Staff leader, or a designee of administration. Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. Nothing may be removed from the file, but copies can be made. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

Section 2. Qualifications for Membership And/or Privileges

2.1 No practitioner shall be entitled to membership on the Medical Staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

2.2 The following qualifications must be met by all applicants for Medical Staff appointment, reappointment, or clinical privileges:

2.2.1 Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, or applicable recognized course of training in a clinical profession eligible to hold privileges.

2.2.2 Have a current unrestricted state or federal license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Indiana.

2.2.3 Have a record that is free from current Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals/Entities.

2.2.4 Have a record that is free of felony convictions within the last three (3) years, or occurrences that would raise questions of undesirable conduct (this excludes routine traffic violations) which could injure the reputation of the Medical Staff or Hospital.

2.2.5 A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) , or have successfully completed a qualified training program for board certification and be currently board certified or become board certified within five (5) years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association. The board certification must be in the field of current credentialed privileges. Medical Staff currently credentialed and practicing in a field other than the field of board certification may be allowed to maintain privileges in the current field of practice (11/24/2010). An exception to this qualification exists within the Emergency Department. Providers within the ED must be board certified in their specialty and will be required to work alongside the Emergency Medicine board certified physician on duty.

2.2.6 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation.

2.2.7 Oromaxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within five (5) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery.

2.2.8 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within five (5) years of completing formal training as determined by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine.

2.2.9 A psychologist must have earned a doctorate degree, (PhD or Psy.D, in psychology) from an educational institution accredited by the American Psychological Association and have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed psychologist, one (1) year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA), and be board certified as appropriate to the area of clinical practice;

2.2.10 Possess a current, valid, unrestricted drug enforcement administration (DEA) number and Indiana Controlled Substances Registration (CSR) certificate if applicable.

2.2.11 Have appropriate written and verbal communication skills.

2.2.12 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:

a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities.

b. A history of consistently acting in a professional, appropriate, and collegial manner with others in previous clinical and professional settings.

The following qualifications must also be met by all applicants requesting clinical privileges:

2.2.13 Demonstrate his/her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested.

2.2.14 Upon request provide evidence of both physical and mental health that does not impair the fulfillment of his/her responsibilities of Medical Staff membership and the specific privileges requested by and granted to the applicant.

2.2.15 Any practitioner granted privileges who may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Board.

2.2.16 The applicant is requesting privileges for a service the Board has determined appropriate for performance at the Hospital. There must also be a need for this service under any Board approved Medical Staff development plan.

2.2.17 Provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board after consultation with the MEC, and proof of continuous enrollment in the Indiana Patient Compensation Fund.

2.2.18 Meet immunization requirements as outlined in Hospital Medical Staff and Hospital policies.

2.3 Exceptions:

2.3.1 All practitioners who are current Medical Staff members and/or hold privileges as of July 1, 1989 who have met prior qualifications for membership and/or privileges shall be exempt from board certification requirements.

2.3.2 Only the Board may create additional exceptions to the above Section 2.2 after consultation with the MEC.

Section 3. Initial Appointment Procedure

3.1 Completion of Application

3.1.1 All requests for applications for appointment to the Medical Staff and requests for clinical privileges will be submitted to the Central Verification Office at IU Health. Upon receipt of the request, the CVO will provide the applicant an application package, which will include a complete set or overview of the Medical Staff bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for Medical Staff membership and/or privileges and a list of expectations of performance for individuals granted Medical Staff membership or privileges (if such expectations have been adopted by the Medical Staff).

A completed application includes, at a minimum:

a. A completed, signed, dated application form,

b. A completed privilege delineation form if requesting privileges,

c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency,

d. All applicable fees,

e. A current picture ID card issued by a state or federal agency (e.g., driver's license or passport) or current picture hospital ID card,

f. Receipt of at least three references shall come from peers knowledgeable about the applicant's experience, ability, and current competence to perform the privileges being requested,

g. Relevant practitioner-specific data as compared to aggregate data, when available,

h. Morbidity and mortality data, when available, and

i. Practitioner coverage arrangements.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed, and the applicant will not be entitled to a fair hearing. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated, and no further action taken.

3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the Medical Staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the Hospital, that the applicant meets the requirements for Medical Staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the applicant. If the requested information is not returned to the Medical Staff office within forty (40) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

3.1.3 Upon receipt of a completed application the credentials chair or designee, in collaboration with the Medical Staff office, will determine if the requirements of Section 2.2 are met. In the event the requirements of section 2.2 are not met, the potential applicant will be notified that s/he is ineligible to apply for membership or privileges on the Medical Staff, the application will not be processed, and the applicant will not be eligible for a fair hearing. If the requirements of Section 2.2 are met, the application will be accepted for further processing.

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

3.1.5 Upon receipt of a completed application, the Medical Staff office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the Medical Staff office will collect relevant additional information which may include:

a. Information from all prior and current liability insurance carriers, and the Indiana Department of Insurance, concerning claims, suits, settlements, and judgments, (if any) during the past ten (10) years.

b. Documentation of the applicant's past clinical work experience.

c. All hospital affiliations at the time of initial application, and current and/or change in membership at time of reappointment. Exception would be for Telemedicine/Locum Tenen which will include one (1) Primary location, and four (4) other active locations.

d. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the Medical Staff office will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration. Primary source verification may be conducted through the Indiana State Government Web site.

e. Information from the AMA or AOA Physician Profile and the OIG list of Excluded Individuals/Entities.

f. Information from professional training programs including residency and fellowship programs.

g. Information from the National Practitioner Data Bank (NPDB); in addition, the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested.

h. Other information about adverse credentialing and privileging decisions.

i. One or more peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current patient care, medical/clinical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, system-based practice, and physical, mental, and emotional ability to perform requested privileges.

j. Information from a criminal background check.

k. Information from any other sources relevant to the qualifications of the applicant to serve on the Medical Staff and/or hold privileges.

l. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available.

Note: In the event there is undue delay in obtaining required information, the Medical Staff office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after forty-five calendar days will be deemed a withdrawal of the application.

3.1.6 When the items identified in Section 3.1 above have been obtained, the file will be considered verified and complete and eligible for evaluation.

3.2 Applicant's Attestation, Authorization and Acknowledgement

The applicant must complete and sign the application form. By signing this application, the applicant:

3.2.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agreement that any inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission, or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges shall lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal.

3.2.2 Consents to appear for any requested interviews in regard to his/her application.

3.2.3 Authorizes the Hospital and Medical Staff representatives to consult with prior and current associates and others who may have information bearing on his/her professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

3.2.4 Consents to Hospital and Medical Staff representatives' inspection of all records and documents that may be material to an evaluation of:

a. Professional qualifications and competence to carry out the clinical privileges requested.

b. Physical and mental/emotional health status to the extent relevant to safely perform requested privileges.

c. Professional and ethical qualifications.

d. Professional liability actions including currently pending claims involving the applicant.

e. Any other issue relevant to establishing the applicant's suitability for membership and/or privileges.

3.2.5 Releases from liability, promises not to sue and grants immunity to the Hospital, its Medical Staff, and its representatives for acts performed and statements made in connection with evaluation of the application and his/her credentials and qualifications to the fullest extent permitted by the law.

3.2.6 Releases from liability and promises not to sue, all individuals and organizations who provide information to the Hospital or the Medical Staff, including otherwise privileged or confidential information to the Hospital representatives concerning his/her background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.

3.2.7 Authorizes the Hospital Medical Staff and administrative representatives to release credentialing and peer review information to other hospitals, medical associations, licensing boards, appropriate government bodies and other health care entities concerned with this provider's performance and releases representatives of the Hospital from liability for so doing.

3.2.8 Acknowledges that the applicant has had access to the Medical Staff bylaws, including all rules, regulations, policies, and procedures of the Medical Staff and agrees to abide by their provisions.

Notwithstanding section 3.2.5 through 3.2.7, if an individual institutes legal action and does not prevail, s/he shall reimburse the Hospital and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.

3.2.9 Agrees to provide accurate answers to the following questions and agrees to immediately notify the Hospital in writing should any of the information regarding these items change during the period of the applicant's Medical Staff membership or privileges. If the applicant answers any of the following questions affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

a. Have any disciplinary actions been initiated or are any pending against you by any state licensure board?

b. Has your license to practice or registration in any state ever been relinquished, denied, challenged, limited, suspended, or revoked, whether voluntarily or involuntarily?

c. Have you ever been asked to surrender your professional license?

d. Have you ever been suspended, sanctioned, excluded, or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, TriCare, or Medicaid)?

e. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program?

f. Has your DEA certificate or Indiana CSR ever been relinquished, limited, denied, suspended, or revoked?

g. Is your DEA certificate or Indiana CSR currently being challenged?

h. Have you ever been named as a defendant in any criminal proceedings or been arrested or charged with a crime?

i. Has your employment, Medical Staff membership, or clinical privileges ever been reduced, suspended, diminished, revoked, refused, or limited at any hospital or other health care facility, whether voluntarily or involuntarily?

j. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the Medical Staff before a hospital's or health facility's board made a decision?

k. Have you ever been the subject of a formal or informal disciplinary or corrective action investigation?

l. Have you ever been the subject of an investigation because of inappropriate conduct, disruptive behavior, or unprofessional actions (e.g., sexual harassment)?

m. Have you ever been the subject of focused individual monitoring at any hospital or health care facility other than to confirm competency immediately following an initial grant of a privilege(s)?

If you are not currently board certified please answer n. through q. below (if board certified skip to r below):

n. Have you ever been examined by any specialty board, but failed to pass the examination? Please provide details.

o. If not certified, have you applied for the certification exam?

p. Have you ever been accepted to take the certification exam?

q. If yes, what dates are you scheduled to take the certification exam?

r. Have any professional liability claims or suits ever been filed against you or are any presently pending?

s. Have any judgments or settlements been made against you in professional liability cases? (If yes, please provide a short synopsis of the allegations and outcome of the case).

t. Have you ever been refused or denied coverage, had coverage cancelled, or had specific privileges excluded by a malpractice liability carrier?

u. Have you ever entered into an agreement with the federal or state government as a result of violations of state or federal regulations or law (e.g., a corporate integrity agreement)?

v. Are you currently taking any substances or medications which could impair your ability to safely perform the privileges which you are requesting in this application?

w. Have you ever been disciplined or formally reprimanded because of inappropriate conduct, disruptive behavior, or unprofessional interactions (e.g., sexual harassment)?

3.3 Application Evaluation

3.3.1 Expedited Credentialing: An expedited review and approval process may be used for initial appointment only when necessary and approved by the Chief of Staff and the Credentials Chair. All initial applications for membership and/or privileges will be designated Category 1 or Category 2 as follows.

Category 1: A completed application that does not raise concerns as identified in the criteria for Category 2. Applicants in Category 1 will be granted Medical Staff membership and/or privileges after review and action by the following: service line representative, credentials chair acting on behalf of the credentials committee, the MEC and a Board committee consisting of at least two individuals.

Category 2: If one or more of the following criteria are identified while reviewing a completed and verified application, the application will be treated as Category 2. The service line representative, credentials committee, MEC, and the Board, review, and act on applications in Category 2. The credentials committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that s/he meets the criteria for membership on the Medical Staff and for the granting of requested privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

a. The application is deemed to be incomplete.

b. The final recommendation of the MEC is adverse or with limitation.

c. The applicant is found to have experienced an involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration.

d. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions.

e. Applicant has had two (2) or more or an unusual pattern of malpractice cases filed within the past five (5) years.

f. Applicant changed medical schools or residency programs or has gaps in training or practice.

g. Applicant has changed practice locations more than three times in the past ten (10) years.

h. Applicant has one or more reference responses that raise concerns or questions.

i. Discrepancy is found between information received from the applicant and references or verified information.

j. Applicant has an adverse National Practitioner Data Bank report.

k. The request for privileges is not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria.

l. Applicant has been removed from a managed care panel for reasons of professional conduct or quality.

m. Applicant has potentially relevant physical, mental and/or emotional health problems.

n. Other reasons as determined by a Medical Staff leader or other representative of the Hospital which raise questions about the qualifications, competency, professionalism, or appropriateness of the applicant for membership or privileges.

3.3.2 Applicant Interview

a. All applicants for appointment to the Medical Staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the credentials committee, service line representative, MEC or Board. The interview may take place in person or virtually at the discretion of the Hospital or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. The interview may also be used to communicate Medical Staff performance expectations.

b. Procedure: the applicant will be notified if an interview is requested. Failure of the applicant to appear for a scheduled interview will be deemed a withdrawal of the application.

3.3.3 Service Line Action

All completed applications are presented to the service line representative for review, and evaluation. The service line representative reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. If previously approved by the Chief of Staff and the Credentials chair, the service line representative, in consultation with the Medical Staff professional, determines whether the application is forwarded as a Category 1 or Category 2. The Service Line Representative may obtain input if necessary, from an appropriate subject matter expert. If a service line representative believes a conflict of interest exists that might preclude his/her ability to make an unbiased recommendation s/he will notify the credentials chair and forward the application without comment.

The service line representative forwards to the Medical Staff credentials committee the following:

a. A recommendation as to whether the application should be acted on as Category 1 or Category 2.

b. Input regarding the applicant's request for membership and/or privileges.

c. Input to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

d. Comments supporting the recommendations in 3.3.3 a, b, and c above.

3.3.4 Medical Staff Credentials Committee Action

If the application is designated Category 1, it is presented to the credentials chair or designee for review and recommendation. The credentials chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The credentials chair can determine whether the application is forwarded as a Category 1 or may change the designation to a Category 2. If forwarded as a Category 1, the credentials chair acts on behalf of the Medical Staff credentials committee and the applications are presented to the MEC for review and recommendation. If designated Category 2, the Medical Staff credentials committee reviews the application and forwards the following to the MEC:

a. A recommendation as to whether the application should be acted on as Category 1 or Category 2.

b. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges.

c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

d. Comments supporting the recommendations in 3.3.4 a, b, and c above.

3.3.5 MEC Action

If the application is designated Category 1, it is presented to the MEC which may meet in accordance with quorum requirements established for expedited credentialing. The Chief of Staff can determine whether the application is forwarded as a Category 1 or may change the designation to a Category 2. The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

a. A recommendation as to whether the application should be acted on as Category 1 or Category 2.

b. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges.

c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

d. Comments supporting the recommendations in 3.3.5 a, b, and c above.

e. Whenever the MEC makes an adverse recommendation to the Board, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.6 Board Action:

If the application is designated by the MEC as Category 1 it is presented to the Board or an appropriate subcommittee of at least two (2) members where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. If the Board or subcommittee agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed twenty-four (24) months. If a subcommittee takes the action, it is reported to the entire Board at its next scheduled meeting. If the Board or subcommittee disagrees with the recommendation, then the procedure for processing Category 2 applications will be followed.

If the application is designated as a Category 2, the Board reviews the application and votes for one of the following actions:

a. The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant's request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months.

b. If the Board's action is adverse to the applicant, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

c. The Board shall take final action in the matter as provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.7 Notice of final decision: Notice of the Board's final decision shall be given, through the Hospital President to the MEC and to the chair of each service concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the service to which s/he is assigned, the clinical privileges s/he may exercise, and any special conditions attached to the appointment.

3.3.8 Time periods for processing: All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days.

a. These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.

3.4 New Medical Staff Orientation

Credentialed providers are required to attend orientation program as provided by Medical Staff Services Department. Failure to attend may result in disciplinary actions as designated by the Chief of Staff.

Section 4. Professional Practice Evaluation

All initially requested privileges shall be subject to a period of focused professional practice evaluation (FPPE). The credentials committee, after receiving input from the service line representative, and with the approval of the MEC will define circumstances which require monitoring and evaluation of the clinical performance of each practitioner following his or her initial grant of clinical privileges at the Hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The credentials committee will also establish the duration for such FPPE and triggers that indicate the need for performance monitoring.

The Medical Staff will also engage in ongoing professional practice evaluation (OPPE) to identify professional practice trends that impact on quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. The OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of practitioner's current clinical competency. Information collected for the Advanced Practice Provider OPPE may be linked to the OPPE data of their collaborating physician.

In addition, each practitioner may be subject to a FPPE when issues affecting the provision of safe, high quality patient care are identified. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

Section 5. Reappointment

5.1 Criteria for reappointment

It is the policy of the Hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in section 2. The practitioner must also be determined by the MEC to be a provider of effective care that is consistent with the Hospital standards of ongoing quality and the Hospital performance improvement program and provide the information enumerated in Section 5.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing Medical Staff members will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 4 above concerning focused professional practice evaluation. A suitable peer shall substitute for the service line representative evaluation of current competency of the said representative and provide input to the credentials committee.

5.2 Information collection and verification

5.2.1 From appointee: On or before four (4) months prior to the date of expiration of a Medical Staff appointment or grant of privileges, a representative from the Medical Staff office notifies the practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least sixty (60) calendar days prior to this date the practitioner must return the following to the Medical Staff office:

a. A completed reapplication form, which includes complete information to update his/her file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees.

b. Information concerning continuing training and education internal and external to the Hospital during the preceding period, as required by the current Rules and Regulations.

c. By signing the reapplication form the appointee agrees to the same terms as identified in Section 3.2 above.

5.2.2 From internal and/or external sources: The Medical Staff office collects and verifies information regarding each staff appointee's professional and collegial activities to include those items listed in Section 3.2.9, items a.-w.

5.2.3 The following information is also collected and verified:

a. A summary of clinical activity at this Hospital for each appointee due for reappointment.

b. Performance and conduct in this Hospital and other healthcare organizations in which the practitioner has provided substantial clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice.

c. Documentation of any required hours of continuing medical education activity, as required by the current Rules and Regulations.

d. Service on Medical Staff, service, and Hospital committees.

e. Timely and accurate completion of medical records.

f. Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the Hospital and Medical Staff.

g. Any significant gaps in employment or practice since the previous appointment or reappointment.

h. Verification of current licensure.

i. National Practitioner Data Bank query.

j. When sufficient peer review data is not available to evaluate competency, one or more peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current patient care, medical/clinical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, system-based practice and physical, mental and emotional ability to perform requested privileges;

k. Malpractice history for the past two (2) years which is primary source verified by the Medical Staff office with the practitioner's malpractice carrier(s) and the state department of insurance.

5.2.4 Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the Medical Staff office verifies this additional information and notifies the staff appointee of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

5.3 Evaluation of Application for Reappointment of Membership and/or Privileges

5.3.1 Expedited review reappointment applications will be categorized as described in Section 3.3.1 above.

5.3.2 The reappointment application will be reviewed and acted upon as described in Sections 3.3.3 through 3.3.8 above. For the purpose of reappointment an "adverse recommendation" by the Board as used in section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant to a Fair Hearing under Part II of the Medical Staff bylaws. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "staff appointee" and "reappointment".

Section 6. Clinical Privileges

6.1 Exercise of privileges

A practitioner providing clinical services at the Hospital may exercise only those privileges granted to him/her by the Board or emergency and disaster privileges as described herein. Privileges may be granted by the Board upon recommendation of the MEC to practitioners who are not members of the Medical Staff. Such individuals may be Advance Practice Registered Nurses (APRN's), Physician Assistants (PA's), psychologist, physicians serving short locum tenens positions, telemedicine physicians or others deemed appropriate by the MEC and Board.

6.2 Requests

When applicable, each application for appointment or reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

6.3 Basis for privileges determination

6.3.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the Hospital in its Board approved criteria for clinical privileges.

6.3.2 Privileges for which no criteria have been established:

In the event a request for a privilege is submitted for a new technology, a procedure new to the Hospital, an existing procedure used in a significantly different manner, or involving a cross-specialty privilege for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) calendar days. During this time the MEC will:

a. Review the community, patient and Hospital need for the privilege and reach agreement with management and the Board that the privilege is approved to be exercised at the Hospital.

b. Review with members of the credentials committee the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting–specific area of the Hospital by appropriate regulatory agencies (FDA, OSHA, etc.).

c. Meet with Hospital management to ensure that the new privilege is consistent with the Hospital's mission, values, strategic, operating, capital, information, and staffing plans.

d. Work with Hospital management to ensure that any/all exclusive contract issues, if applicable are resolved in such a way to allow the new or cross-specialty privileges in question to be provided without violating the existing contract. Upon recommendation from the credentials committee and appropriate clinical service/specialty or subject matter experts (as determined by the credentials committee), the MEC will formulate the necessary criteria and recommend these to the Board. Once objective criteria have been established, the original request will be processed as described herein.

For the development of criteria, the Medical Staff service professional (or designee) will compile information relevant to the privileges requested which may include, but need not be limited to, position and opinion papers from specialty organizations, white papers from the Credentialing Resource Center and others as available, position and opinion statements from interested individuals or groups, and documentation from other Hospitals in the region as appropriate.

Criteria to be established for the privilege(s) in question include education, training, board status, or certification (if applicable), experience, and evidence of current competence. Proctoring requirements, if any, will be addressed including who may serve as proctor and how many proctored cases will be required. Hospital related issues such as exclusive contracts, equipment, clinical support staff and management will be referred to the appropriate Hospital administrator and/or department director.

If the privileges requested overlap two or more specialty disciplines, each involved specialty will present their case to the credentials committee. The credentials committee will develop the final criteria for the new privilege.

6.3.3 Requests for clinical privileges will be consistently evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs and the Hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the staff's performance improvement program activities. Privilege's determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.

6.3.4 The procedure by which requests for clinical privileges are processed are as outlined in Section 3 above.

6.4 Special conditions for dental privileges

Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oromaxillofacial surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff with privileges to perform such an evaluation, which will be recorded in the medical record.

6.5 Special conditions for licensed independent practitioners not qualified for Medical Staff appointment but practicing pursuant to clinical privileges per Hospital policy

Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by providers eligible for Medical Staff membership, with the exception that such individuals are not eligible for membership on the Medical Staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the Board for providing services at the Hospital are eligible to apply for privileges. These categories are referred to as the Advanced Practice Provider (APP), which includes: Advanced Practice Registered Nurse, Certified Nurse Midwife, Physician Assistant and Licensed Clinical Psychologist. The APP may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the collaborative agreement of a physician who has been accorded privileges to provide such care. The privileges of these APP's shall terminate immediately, without right to due process, if the employment of the APP with the Hospital is terminated for any reason or if the employment contract or sponsorship of the APP with a physician member of the Medical Staff organization is terminated for any reason.

6.6 Special conditions for podiatric privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a MD/DO member of the Medical Staff, or by a podiatrist credentialed to perform a full History and Physical, that will be recorded in the medical record.

6.7 Special conditions for residents or fellows in training

Residents or fellows in training in the Hospital shall not normally hold membership on the Medical Staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the director of continuing medical education, a professional graduate education committee, or medical director in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate Medical Staff and Hospital leaders.

The post-graduate education program director or committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

6.8 Telemedicine Privileges

Practitioners providing only telemedicine services to the Hospital from a distant site will not be appointed to the Medical Staff but must be granted privileges at this Hospital if, and only if, these services include prescribing care or otherwise treating patients. Practitioners providing official readings of images, tracings or specimens through a telemedicine mechanism must:

a. Be granted clinical privileges that include these services at the Hospital and the distant site, where the Hospital is the site where the patient is receiving care and the distant site is the site from which the services are provided; or

b. Contract with the Hospital for the provision of these services by the provider. If the Hospital contracts for the provision of these services, they must be provided consistent with the terms described in Section 10 of these procedures addressing contracted services.

6.8.1 Requests for telemedicine privileges at the originating site hospital will be processed through the established procedure for reviewing and granting privileges at the originating site hospital. Information included in the completed practitioner application for telemedicine privileges at the originating site hospital may be collected in the usual manner or may be collected from the distant site hospital or organization if Joint Commission approved.

6.8.2 In order for the originating site to utilize the credentialing and privileging decision from the distant site to make a final privileging decision, the following three (3) conditions must be fulfilled:

a. The distant site is a Joint Commission accredited hospital or ambulatory care organization.

b. The practitioner is privileged at the distant site for those services to be provided at the originating site; and

c. The originating site hospital has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information will include all adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result from the telemedicine services provided and complaints about the practitioner from patients, other Licensed Independent Providers (LIP's), or staff at the originating site.

6.9 Temporary Privileges

Temporary privileges may be granted by the Hospital President, or designee, acting on behalf of the Board and based on the recommendation of the Chief of Staff or designee, provided there is verification of current licensure and current competence. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment, or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

6.9.1 Important Patient Care, Treatment or Service Need: Temporary privileges may be granted on a case-by-case basis when an important patient care, treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days, while the full credentials information is verified and approved. When granting such privileges, the organized Medical Staff verifies current licensure and current competence.

6.9.2 Clean Application Awaiting Approval: Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for Medical Staff membership and/or privileges is waiting for review and recommendation by the MEC and approval by the Board. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which has been verified by the Hospital: current licensure; education training and experience; current competence; current DEA (if applicable); current professional liability insurance in the amount required; malpractice history; one positive reference specific to the applicant's competence from an appropriate medical peer; ability to perform the privileges requested; and results from a query to the National Practitioner Data Bank. Additionally, the application must meet the criteria for Category 1, expedited credentialing consideration as noted in Part III Section 3 of these bylaws.

6.9.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules, and regulations and policies of the Medical Staff and Hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

6.9.4 Termination of temporary privileges: The Hospital President, acting on behalf of the Board and after consultation with the Chief of Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. This includes, but not limited to, adverse recommendation by Credentials Committee, MEC, Board, or failure to complete application process. Where the life or well-being of a patient is determined to be endangered, any person entitled to impose precautionary suspension under the Medical Staff bylaws may affect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the Hospital President or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

6.9.5 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless based on a determination of clinical incompetence or unprofessional conduct.

6.9.6 Emergency Privileges: In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, regardless of service affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

6.9.7 Disaster Privileges:

a. If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the Hospital President and such other individuals as identified in the institution's Disaster Plan with such authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to provide patient care to selected LIP's who must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

   A current picture hospital ID card that clearly identifies professional designation.

   A current license to practice.

Primary source verification of the license.

Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups.

Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).

Identification by a current hospital or Medical Staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

b. The Medical Staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization decides (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

c. Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

d. Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

e. Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the Hospital and will not give rise to a right to a fair hearing or an appeal.

6.10 History and Physical Examination

The History and Physical Examination (H & P) shall be performed and recorded by a Doctor of Medicine or osteopathy, or, for patients admitted only for oral and maxillofacial surgery, by an oral and maxillofacial surgeon, or for patients admitted for podiatric services, by a podiatrist. All or part of the H & P may be delegated to other practitioners in accordance with State law and Hospital policy, but the MD/DO must sign the H & P and as applicable, the update note and assume full responsibility for the H & P.

The History and Physical Examination report must include the following information:

a. Chief complaint or reason for the admission or procedure.

b. A description of the present illness.

c. Past medical history, including past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors.

d. An age-appropriate social history.

e. A pertinent family history.

f. A review of systems.

g. Relevant physical findings.

h. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression, or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

A medical history and appropriate physical examination must be entered in the medical record no more than thirty (30) days before or twenty-four (24) hours after a Hospital inpatient or observation admission. If an H & P Examination has been performed and documented within thirty (30) days of the patient's admission to the Hospital, a legible copy of that H & P examination may be used in the patient's hospital medical record provided that an "Updated History and Physical Examination" is entered in the medical record no more than 24 hours after admission or prior to surgery. Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to all invasive procedures performed in the Hospital's surgical suites.

This Updated History and Physical Examination must:

a. Address the patient's current status and/or any changes in the patient's status (if there are no changes in the patient's status, this should be specifically noted).

b. Include an appropriate physical examination of the patient to update any components of the exam that may have changed since the prior history and physical, or to address any areas where more current data is needed.

c. Confirm that the necessity for the admission, procedure, or care is still present.

d. Be written or otherwise recorded on, or attached to, the previous History and Physical; and

e. Be placed in the patient's medical record within 24 hours after admission or prior to surgery or performance of an invasive procedure for which an H&P is required.

Section 7. Preceptorship

7.1 A practitioner who has not provided acute inpatient care within the past one (1) year who requests clinical privileges at the Hospital must arrange for a preceptorship either with a current member in good standing of the Medical Staff who practices in the same specialty or with a training program or other equivalently competent physician practicing outside of the Hospital. The practitioner must assume responsibility for any financial costs required to fulfill the requirements of sections 7.1 and 7.2**.**

7.2 A description of the preceptorship program, including details of monitoring and consultation must be written and submitted for approval to the service line representative and/or credentials committee and MEC. At a minimum, the preceptorship program description must include the following**:**

7.2.1 The scope and intensity of required preceptorship activities.

7.2.2 The requirement for submission of a written report from the preceptor prior to termination of the preceptorship period assessing, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

Section 8. Reapplication After Modifications of Membership Status or Privileges and Exhaustion of Remedies

8.1 Reapplication after adverse credentials decision

Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the Medical Staff or for clinical privileges for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the Medical Staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

8.2 Request for modification of appointment status or privileges

A staff appointee, either in connection with reappointment or at any other time, may request modification of staff category, service assignment, or clinical privileges by submitting a written request to the Medical Staff office. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment, which is outlined in Part III, Section 5 of these bylaws. A practitioner who determines that s/he no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that s/he has been granted shall send written notice, through the Medical Staff office, to the credentials committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file.

8.3 Resignation of staff appointment or privileges

A practitioner who wishes to resign his/her staff appointment and/or clinical privileges must provide written notice to the appropriate service line representative, Chief of Staff, or designee. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which s/he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

8.4 Exhaustion of administrative remedies

Every practitioner agrees that s/he will exhaust all the administrative remedies afforded in the various sections of this manual, the Governance and the Investigation, Corrective Action, Hearing and Appeal Plan before initiating legal action against the Hospital or its agents.

8.5 Reporting requirements

The Hospital President or his/her designee shall be responsible for assuring that the Hospital satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes. Actions that must be reported include any negative professional review action against a physician related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 9. Leave of Absence

9.1 Leave request

A leave of absence is a matter of courtesy, not of right. If it is determined that a practitioner 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 leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities longer than 30 days if such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the Chief of Staff stating the reasons for the leave and approximate period of time of the leave, which may not exceed one year except for military service or express permission by the Board. (Requests for a leave of absence may also be provided by a health professional or other authorized individual on behalf of the physician who would be on leave if they are unable to provide the request themselves). Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the Board. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities.

9.2 Termination of leave

At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the Chief of Staff. The practitioner must submit a written summary of relevant activities during the leave if the MEC or Board so requests. A practitioner returning from a leave of absence for health reasons must provide a report from his/her physician that answers any questions that the MEC or Board may have as part of considering the request for reinstatement. The MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed. If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the practitioner must apply for reappointment, or his/her appointment and/or clinical privileges shall lapse at the end of the appointment period.

9.3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Part II of these bylaws. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Section 10. Practitioners Providing Contracted Services

10.1 When the Hospital contracts for patient care services with licensed independent practitioners who provide official readings of images, tracings or specimens through a telemedicine mechanism, and these practitioner's services are under the control of a Joint Commission accredited organization, the Hospital will**:**

a. Specify in a contract that the entity providing these services by contract (the contracting entity) will ensure that all services provided under this contract by individuals who are LIPs will be within the scope of those individual's privileges at the contracting entity; or

b. Verify that all individuals who are LIPs and providing services under the contract have privileges that include the services provided under the contract.

10.2 When the Hospital contracts for care services with licensed independent practitioners who provide official readings of images, tracings or specimens through a telemedicine mechanism, and these practitioner's services are not under the control of a Joint Commission accredited organization, all LIPs who will be providing services under this contract will be permitted to do so only after being granted privileges at the Hospital through the mechanisms established in these bylaws' manual**.**

10.3 Exclusivity policy

Whenever Hospital policy specifies that certain Hospital facilities or services may be provided on an exclusive basis in accordance with contracts or letters of agreement between the Hospital and qualified practitioners, then other practitioners must, except in an emergency or life-threatening situation, adhere to the exclusivity policy in arranging for or providing care. Application for initial appointment or for clinical privileges related to the Hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the Hospital. Practitioners who have previously been granted privileges, which now become covered by an exclusive contract, will not be able to exercise those privileges unless they become a party to the contract.

10.4 Qualifications

A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the Hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his/her appointment category as any other applicant or staff appointee.

10.5 The terms of the Medical Staff bylaws will govern disciplinary action taken by or recommended by the MEC.

10.6 Effect of contract or employment expiration or termination

The effect of expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract with the Hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges.

Section 11. Medical Administrative Officers

11.1 A medical administrative officer is a practitioner engaged by the Hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction**.**

11.2 Each medical administrative officer must achieve and maintain Medical Staff appointment and clinical privileges appropriate to his/her clinical responsibilities and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other staff members**.**

11.3 Effect of removal from office or adverse change in appointment status or clinical privileges:

a. Where a contract exists between the officer and the Hospital, its terms govern the effect of removal from the medical administrative office on the officer's staff appointment and privileges and the effect an adverse change in the officer's staff appointment or clinical privileges has on his remaining in office.

b. In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the Board.

c. A medical administrative officer has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from office.

Section 12. Credentialing of Locum Tenens Practitioners

12.1.1 The Medical Staff Policy "Locum Tenens Credentialing" is in place to provide a mechanism to credential physicians and Advanced Practice Providers hired as locum tenens when there is a staffing shortage or when hired to serve for a Medical Staff member who is on leave due to illness, vacation, or medical education opportunities.

Indiana University Health

Bloomington

MEDICAL STAFF BYLAWS

Part IV: Organization and Functions Manual

Revised – October 2021
Board Approved October 2021

Table of Contents Part IV

Section 1. Organization and Functions of the Staff

1.1 Organization of the Medical Staff

The Medical Staff shall be organized as a non-departmentalized staff including the clinical services of medicine, acute care inpatient services, emergency medicine, ambulatory services, OB/Gyn and pediatric services, surgery, oncology, musculoskeletal, anesthesia, pathology, and radiology. A Service Line Medical Executive shall head each clinical service with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

1.2 Responsibilities for Medical Staff Functions

The organized Medical Staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3, below, with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The Medical Staff officers, service line representatives, Hospital, and Medical Staff committee chairs, are responsible for working collaboratively to develop a process for communication of Medical Staff function activities by providing periodic reports as appropriate to the appropriate service/committee and to elevate issues of concern to the MEC as needed to ensure adherence to regulatory/accreditation compliance and appropriate standards of medical care.

1.3 Description of Medical Staff Functions

1.3.1 Governance, direction, coordination, and action:

a. Receive, coordinate and act upon, as necessary, the reports and recommendations from services, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities.

b. Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care at the Hospital.

c. Take reasonable steps to obtain professional and ethical conduct and initiate investigations and pursue corrective action of Medical Staff members when warranted.

d. Make recommendations on medical, administrative, and Hospital clinical and operational matters.

e. Inform the Medical Staff of the accreditation and state licensure status of the Hospital.

f. Act on all matters of Medical Staff business and fulfill any state and federal reporting requirements.

g. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities.

h. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution.

i. Provide oversight concerning the quality of care provided by residents and fellows, interns, students, and ensure that the same act within approved guidelines established by the Medical Staff and governing body.

j. Ensure effective, timely, and adequate comprehensive communication between the members of the Medical Staff and Medical Staff leaders as well as between Medical Staff leaders and Hospital administration and the Board.

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

a. Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise based on the general competencies defined by the Medical Staff.

b. Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to practitioners and develop plans for improving the quality of clinical care provided.

c. Actively be involved in the measurement, assessment, and improvement of activities of practitioner performance that include but are not limited to the following:

Medical assessment and treatment of patients

Use of medications

Use of blood and blood components

Operative and other procedures

Education of patients and families

Accurate, timely, and legible completion of patients' medical records to include the quality of medical histories and physical examinations

Appropriateness of clinical practice patterns

Significant departures from established pattern of clinical performance

Use of developed criteria for autopsies

Sentinel event data

Patient safety data

Coordination of care, treatment, and services with other practitioners and Hospital personnel, as relevant to the care, treatment, and services of an individual patient

Findings of the assessment process relevant to individual performance

d. Communicate findings, conclusions, recommendations, and actions to improve the performance of physicians to Medical Staff leaders and the Board and define in writing the responsibility for acting on recommendations for practitioner improvement.

1.3.3 The Medical Staff shall also participate in Hospital performance improvement and patient safety programs to:

a. Understand the Medical Staff and administration's approach to and methods of performance improvement.

b. Assist the Hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the Hospital.

c. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis.

d. Participate as requested in the Hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

1.3.4 Credential's review (see Credentials Procedures)

1.3.5 Emergency Preparedness: Assist the Hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the Hospital.

1.3.6 Strategic Planning

a. Participate in evaluating existing programs, services, and facilities of the Hospital and Medical Staff; and recommend continuation, expansion, abridgment, or termination of each.

b. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources.

c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to Medical Staff members.

1.3.7 Bylaw's review

a. Conduct periodic review of the Medical Staff bylaw, rules, regulations, and policies.

b. Submit written recommendations to the MEC and to the Board for amendments to the Medical Staff bylaws, rules, regulations, and policies.

1.3.8 Nominating

a. Identify nominees for election to the officer positions and to other elected positions in the Medical Staff organizational structure.

b. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

1.3.9 Infection Control Oversight

a. The Medical Staff oversees the development and coordination of the Hospital-wide program for surveillance, prevention, implementation, and control of infection.

b. Develop and approve policies describing the type and scope of surveillance activities including:

Review of cumulative microbiology recurrence and sensitivity reports; Determination of definitions and criteria for healthcare acquired infections.

Review of prevalence and incidence studies, as appropriate.

Collection of additional data as needed.

c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information.

d. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually.

e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections.

f. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk.

g. Report healthcare acquired infection findings to the attending physician and appropriate clinical or administrative leader.

h. Review all policies and procedures on infection prevention, surveillance, and control at least biannually.

1.3.10 Pharmacy and Therapeutics Functions

a. Maintain a formulary of drugs approved for use by the Hospital.

b. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics.

c. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions).

d. Perform medication usage evaluation studies as required by the Joint Commission.

e. Perform practitioner analysis related to medication use.

f. Approve policies and procedures related to the Joint Commission Care of Patient Standards: to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the Hospital.

g. Develop and measure indicators for the following elements of the patient treatment functions:

Prescribing/ordering of medications.

Preparing and dispensing of medications.

Administrating medications.

Monitoring of the effects of medication.

h. Analyze and profile data regarding the measurement of the patient treatment functions by service and practitioner, where appropriate.

i. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified.

j. Serve as an advisory group to the Hospital and Medical Staff pertaining to the choice of available medications.

1.3.11 Professionalism and Behavior Review Board

a. Evaluate the credibility of a complaint, allegation, or concern and establish a program for identifying and contacting practitioners who have become professionally impaired, in varying degrees, because of drug dependence including alcoholism or because of mental, physical, or aging problems. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment.

b. Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment.

c. Notify the impaired practitioner's clinical service line representative and the MEC whenever the impaired practitioner's actions could endanger patients. The existence of the Professionalism and Behavior Review Board does not alter the primary responsibility of the service line representative for clinical performance within that representatives' service.

d. Create opportunities for referral (including self-referral) while maintaining confidentiality to the greatest extent possible.

e. Report to the MEC all practitioners providing unsafe treatment so that the practitioner can be monitored until his/her rehabilitation is complete and periodically thereafter. The Hospital shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the Hospital has confidence.

1.4 Responsibilities of Chief of Staff

1.4.1 The Chief of Staff is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the Board and the administration of the Hospital facility. The Chief of Staff, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in the Medical Staff bylaws, rules, regulations, and policies. Specific responsibilities and authority are to:

a. Call and preside at all general and special meetings of the Medical Staff.

b. Serve as chair of the MEC and as ex officio member of all other Medical Staff committees without vote, and to participate as invited by the Hospital President or the Board on Hospital or Board committees.

c. Enforce Medical Staff bylaws, rules, regulations, and Medical Staff/Hospital policies.

d. Except as stated otherwise, appoint committee chairs and all members of Medical Staff standing and ad hoc committees; in consultation with Hospital administration, appoint Medical Staff members to appropriate Hospital committees or to serve as Medical Staff advisors or liaisons to carry out specific functions ; in consultation with the chair of the Board, appoint the Medical Staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;

e. Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities.

f. Report to the Board the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners or advanced practice providers who are applying for appointment or privileges, or who are granted privileges or providing services in the Hospital.

g. Continuously evaluate and periodically report to the Hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes.

h. Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the Medical Staff in their relations with each other, the Board, Hospital management, other professional and support staff, and the community the Hospital serves.

i. Communicate and represent the opinions and concerns of the Medical Staff and its individual members on organizational and individual matters affecting Hospital operations to Hospital administration, the MEC, and the Board.

j. Attend Board meetings as an ex-officio member without vote and attend Board committee meetings as invited by the Board.

k. Ensure that the decisions of the Board are communicated and carried out within the Medical Staff.

l. Perform such other duties and exercise such authority commensurate with the office as are set forth in the Medical Staff bylaws.

1.5 Responsibilities of Clinical Service Line Representatives

1.5.1 Formulate continuing education and encourage discussion of patient care issues pertinent to that clinical specialty.

1.5.2 Discuss policies and procedures and recommend same to the appropriate service chair.

1.5.3 Discuss equipment needs pertinent to that clinical section.

1.5.4 Develop recommendations of a specific issue at the request of a service chair or the MEC.

1.5.5 Encourage participation in the development of criteria for clinical privileges and give input on an application or reapplication, when requested by the service chair, credentials committee or MEC.

Section 2. Medical Staff Committees

2.1 General language governing committees

The following shall be committees with Medical Staff representation. A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The Chief of Staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease upon the accomplishment of the purpose of the committee or upon a date set by the Chief of Staff when establishing the committee. The Chief of Staff and the Hospital President, or their designees, are ex officio members of all standing and ad hoc committees.

Medical staff committee members may be removed from the committee by the Chief of Staff or by action of the MEC if there is a significant conflict of interest or for failure to remain a member of the Medical Staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same way the original appointment was made.

2.2 MEC

Description of the MEC is in Part I: Governance; Section 6.2.

2.3 Credentials Committee

Description of the credentials committee is in Part III: Credentials Procedures; Section 1.

2.4 Medical Staff Quality Committee (Medical Staff committee)

2.4.1 **Composition**: The Medical Staff quality committee shall consist of at least seven (7) members of the Medical Staff. Representatives from nursing service and Hospital administration will serve as ex officio members at the invitation of the chair.

2.4.2 **Responsibilities**: The committee shall be responsible for those functions described in section 1.3.2 a-d above.

2.5 Cancer Committee (Medical Staff committee)

2.5.1 **Composition**: The cancer committee shall be multidisciplinary with required members as appropriate to the institution to maintain certification by the American College of Surgeons Commission on Cancer as a Community Hospital Comprehensive Cancer Program. The breast center services shall be multidisciplinary with required members as appropriate to the institution to maintain certification by the National Accreditation Program for Breast Centers. The Breast Program Leadership will report to the Cancer Committee.

2.5.2 **Responsibilities**: The committee provides program leadership with duties as described in the Standards of the Commission on Cancer. The Breast Program Leadership provides program leadership with duties as described in the Standards of the National Accreditation Program for Breast Centers and will report to the Cancer Committee.

2.6 Pharmacy and Therapeutics Committee (Hospital committee)

2.6.1 **Composition**: The pharmacy and therapeutics committee shall consist of at least four (4) members of the Medical Staff. The chair of the committee shall be a physician. Representatives from pharmacy, nursing service, and Hospital administration will serve as members.

2.6.2 **Responsibilities**: The committee shall be responsible for those functions described in section 1.3.10 above.

2.7 Infection Control Committee (Hospital committee)

2.7.1 **Composition**: The infection control committee shall consist of at least four (4) members of the Medical Staff. The chair of the committee shall be a physician. The infection control coordinator shall serve as a member. Consulting members, who shall attend at the invitation of the chair, shall include representatives from dietary, environmental services, central supply, operating room, and nursing services.

2.7.2 **Responsibilities**: The committee shall be responsible for those functions described in section 1.3.9 above.

2.8 Bylaws Committee (Medical Staff ad hoc committee)

2.8.1 **Composition**: The bylaws committee shall consist of at least five (5) members of the Medical Staff, two of whom shall be past chiefs of staff.

2.8.2 **Responsibilities**: The committee shall be responsible for those functions described in section 1.3.7 above.

2.9 Operating Room Committee (Hospital committee)

2.9.1 **Composition**: The operating room committee shall consist of representatives from Anesthesia, OB/GYN, and Surgery; and additional members representing the various disciplines of Surgery who will be appointed by their appropriate sections. The chair of the committee shall be a physician. The Surgical Services Coordinator, Director of Nurses, and Hospital President or his/her representative will serve as members.

2.9.2 **Responsibilities**: The committee has the responsibility of reviewing operating room procedures; updating operating room policies; and considering issues that pertain to the operating room. The committee will make recommendations from time to time on matters concerning the operating room policies and procedures.

2.10 Continuing Medical Education (CME) Advisory Committee (Medical Staff committee)

2.10.1 **Composition**: The CME advisory committee shall be multidisciplinary with required members to be consistent with the recommendations of the ACGME and the Indiana State Medical Society. The director of medical education will be a member of the committee.

2.10.2 **Responsibilities**: The committee provides program leadership with duties as described by the Indiana Medical Society Accreditation Committee.

2.11 Trauma Quality Improvement Committee (Medical Staff committee)

2.11.1 **Composition**: The Trauma Quality Improvement Committee shall include the Trauma Medical Director, Service Line Medical Executive or appointee from the Surgical Specialties service line, director of Surgical Intensive Care Unit (SICU), or designee; and Medical Staff representatives from the following: anesthesiology, emergency medicine, neurosurgery, orthopedic surgery, , medicine service line, and radiology; APP Staff representatives from the following: emergency medicine, acute care surgery, Trauma Program Manager, Trauma RN-Registrar and Trauma Registrar.

2.11.2 **Responsibilities**: The Quality Improvement Committee is tasked with review of traumatic deaths, patients transferred to a higher level of trauma care and patients with complications related to traumatic injury. The committee will make the following possible determinations required by the American College of Surgeons for each case reviewed: event with opportunity for improvement, event without opportunity for improvement, mortality with opportunity for improvement, and mortality without opportunity for improvement. Reviewed cases may be recommended by the committee for further review at Medical Staff Quality Committee and/or reviewed by an outside trauma authority. Members are required to attend 50% or more of the monthly meetings in a one-year time period beginning on January 1 and ending on December 31.

2.12 Medical Ethics Committee (Hospital committee)

2.12.1 **Composition**: The medical ethics committee shall be multidisciplinary consisting of members of the Medical Staff, nursing, social services, Hospital chaplain, risk management director, and an administrative representative. Various Hospital personnel necessary to assess and resolve ethical issues may augment the committee.

2.12.2 **Responsibilities**: This committee shall be responsible for those functions described in section 1.3.1.h above.

2.13 Professional and Behavior Review Board (Review Board) (Medical Staff ad hoc committee)

2.13.1 **Composition**: The Review Board shall consist of three (3) to seven (7) members of the active Medical Staff. A physician who is not a member of the IU Health Bloomington Medical Staff may be included in the composition of the Review Board committee. The chair and members of the committee shall be appointed by the Chief of Staff.

2.13.2 **Responsibilities:** This Review Board shall be responsible for those functions described in section 1.3.11 above.

2.14 Nominating Committee (Medical Staff ad hoc committee)

2.14.1 **Composition:** The nominating committee shall consist of the officers of the Medical Staff. The chair shall be the immediate past Chief of Staff**.**

2.14.2 **Responsibilities:** The committee shall:

a. Develop criteria for leadership positions to include tenure, leadership training, previous experience in leadership positions and character.

b. Provide a slate of nominees for the elected Medical Staff positions.

c. Provide a list of potential leaders.

d. Define a process for evaluating current leaders e.g., service chairs, committee chairs, Medical Staff officers, and MEC members and potential leadership candidates.

e. Outline a plan and processes for leadership development of potential leaders.

f. Submit recommendations for Medical Staff committee chairs based on the potential leaders' needs for development and readiness to serve (the Chief of Staff will consider these recommendations for committee chairs but will not be bound by them).

g. Develop job descriptions for officer positions.

h. Report to the MEC as needed.

2.15 Patient Care Committee (Hospital committee)

2.15.1 **Composition:** Each Service Line Medical Executive shall appoint one member from their service line to participate in this committee. The committee will be multidisciplinary with representatives from several clinical departments and administration. The Chief of Staff Elect shall serve as Chair.

2.15.2 **Responsibilities:** The committee's duties shall include:

a. Be primarily concerned with improving patient care as identified by our patients,

b. Evaluate current systems of patient care to identify the source of problems that impact directly upon patients,

c. Review information from a variety of sources including patient complaint surveys, community focus groups and the county health board,

d. Refer priority problems for assessment and corrective action to appropriate action committees of the Hospital or Medical Staff,

e. Facilitate an attitude of respect and support among health professionals for the betterment of patient care, and

f. Submit regular confidential reports to the Medical Staff Executive Committee on the quality of medical care provided and on quality review activities conducted. The Chief of Staff will be the reporting officer if no other member sits on the MEC.

Section 3. Confidentiality, Immunity, Releases, and Conflict of Interest

3.1 Confidentiality of Information

To the fullest extent permitted by law, the following shall be kept confidential: information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or Medical Staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided; evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; contributions to teaching or clinical research; or determinations that healthcare services were indicated or performed in compliance with an applicable standard of care. This information will not be disseminated to anyone other than a representative of the Hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

3.2 Immunity from Liability

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of the Hospital or Medical Staff or for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

3.3 Covered Activities

3.3.1 The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facilities or organization's activities concerning, but not limited to:

a. applications for appointment/affiliation, clinical privileges, or specified services.

b. periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services.

c. corrective or disciplinary actions.

d. hearings and appellate reviews.

e. quality assessment and performance improvement/peer review activities.

f. utilization review and improvement activities.

g. claims reviews.

h. risk management and liability prevention activities.

i. other Hospital, committee, service, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

3.4 Releases

Each practitioner shall, upon request of the Hospital, execute general and specific releases when requested by the Chief of Staff or designee. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.