# MEDICAL STAFF BYLAWS, POLICIES, AND RULES & REGULATIONS OF INDIANA UNIVERSITY HEALTH FORT WAYNE HOSPITAL

# MEDICAL STAFF ORGANIZATION MANUAL

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**TABLE OF CONTENTS**

**1. GENERAL**

A. DEFINITIONS

B. TIME LIMITS

C. DELEGATION OF FUNCTIONS

**2. CLINICAL SECTIONS**

A. LIST OF CLINICAL SECTIONS

B. COMPOSITION

C. DUTIES

D. MEETINGS

**3. MEDICAL STAFF COMMITTEES**

A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

B. MEETINGS, REPORTS AND RECOMMENDATIONS

C. BYLAWS COMMITTEE

D. CREDENTIALS COMMITTEE

E. MEDICAL EXECUTIVE COMMITTEE

F. QUALITY AND PATIENT SAFETY COMMITTEE

G. PHARMACY AND THERAPEUTICS COMMITTEE

H. UTILIZATION REVIEW COMMITTEE

I. MEDICAL STAFF QUALITY COMMITTEE

**4. AMENDMENTS**

**5. ADOPTION**

# ARTICLE 1
# GENERAL

### A. DEFINITIONS

The definitions that apply to terms used in all the Related Medical Staff Documents are set forth in the Credentials Policy.

### B. TIME LIMITS

Time limits referred to in this Medical Staff Organizational Manual (Manual) are advisory only and are not mandatory unless it is expressly stated.

### C. DELEGATION OF FUNCTIONS

When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chairman, may delegate performance of the function to one or more qualified designees.

# ARTICLE 2
# CLINICAL SECTIONS

### A. LIST OF CLINICAL SECTIONS

The following initial clinical sections are established for the Hospital:

- Anesthesia Section
- Cardiology Section
- Emergency Medicine Section
- Gastroenterology Section
- Gynecology Section
- Internal Medicine Section
- Neurology Section
- Orthopedic Section
- Radiology Section
- Surgery Section

### B. COMPOSITION

Sections are open to all Members of the Medical Staff and Allied Health Staff and assigned upon initial appointment. Subject to the approval of the Board, the Medical Executive Committee (MEC) may create new Sections, eliminate Sections, create divisions of Sections, or otherwise reorganize the Section structure.

### C. DUTIES

The duties of the Section are set forth in the Medical Staff Bylaws.

### D. MEETINGS

The meeting(s) schedule will be determined by the Section chairperson.

# ARTICLE 3
# MEDICAL STAFF COMMITTEES

## A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article outlines the Medical Staff Committees of Indiana University Health Fort Wayne Hospital that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.

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

## B. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual will meet as necessary and will maintain a permanent record of its findings, proceedings, and actions. Each committee will make a timely written report after each meeting to the Medical Executive Committee (MEC) and to other committees and individuals, as may be indicated in this Manual.

## C. BYLAWS COMMITTEE

1. **Purpose:**

The purpose of the Bylaws Committee is to review and recommend amendments to the Related Medical Staff Documents.

2. **Composition**:

The Bylaws Committee shall consist of an appropriate number of Active Members of the Medical Staff as appointed by the Chair of the MEC in consultation with the MEC. The Chair of the MEC and Chief Medical Officer (CMO) will recommend the Chair of the Bylaws Committee.

3. **Duties**:

The Bylaws Committee shall:

a. Review the Related Medical Staff Documents (Medical Staff Bylaws, Medical Staff Organizational Manual, Credentials Policy, Medical Staff Rules and Regulations, and other applicable Medical Staff forms and policies) and propose corrections, changes and amendments to the MEC; and
b. Ensure that the Related Medical Staff Documents reflect the current practice and structure of the Medical Staff and comply with changes which are required by state or federal law, The Joint Commission (TJC) accreditation standards, and Centers for Medicare & Medicaid Services ("CMS") Conditions of Participation.

4. **Meetings**:

The Bylaws Committee shall meet on a periodic and as-needed basis or at the call of the chair.

## D. CREDENTIALS COMMITTEE

1. **Purpose:**

The purpose of the Credentialing Committee is to review and approve the qualifications, clinical competence, and privileges of applicants before granting Medical Staff or Allied Health Staff appointment, reappointment, and clinical privileges.

2. **Composition**:

The Credentials Committee shall consist of an appropriate number of Active Members of the Medical Staff representing the major clinical sections as appointed by the Chair of the MEC in consultation with the MEC. Particular consideration shall be given to past Medical Staff Officers, section chairs, standards chairs or committee members, and other physicians knowledgeable in credentialing and quality improvement processes. The CMO will recommend the Chair of the Credentials Committee.

3. **Duties**:

The Credentials Committee shall:

a. In accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff and Allied Health Staff for appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;
b. Review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Allied Health Staff and, as a result of such review, make a written report of its findings and recommendations;
c. Recommend the numbers and types of cases to be reviewed as part of the initial focused professional practice evaluation ("FPPE");
d. Review and approve specialty-specific triggers for ongoing professional practice evaluation ("OPPE"), and triggers when to initiate a FPPE as to an identified concern; and
e. Recommendation appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in the Credentials Policy.

4. **Meetings**:

The Credentials Committee shall generally meet monthly or at the call of the chair.

## E. MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the Medical Executive Committee (MEC) are set forth in the Medical Staff Bylaws.

## F. QUALITY AND PATIENT SAFETY COMMITTEE

1. **Purpose:**

The purpose of the Quality and Patient Safety (Q&S) Committee is to provide specialized clinical oversight to conduct evaluation of patient care services and ensure that patient care is delivered in a safe, effective, and high-quality manner by monitoring, evaluating, and improving the quality of care and patient safety across the Hospital. The Q&S Committee also functions as the Hospital's infection prevention committee and is responsible for coordinating and integrating a program to prevent, detect, and control healthcare-associated infections and protect patients, staff and visitors from infectious hazards through a coordinated, evidence-based effort across all departments.

2. **Composition**:

The Quality and Patient Safety (Q&S) Committee shall consist of at least six (6) members of the Active Members of the Medical Staff, the Infection Preventionist, at least one representative from Nursing, and at least one representative from a Hospital service area (such as Surgery, Central Sterile, Environmental Services, Facilities, Lab or Pharmacy). The Q&S Committee shall include representation from the Clinical Sections as recommended by the CMO and appointed by the Chair of the MEC. The Q&S Committee chair may appoint individuals to temporary ad hoc positions on the Q&S Committee when it is determined that their expertise may be necessary or of assistance for a particular issue. The Chair of the MEC and CMO will recommend the Chair of the Q&S Committee, which chair shall be a physician.

3. **Duties**:

The Quality and Patient Safety (Q&S) Committee shall:

a. Advise the development of the annual Quality and Safety Plan and recommend it to the Board for approval;
b. Adopt the annual Quality and Safety Plan as the guide for the Q&S Committee's work, to include direction and prioritization of quality and safety metrics and periodic evaluation of performance towards goal achievement and preeminence;
c. Periodically review progress on quality and safety metrics; of firing guidance, barrier removal, and resource recommendations;
d. Provide oversight and direction on matters related to patient safety, including event report trends, patient injuries, serious medical error / Indiana State Department of Health medical error reporting, and patient safety team activities;
e. Work closely and collaboratively to support the Quality Department and related Hospital Department efforts;
f. Review and advise specific reports and functions to include: National Database for Nursing Quality Improvement measures, restraint and seclusion audits, Indiana Donor Network (IDN) reports, code blue review, and blood utilization/transfusion reactions;
g. Review and support activities from the following committees: Environment of Care, and Pharmacy & Therapeutics;
h. Review and approve all Hospital clinical policies, as delegated by the Medical Executive Committee;
I. Provide oversight of activities related to regulatory and licensure compliance and readiness;
j. Review health information (medical record) timeliness, appropriateness, and pertinence; in coordination with IU Health System resources;
k. Report promptly and regularly to the Board on all actions taken;
l. Perform such other functions as the Board may request from time to time;
m. Review and approve clinical policies, participate in performance improvement and patient safety activities, monitor quality indicator and key functions, as a delegated and recognized Committee of the Medical Staff.
n. Develop and maintain a Hospital wide infection prevention program and maintain surveillance over the program;
o. Develop a system for identifying, analyzing, and reporting the incidence and cause of healthcare acquired conditions;
p. Monitor infection surveillance data for evidence of epidemics, clusters, and unusual pathogens, and report such data and educate the Medical Staff f and involved Hospital services on appropriate prevention and treatment protocols;
q. Advise the development of the annual Infection Prevention Plan and recommend it to the Board for approval;
r. Review the surveillance and infection prevention policies related to all phases of the Hospital's activities and recommend opportunities for improvement to the particular department or section; and
s. Collaborate with the Pharmacy and Therapeutics Committee on the selection of antibiotics and antiviral agents for the Hospital formulary.

4. **Meetings**:

The Quality and Patient Safety (Q&S) Committee shall generally meet at least ten (10) times each year or at the call of the chair. A quorum will be defined as those in attendance at the meeting. Agreement of a decision is a majority consensus of votes cast.

**G. PHARMACY AND THERAPEUTICS COMMITTEE**

1. **Purpose:**

The purpose of the Pharmacy and Therapeutics (P&T) Committee is to provide formulary oversight and medication safety governance.

2. **Composition**:

a. The Pharmacy and Therapeutics Committee (P&T) shall consist of an appropriate number of Active Members of the Medical Staff and such other health care providers as appointed by the Chair of the MEC in consultation with the MEC. The P&T Committee may function within a regional or shared committee serving on or more affiliated hospitals within the health system.
b. Other members may include the Director of Pharmacy, Pharmacy Manager, pharmacist with content expertise, and representatives from Hospital Administration, Nursing Services, and other disciplines deemed appropriate by the P&T Committee chair.
c. The Chair of the MEC and CMO will recommend the Chair of the P&T Committee.

3. **Duties**:

The Pharmacy and Therapeutics (P&T) Committee shall:

a. Be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital;
b. Assist in the formulation of policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital;
c. Advise the Medical Staff f and the pharmaceutical Section on matters pertaining to the choice of available drugs;
d. Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
e. Develop and review periodically a formulary or drug list for use in the Hospital;
f. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;
g. Recommend education programs for staff regarding drugs and their appropriate therapeutic use;
h. Oversee drug specialty panels;
I. Establish guidelines for pharmaceutical representatives; and
j. Facilitate communication between the P&T Committee and the Institutional Review Boards, as warranted.

4. **Meetings**:

The Pharmacy and Therapeutics (P&T) Committee shall generally meet at least six (6) times each year.

**H. UTILIZATION REVIEW COMMITTEE**

1. **Purpose:**

The purpose of the Utilization Review (UR) Committee is to review Hospital services and professional care to determine medical necessity, promote efficient use or resources, and ensure compliance with regulations for Medicare and Medicaid patients.

2. **Composition**:

The Utilization Review (UR) Committee shall consist of at least two (2) Active Members of the Medical Staff as appointed by the Chair of the MEC in consultation with the MEC. The UR Committee may also include voting representation as recommended by the CMO from Hospital Departments including Nursing, Case Management, Social Work, Revenue Cycle, and Quality. Ad-hoc consulting members may be assigned as needed by the UR chair. The Chair of the MEC and CMO will recommend the Chair of the UR Committee.

3. **Duties**:

The Utilization Review (UR) Committee shall:

a. Review medical necessity trends with respect to admission, duration of stay, and utilization of services;
b. Review and render decisions regarding specific cases with regard to appeals, etc.;
c. Stay abreast of federal regulations;
d. Review and monitor Recovery Audit Contractor (RAC), Condition Code 44, Two Midnight Rule, and other related activities;
e. Primary point of contact for Health Care Excel notices.; and
f. Review and monitor readmission rates and trends.

4. **Meetings**:

The Utilization Review (UR) Committee shall generally meet at least four (4) times each year or at the call of the chair. A quorum will be defined as those in attendance at the meeting. Agreement of a decision is a majority consensus of votes cast.

## I. MEDICAL STAFF QUALITY COMMITTEE

1. **Purpose:**

The Medical Staff Quality Committee ("MSQC") is responsible for conducting and overseeing the peer review process and professional practice evaluation activities for all members of the Medical Staff and Allied Health Staff who hold clinical privileges at the Hospital, including evaluation of qualifications and care rendered, review of patient care concerns, practitioner-specific trends, FPPE and OPPE results, or merits of complaints based on competence or professional conduct, and other matters affecting the quality and safety of patient care. The MSQC promotes continuous improvement, patient safety, and high standards of professional practice, and may make recommendations for educational, collegial, corrective, or performance-improvement actions when appropriate; all in accordance with applicable Medical Staff governing documents and policies.

2. **Composition**:

a. At all times, the composition of the MSQC shall be organized in accordance with Ind. Code 34-6-2.1-145 functioning as a peer review committee and subject to confidentiality and peer review privileges.
b. The MSQC shall be a multi-specialty peer review committee comprised of at least five (5) Active Staff of the Medical Staff from the various Clinical Sections, in good standing, appointed by the Chair of the MEC in consultation with the MEC and CMO. In the event a provider under review by the MSQC and their medical specialty is not represented by a Clinical Section member on the MSQC, the MSQC chair may invite an Active Staff member of such Clinical Section to participate in the peer review committee meeting, but it is not required.

c. The CMO; Quality Director and/or Manager; Medical Staff Office Manager; and Chief Nursing Officer will serve as ex-officio members with no vote, all of whom with be subject to the confidentiality provisions of Ind. Code 34-30-15-1 *et seq*.
d. The Chair of the MEC and CMO will recommend the Chair of the MSQC who will be appointed for an initial two (2)-year term. Members on MSQC will be appointed for two (2)-year terms and are permitted to serve up to four (4) consecutive terms.

3. **Duties**:

The goals of the MSQC include monitoring and promoting continuous quality improvement of Privileged Providers' performance on an individual basis to accomplish the following:

a. Improvement in patient outcomes by pursuing and maintaining excellence in provider performance;
b. Creation of a just culture with a positive approach to provider peer review by recognizing provider excellence as well as identifying improvement opportunities;
c. Promotion of efficient use of provider, medical staff services and quality improvement staff resources;
d. Provision of a linkage with the hospital quality improvement structure to assure responsiveness to system-wide improvement opportunities identified by the medical staff;
e. Assurance that the process for professional practice evaluation and peer review is clearly defined, objective, equitable, timely and useful;
f. Utilize FPPE/OPPE, as defined above, to identify individual professional practice trends and triggers that may impact quality of care and patient safety. OPPE performance indicators will be reviewed annually and approved by the Credentials Committees or MEC. MSQC will be provided a summary report after each OPPE review; and
g. MSQC will assist Standards/Sections with the credentialing process.

4. **Meetings**:

The MSQC shall generally meet monthly (or more often as necessary) if there is business to be brought before it. The MSQC meetings shall be run in a manner determined by the individual who is the Chair of the meeting. The MSQC shall maintain a permanent record of its proceedings and actions, and shall include a record of attendance of members and the vote taken on each matter. A permanent file of the minutes of each meeting shall be maintained and kept by the Medical Staff Office. The Chair of the MSQC shall be available to meet with Medical Staff leaders, Credentials Committee, and MEC on all recommendations sent forward from the MSQC.

# ARTICLE 4
# AMENDMENTS

This Manual may be amended in accordance with the Medical Staff Bylaws.

# ARTICLE 5
# ADOPTION

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