

**MEDICAL STAFF BYLAWS, POLICIES, AND  
RULES AND REGULATIONS  
OF  
INDIANA UNIVERSITY HEALTH  
METRO REGION**



**ORGANIZATION MANUAL**

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## ARTICLE 1

### GENERAL

#### 1.A. DEFINITIONS

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

#### 1.B. TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated.

#### 1.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 chair, may delegate performance of the function to one or more qualified designees.

## ARTICLE 2

### CLINICAL SECTIONS

#### 2.A. LIST OF SECTIONS

The following clinical sections are established for the Hospital:

- Anesthesia Section (including but not necessarily limited to Anesthesia, Cardiovascular Anesthesia, Pain Management and Pediatric Anesthesia)
- Cardiology Section
- Cardiovascular Surgery Section
- Dermatology Section
- Emergency Medicine Section (including but not necessarily limited to General Emergency Medicine, Pediatric Emergency Medicine, Medical Toxicology, Aeromedical Transport, and Emergency Medical Sections)
- Family Practice Section
- Gastroenterology Section
- Hematology/Oncology Section (including but not necessarily limited to Bone Marrow Transplant)
- Infectious Diseases Section
- Internal Medicine Section (including but not necessarily limited to Allergy/Immunology, Clinical Pharmacology (physician only), Geriatrics, Occupational Medicine and Rheumatology)
- Medical & Molecular Genetics Section
- Nephrology Section
- Neurology Section
- Neurosurgery Section
- Obstetrics and Gynecology Section (including but not necessarily limited to General Obstetrics/Gynecology, Gynecological Oncology, Gynecology, Infertility, Maternal Fetal Medicine, Reproductive Endocrinology and Urogynecology)
- Ophthalmology Section (including but not necessarily limited to Adult Ophthalmology, Neuro-Ophthalmology and Pediatric Ophthalmology)

- Oral & Maxillofacial Surgery and Dentistry Section (including but not necessarily limited to Adult Dentistry, Oral Medicine/TMD, Oral Surgery Orthodontics and Pediatric Dentistry)
- Orthopaedics Section (including but not necessarily limited to Orthopaedic Surgery, Pediatric Orthopaedics and Sports Medicine)
- Otolaryngology and Head & Neck Surgery Section (including but not necessarily limited to Audiology and Speech, Facial Plastics, Head and Neck and Pediatric Otolaryngology)
- Pathology and Laboratory Sections (including but not necessarily limited to Blood Banking/Transfusion Medicine, Chemical Pathology, Cytopathology, Dermatopathology, Forensic Pathology, Hematology, Medical Microbiology, Necropsy, Neuropathology, Pediatric Pathology and Surgical Pathology)
- Pediatrics, General Section
- Pediatrics, Specialty Sections
- Pediatric Surgery
- Physical Medicine and Rehabilitation Section
- Plastic Surgery Section
- Psychiatry Section (including but not necessarily limited to Adult Psychiatry and Child and Adolescent)
- Pulmonology & Critical Care Medicine Section
- Radiation Oncology Section
- Radiology Section (including but not necessarily limited to Abdominal Imaging, Adult Radiology, Breast Imaging, Chest Radiology, Emergency Room Radiology, General Radiology, Musculoskeletal Radiology, Neuroradiology, Nuclear Medicine, Pediatric Radiology and Vascular/Interventional Radiology)
- Surgery Section (including but not necessarily limited to General Surgery, Transplant Surgery and Trauma Surgery)
- Urology Section (including but not necessarily limited to Adult Urology and Pediatric Urology)
- Vascular Surgery

## 2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND DIVISIONS

The functions and responsibilities of sections, sub-sections, section chairs and sub-section chairs are set forth in Article 4 of the Medical Staff Bylaws.

## ARTICLE 3

### MEDICAL STAFF COMMITTEES

#### 3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

- (1) This Article outlines the Medical Staff committees of Indiana University Health Academic Health Center that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.
- (2) Procedures for the appointment of committee chairs and physician members of the committees are set forth in Article 5 of the Medical Staff Bylaws.
- (3) Unless otherwise provided, all Hospital and administrative representatives on the committees shall be appointed by the Chief Executive Officer or designee.

#### 3.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 Staff Executive Committee (“MSEC”) and to other committees and individuals as may be indicated in this Manual.

#### 3.C. BYLAWS COMMITTEE

##### 3.C.1. Composition:

The Bylaws Committee shall be composed of an appropriate number of Active Members of the Medical Staff.

##### 3.C.2. Duties:

The Bylaws Committee shall:

- (a) meet as needed, at least annually, to review, draft and recommend corrections, changes and amendments to the Medical Staff Bylaws, Rules and Regulations, manuals and other applicable Medical Staff policies;
- (b) ensure that the Bylaws and related documents reflect the current practice and structure of the Medical Staff and comply with changes which are required by state or federal law, Joint Commission (“JC”) accreditation standards, and Centers for Medicare & Medicaid Services (“CMS”) Conditions of Participation; and

- (c) recommend changes and amendments as appropriate to the MSEC per Article 8 of the Medical Staff Bylaws.

### 3.D. CANCER COMMITTEE

#### 3.D.1. Composition:

- (a) The Cancer Committee shall be multidisciplinary with required members as appropriate to the institution to maintain accreditation by the American College of Surgeons, Commission on Cancer.
- (b) The breast center services shall be multidisciplinary with required members as appropriate to the institution to maintain accreditation by the National Accreditation Program for Breast Center. The Breast Program Leadership will report to the Cancer Committee.
- (c) The majority of the members of the Cancer Committee shall consist of members of the Active Staff and shall include both adult and pediatric representatives.

#### 3.D.2. Duties:

The Cancer Committee provides program leadership with duties as described in the Standards of the Commission on Cancer.

#### 3.D.3. Meetings:

The Cancer Committee shall meet at least quarterly or at the call of the chair. Subcommittees will meet as needed for the completion of cancer committee and Breast Program Leadership activities. A quorum as defined in the Bylaws Section 6.D.2.

### 3.E. COMMITTEE FOR PROFESSIONAL ENHANCEMENT (“CPE”)

#### 3.E.1. Composition:

- (a) The CPE shall consist of the following voting members:
  - (1) Immediate Past President of the Medical Staff;
  - (2) another experienced past Medical Staff Leader;
  - (3) additional Medical Staff members who are:
    - (i) broadly representative of the clinical specialties on the Medical Staff, including both adult and pediatric representatives;

- (ii) interested or experienced in credentialing, privileging, PPE/peer review, or other Medical Staff affairs;
- (iii) supportive of evidence-based medicine protocols; and
- (iv) consistent with the non-disciplinary nature of the CPE, generally do not also serve on the MSEC.

In appointing these individuals, the Leadership Council will give preference to Practitioners who have been selected to either serve as an individual Clinical Specialty Reviewer or to chair a committee that functions as a Clinical Specialty Reviewer, as described in the Professional Practice Evaluation Policy (Peer Review); and

- (4) at least one Advanced Practice Provider appointed by the Leadership Council.
- (b) The following individuals shall serve as non-voting members to facilitate the CPE's activities:
    - (1) the Facility CMOs; and
    - (2) one or more members of the Medical Staff Quality Team.
  - (c) The Leadership Council shall appoint the CPE members and shall designate one voting member as CPE Chair.
  - (d) If the Immediate Past President of the Medical Staff is unwilling or unable to serve, the Leadership Council shall appoint another former Medical Staff Leader who is experienced in credentialing, privileging, PPE/peer review, or Medical Staff matters.
  - (e) To the fullest extent possible, CPE members shall serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms.
  - (f) Before any CPE member begins serving, the member must review the expectations and requirements of the position and affirmatively accept them. Members must also participate in periodic training on professional practice evaluation, with the nature of the training to be identified by the Leadership Council or CPE.
  - (g) Other appropriate individuals (e.g., Clinical Specialty Reviewers and other Medical Staff members, Advanced Practice Providers, Chief Nursing Officer, other Hospital personnel, representatives from IUHP, IU Health, or the IU School of Medicine, etc.) may be invited to attend a particular CPE meeting (as guests,

without vote) in order to assist the CPE in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the CPE.

- (h) Between meetings of the CPE, the CPE Chair, in conjunction with a Facility CMO or another CPE member, may take steps as necessary to implement and operationalize the decisions of the CPE. By way of example and not limitation, this may include providing clarifications to a Practitioner regarding the CPE's decisions or expectations, reviewing and approving communications with the Practitioner, responding to questions posed by an internal or external reviewer, and similar matters.

### 3.E.2. Duties:

The CPE is a non-disciplinary body, whose primary charge is to attempt to resolve the clinical performance issues referred to it in a constructive and successful manner. The CPE makes recommendations to colleagues when appropriate, but does not have the authority to require any particular action. Only the MSEC, acting in accordance with the Medical Staff Bylaws documents, possesses disciplinary authority. The CPE shall perform the following specific functions:

- (a) oversee the implementation of the Professional Practice Evaluation Policy (Peer Review) (“PPE Policy”) and ensure that all components of the process receive appropriate training and support;
- (b) review reports showing the number of cases being reviewed through the PPE Policy, by department or specialty, in order to help ensure consistency and effectiveness of the process, and recommend revisions to the process as may be necessary;
- (c) review, approve, and periodically update Ongoing Professional Practice Evaluation (“OPPE”) data elements that are identified by individual departments and adopt Medical Staff-wide data elements;
- (d) review, approve, and periodically update the specialty-specific quality indicators identified by the departments that will trigger the professional practice evaluation/peer review process;
- (e) identify variances from rules, regulations, policies, or protocols which do not require physician review, but for which an Informational Letter may be sent to the Practitioner involved in the case;
- (f) review cases referred to it as outlined in the PPE Policy;

- (g) monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved;
- (h) work with Section Chiefs to disseminate educational lessons learned from the review of cases pursuant to the PPE Policy, either through peer learning sessions in the department or through some other mechanism; and
- (i) perform any additional functions as may be set forth in applicable policy or as requested by the Leadership Council, the MSEC, or the Board.

### 3.E.3. Meetings, Reports, and Recommendations:

The CPE shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The CPE shall submit reports of its activities to the MSEC and the Board on a regular basis. The CPE's reports will provide aggregate information regarding the PPE process (e.g., numbers of cases reviewed by department or specialty; types and numbers of dispositions for the cases; listing of education initiatives based on reviews; listing of system issues identified). These reports will generally not include the details of any reviews or findings regarding specific Practitioners.

## 3.F. CREDENTIALS COMMITTEE

### 3.F.1. Composition:

The Credentials Committee shall consist of an appropriate number of members of the Active Staff representing the major clinical sections. Particular consideration is to be given to Past Presidents of the Medical Staff, past section chairs, and other physicians knowledgeable in the credentialing and quality improvement processes.

### 3.F.2. Duties:

The Credentials Committee shall:

- (a) in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff and Allied Health Professionals 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 Professionals and, as a result of such review, make a written report of its findings and recommendations; and

- (c) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in Section 4.A.4 (“Clinical Privileges for New Procedures”) and Section 4.A.5 (“Clinical Privileges That Cross Specialty Lines”) of the Credentials Policy.

### 3.F.3. Meetings:

The Credentials Committee shall meet monthly or at the call of the chairs. A quorum as defined in the Bylaws Section 6.D.2.

## 3.G. INFECTION CONTROL COMMITTEE

### 3.G.1. Composition:

The Infection Control Committee shall consist of an appropriate number of members of the Active Staff, representing the medical and surgical sections. The individual employed by the Hospital for management of the infection control program, such as an infection control nurse, and at least one representative each from Nursing Sections and Hospital administration shall also serve on the committee. The chair may appoint individuals to temporary ad hoc positions on the committee when it is determined that their expertise may be necessary or of assistance for a particular issue.

### 3.G.2. Duties:

The Infection Control Committee shall:

- (a) develop and maintain a Hospital-wide infection control program and maintain surveillance over the program;
- (b) develop a system for identifying, analyzing, and reporting the incidence and cause of nosocomial infections in the Hospital;
- (c) monitor infection surveillance data to uncover epidemics, cluster infections and unusual pathogens, and report such data and educate the Medical Staff and involved Hospital services on appropriate prevention and treatment protocols;
- (d) review the surveillance and infection control policies related to all phases of the Hospital’s activities and recommend opportunities for improvement to the particular department or section; and
- (e) collaborate with the pharmacy leadership on the selection of antibiotics and antiviral agents for the Hospital formulary.

### 3.G.3. Meetings:

The Infection Control Committee shall meet at least six times per year or at the call of the chair. A quorum as defined in the Bylaws Section 6.D.2.

## 3.H. LEADERSHIP COUNCIL

### 3.H.1. Composition:

(a) The Leadership Council shall be comprised of the following voting members:

- (1) Medical Staff President, who shall serve as Chair;
- (2) Medical Staff Vice President;
- (3) Chair, Committee for Professional Enhancement (“CPE”);
- (4) Co-Chairs, Credentials Committee;
- (5) the Chair of the former Professional Standards Committee.\*

\* The Chair of the former Professional Standards Committee will confirm their continuing desire to serve on the committee every two years. If they are unwilling to serve, another individual with Medical Staff leadership experience may be appointed to fill this position.

(b) The following individuals shall serve as non-voting members to facilitate the Leadership Council’s activities:

- (1) the Facility CMOs; and
- (2) one or more members of the Medical Staff Quality Team as designated by the voting members of the Leadership Council.

An Advanced Practice leader may also be invited to serve as an ad hoc member of the Leadership Council when a matter involves an Advanced Practice Provider.

(c) Other appropriate individuals (e.g., Medical Staff members, Advanced Practice Providers, Chief Nursing Officer, other Hospital personnel, representatives from IUHP, IU Health, or the IU School of Medicine, etc.) may be invited to attend a particular Leadership Council meeting (as guests, without vote) in order to assist the Leadership Council in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the Leadership Council review process and are bound by the same confidentiality requirements as the standing members of the Leadership Council.

- (d) Between meetings of the Leadership Council, the Medical Staff President as Chair, in conjunction with the Facility CMOs or another Leadership Council member, may take steps as necessary to implement and operationalize the decisions of the Leadership Council. By way of example and not limitation, this may include providing clarifications to a Practitioner regarding the Leadership Council's decisions or expectations, reviewing and approving communications with the Practitioner, and similar matters.

### 3.H.2. Duties:

The Leadership Council is a non-disciplinary body, whose primary charge is to attempt to resolve the performance issues referred to it in a constructive and successful manner. The Leadership Council makes recommendations to colleagues when appropriate, but does not have the authority to require any particular action. Only the MSEC, acting in accordance with the Medical Staff Bylaws documents, possesses disciplinary authority. The Leadership Council shall perform the following specific functions:

- (a) review and address concerns about Practitioners' professional conduct as outlined in the Medical Staff Professionalism Policy;
- (b) review and address possible health issues that may affect a Practitioner's ability to practice safely as outlined in the Practitioner Health Policy;
- (c) review and address issues regarding Practitioners' clinical practice as outlined in the Professional Practice Evaluation Policy (Peer Review);
- (d) meet, as necessary, to consider and address any situation involving a Practitioner that may require immediate action;
- (e) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all services within the Hospital;
- (f) identify and nominate a slate of qualified individuals to serve as the Medical Staff Officers and any at-large members of the MSEC, to be presented to and elected by the Medical Staff;
- (g) appoint the chairs and members of all Medical Staff committees, except for the MSEC;
- (h) cultivate a physician leadership identification, development, education, and succession process to promote effective and successful Medical Staff Leaders at present and in the future; and
- (i) perform any additional functions as may be requested by the CPE, the MSEC, or the Board.

### 3.H.3. Meetings, Reports, and Recommendations:

The Leadership Council shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The Leadership Council shall report to the CPE, the MSEC, the Board, and others as described in the Policies noted above. The Leadership Council's reports to the MSEC and the Board will provide summary and aggregate information regarding the committee's activities. These reports will generally not include the details of any reviews or findings regarding specific Practitioners.

### 3.I. MEDICAL STAFF EXECUTIVE COMMITTEE

The composition and duties of the MSEC are set forth in Section 5.A of the Medical Staff Bylaws.

### 3.J. SEDATION COMMITTEE

#### 3.J.1. Composition:

The Sedation Committee shall consist of the appropriate number of physicians and nurses from multidisciplinary sections. Nurse members shall use their expertise in their specific areas of service and convey messages back to their facilities/departments.

#### 3.J.2. Duties:

The Sedation Committee shall:

- (a) provide high quality standards for sedation;
- (b) develop and maintain policies and procedures that are derived from evidence-based literature and supportive of regulatory guidelines;
- (c) monitor deep/moderate sedation processes throughout the organization;
- (d) collect and analyze data to determine outcomes and opportunities for improvement and develop action plans, when appropriate;
- (e) recommend education programs for staff and physicians in regard to the use of sedation;
- (f) enforce competencies regarding deep and moderate sedations; and
- (g) discuss and address other issues of sedation concern.

### 3.J.3. Meetings:

The Sedation Committee shall meet at least quarterly or at the call of the chair. A quorum as defined in the Bylaws Section 6.D.2.

### 3.K. TRAUMA PEER REVIEW COMMITTEES (Adult and Pediatric)

#### 3.K.1. Composition:

The Trauma Peer Review Committee shall consist of the Trauma Medical Director or designee, physician from the core trauma general surgeons, and physician representatives from: orthopedics, neurosurgery, emergency medicine, anesthesia, and trauma critical care.

#### 3.K.2. Duties:

The Trauma Peer Review Committee shall:

- (a) perform peer review activities on all trauma related deaths;
- (b) develop and maintain policies and procedures;
- (c) identify opportunities for patient improvement/outcomes;
- (d) identify educational needs of staff and physicians; and
- (e) analyze aggregate data.

#### 3.K.3. Meetings:

The Trauma Peer Review Committee will typically meet monthly, but the frequency is determined by the Trauma Medical Director based upon the needs of the Performance Improvement and Patient Safety Committee of the American College of Surgeons Committee on Trauma. A quorum as defined in the Bylaws Section 6.D.2.

ARTICLE 4  
AMENDMENTS

This Manual may be amended in accordance with Article 8 of the Medical Staff Bylaws.

## ARTICLE 5

### ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Medical Staff and the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein.

Originally adopted by the Medical Staff on February 15, 2011 and approved by the Board on February 24, 2012

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