DECATUR COUNTY MEMORIAL HOSPITAL

MEDICAL STAFF
BYLAWS

Effective Date: February 25, 2021

DECATUR COUNTY MEMORIAL HOSPITAL

MEDICAL STAFF BYLAWS

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TERM DEFINITION

For the purposes of these Bylaws and Rules and Regulations, the following terms are defined:

Allied Health Professional (AHP) - Individuals, other than licensed physicians, podiatrists, or dentists, who are accorded specific privileges in the Hospital within their areas of training and demonstrated competence.

Allied Health Staff - The Allied Health Staff shall be divided into two categories: Independent Allied Health Professional and Dependent Allied Health Professional.

Board of Trustees - The Board of Trustees of Decatur County Memorial Hospital, 720 North Lincoln Street, Greensburg, IN 47240, also called the Governing Body.

Credentialing - The process of determining the qualifications of an applicant prior to granting or reviewing clinical privileges or membership to the Decatur County Memorial Hospital Medical Staff.

Clinical Privileges - Permits access to the Hospital's equipment, personnel, and other resources necessary to provide health care to Hospital patients.

Clinical Privileging - The process for granting the right to practice medicine in specific clinical situations with access to the Hospital's equipment, personnel and resources for the purpose of providing patient care. Under certain circumstances clinical privileges may be granted to credentialed healthcare providers who are not Medical Staff members.

Dependent Practitioner - Allied Health Professionals such as certified registered nurse anesthetists, physicians' assistants, and nurse practitioners, who are subject to some degree of supervision within the Hospital.

Department - Sections of the Medical Staff with reporting and other functional connection to specific Medical Staff services.

MEC - The Medical Staff Executive Committee, unless specific reference is made to the Executive Committee of the Board of Trustees.

Ex-officio - Service as a member of a body by virtue of an office or a position held, and unless otherwise expressly provided for, with voting rights.

Good Standing - A staff member who has met the attendance and Committee participation requirements during the previous Medical Staff year, is not in arrears on dues payments, and has not received a suspension or curtailment of his/her appointment or admitting privileges in the previous twelve (12) months, other than for a medical record completion delinquency.

Hospital - Decatur County Memorial Hospital, 720 North Lincoln Street, Greensburg, IN 47240.

Medical Care - Encompasses the field of total medical, dental, and other professional care, the evaluation and management of health as well as disease management, utilizing supporting personnel, services, and facilities of the Hospital.

Medical Education - Education in all of the disciplines at all levels, in all of the professional and technical fields that can contribute to the effectiveness of health and medical care. It is not limited to the education of physicians and dentists.

Medical Staff - All physicians, podiatrists, and dentists who are privileged to attend patients at Decatur County Memorial Hospital. Podiatrists and dentists are non-voting members of the Medical Staff.

Medical Staff Membership-Appointment by the Hospital Board of Trustees to the Hospital's Medical Staff. Membership does not automatically confer clinical privileges.

Member - Unless the text specifically indicates otherwise, a dentist, podiatrist, or physician appointed to the Medical Staff of Decatur County Memorial Hospital by the authority of the Board of Trustees in accordance with these Bylaws.

Patients - All patients admitted to or treated in any of the clinical areas of the Hospital, whether inpatients, outpatients, emergency patients or otherwise, as well as all other persons receiving health services subject to the jurisdiction of the Hospital.

Practitioner - A licensed allopathic or osteopathic physician, dentist, podiatrist, or allied health professional.

President - The Chief Executive Officer of the Hospital.

Probation - Not a specific corrective action. Places a practitioner on notice that: some aspect(s) of his/her competence or professional conduct is being reviewed by peers for a specific period as recommended by the MEC and approved by the Board of Trustees. Staff privileges or memberships are under formal review and at risk.

Rules and Regulations -.A separate document periodically reviewed and updated by the Medical Staff that describes certain expectations for Physicians and other Practitioners regarding membership on the staff and Hospital patient care.

Quorum - A quorum, unless otherwise provided for herein, shall be at least two members of the body in question. The presence of thirty percent (30%) of the total membership of the Active Medical Staff at any regular or special meeting, except the bi-annual meeting, shall constitute a quorum for purposes of amendments to these Bylaws, Rules and Regulations, as well as all other actions. The quorum for the bi-annual meeting for the purpose of election of officers shall be fifty percent (50%). The quorum for the Medical Executive Committee is fifty percent (50%).

Voting in Absentia - Voting in absentia (or by proxy) shall only be considered legitimate in situations not contradictory with these Bylaws and Rules and Regulations. The proxy will be considered valid only if it is requested in writing with an authenticated date at least 48 hours prior to the date of the vote, and addressed to the President or Chief of the Medical Staff.

ABBREVIATION	DEFINITION
ACLS	Advanced Cardiac Life Support
ACU	Advanced Care Unit
AMA	Against Medical Advice
CME	Continuing Medical Education
CRNA	Certified Registered Nurse Anesthetist
CRTI	Certified Respiratory Therapy Technician
DC	Doctor of Chiropractic
DDS	Doctor of Dental Science
DEA	Drug Enforcement Agency
DMD	Doctor of Dental Medicine
DO	Doctor of Osteopathy
DPM	Doctor of Podiatry
ECFMG	Education Commission for Foreign Medical Graduates
ED	Emergency Department
ER	Emergency Room
IV	Intravenous
LPN	Licensed Practical Nurse
MD	Medical Doctor
MEC	Medical Staff Executive Committee
MLT	Medical Laboratory Technician
MT	Medical Technologist
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
OB	Obstetrics
OR	Operating Room
OTR	Registered Occupational Therapist
PA-C	Physician's Assistant, Certified
RCP	Respiratory Care Practitioner
RD	Registered Dietician
RN	Registered Nurse
RPh	Registered Pharmacist
RPT	Registered Physical Therapist
RRT	Registered Respiratory Therapist
RTR	Registered Radiology Technician Total
TPN	Parenteral Nutrition

DECATUR COUNTY MEMORIAL HOSPITAL MEDICAL
STAFF BYLAWS
PREAMBLE

WHEREAS, Decatur County Memorial Hospital is an Indiana county Hospital and non-profit organized and existing under the laws of the State of Indiana; and

WHEREAS, its purpose is to serve as a general hospital providing patient care to citizens of Decatur County, Indiana and the surrounding areas; and

WHEREAS, it is recognized that the Medical Staff is responsible to the Governing Board of the Hospital for the quality of the medical and dental care in the Hospital, including that provided by health care professionals under contract to the Hospital. The Medical Staff is responsible to the Governing Board for the ethical and professional conduct of its members; and

WHEREAS; it is recognized that the interests of patients attended in the Hospital are best served by the concerted effort of the Medical Staff practicing in this Hospital;

NOW THEREFORE, the Medical Staff formulates these Bylaws and Rules and Regulations, as well as Medical Staff policies, for their governance in conformity with the Bylaws of the Hospital. These Bylaws and Rules and Regulations shall, at all times, be in conformity with the laws and statutes of the State of Indiana and in conformity with the Bylaws of Decatur County Memorial Hospital. In the event of a conflict between these Bylaws or Rules and Regulations and the Bylaws of the Hospital, the latter shall prevail.

DECATUR COUNTY MEMORIAL HOSPITAL

MEDICAL STAFF BYLAWS

ARTICLE I. NAME

The name of this organization shall be the "Medical Staff of Decatur County Memorial Hospital" hereinafter sometimes referred to as the "Medical Staff or as the "Staff."

ARTICLE II. PURPOSE

The Purpose of this Organization shall be:

1. To strive toward assuring that patient care in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and resources locally available, irrespective of race, color, creed, national origin, or sexual orientation.

2. To establish and maintain high professional and ethical standards in general conformity with the requirements established by the Indiana State Licensure Standards, Medicare Conditions of Participation, and any other standards as approved by the Board of Trustees to the end that the Hospital shall maintain its status as an exemplary regional hospital.

3. To assist the Board of Trustees, at their request, in all matters pertaining to the well-being of the Hospital.

4. To initiate and maintain Bylaws and Rules and Regulations for the governance of the Medical Staff with a means of accountability to the Board of Trustees.

5. To assure a high level of performance by Medical and Allied Health Staff members through appropriate delineation of Staff privileges, and the continuous review and evaluation of the Hospital activities.

6. To provide a means whereby issues of a medical administrative nature may be discussed by the Medical Staff with the Board of Trustees and Administration.

7. To provide and maintain such medical education and educational standards as will provide current competence in all clinical care rendered.

8. To support such programs associated with community public health needs as are deemed appropriate by the Board of Trustees.

9. To render such other services as are reasonably necessary to carry out the foregoing purposes.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 1: Nature of Medical Staff Membership

Membership on the Medical Staff is a privilege that shall be extended by the Board of Trustees, based upon need, only to those individuals who meet and continue to meet the standards and requirements set forth in these Bylaws and Rules and Regulations, and the Bylaws of the Hospital.

Section 2: Qualifications for Membership

To qualify for Staff membership and to continue as a member, an individual must meet and be able to document the following general qualifications:

a. Hold a license from the Indiana Medical Licensing Board, the Indiana Board of Osteopathic Examination and Registration, the Indiana State Board of Dental Examiners, or the Indiana Board of Licensure of Podiatric Medicine which license is currently in effect and not subject to any suspension or revocation.

b. Meet recognized standards of training, experience, ability and demonstrated competence as established by the Staff and Board.

c. Meet recognized ethical standards for practice in his or her profession, as defined by the applicable licensing board, medical or dental association, or specialty organization.

d. Have demonstrated an ability to relate professionally and work cooperatively with peers and others in the institutional setting.

e. Be free of, or have under adequate control such that with reasonable accommodation patient care is not likely to be adversely affected, any significant physical, behavioral, mental, or substance abuse impairment.

f. Be in a state of health adequate with reasonable accommodation to provide patients with care at a generally recognized professional level of quality, consistent with current medical knowledge and clinical experience.

g. Have provided evidence of the maintenance of adequate professional liability insurance consistent with the requirements of the Indiana Patient Compensation Act, as established by the Board of Trustees.

h. If applying for privileges to treat patients in the Hospital, must reside within a reasonable distance of the Hospital. Any exception to this rule must be made by the MEC and approved by the Board of Trustees. The MEC shall define reasonable distance whenever necessary, with due regard to response time and coverage needs of the specialty.

i. No applicant shall be denied appointment to the Medical Staff on the basis of sex, race, color, creed, national origin, or sexual orientation.

Section 3: Ethics and Responsibilities

Acceptance of active or courtesy membership on the Medical Staff shall constitute the Staff member's agreement that (s)he will strictly abide by the following ethics and responsibilities:

a. To provide or arrange for continuous care and supervision of his/her admitted patients.

b. To comply with the Medical Staff Bylaws, Rules and Regulations, and all Medical Staff, Hospital, and appropriate departmental policies.

c. Agree with the principle not to engage in the practice of division of fees under any guise whatsoever; not to receive from, or pay to, another physician or dentist, or any other person, either directly or indirectly, any part of a fee received for professional services except as otherwise permitted under federal, state, and local statutory or administrative law.

d. Demonstrate the ability to work cooperatively and professionally with the Hospital Staff, its Allied Health Staff, and the Medical Staff, and refrain from disruptive behavior, which has or could interfere with patient care or the orderly operation of the Hospital and its Medical Staff.

e. Practice a branch of health care or a specialty which is consistent with the mission, vision, purposes, philosophy, treatment methods, and resources of the Hospital and for which the Hospital has a current need.

f. Accept appropriate requests for consultation.

g. Work cooperatively in the area of quality improvement and utilization review with the MEC and the administration to meet and practice within the guidelines established by the Hospital, its Medical Staff or local professional review organization, to minimize or eliminate disallowed admissions, to eliminate technical diagnosis, entry and coding errors, to order or utilize supporting or ancillary services only when necessary, and to shorten length of stay at the Hospital where medically appropriate. All members with clinical privileges will be subject to all applicable quality improvement activities, including peer review, and discharge such Staff, Service, Department, Committee, or Hospital functions for which (s)he is responsible by appointment, election, or otherwise.

h. Complete all medical records, both hospital and ambulatory, in accordance with Medical Staff Bylaws and Rules and Regulations.

i. Comply with all applicable state and federal laws and regulations; render care to patients that are consistent with applicable standards of quality and appropriateness; and disclose personal or professional conflicts of interest in fulfilling his/ her function as a Medical Staff Member and in the provision of patient care.

j. Promptly notify the President of the revocation or suspension of his/her professional license, or the imposition of terms of probation or limitation of practice by any state licensing agency; his/her loss of staff membership or loss, curtailment, or restriction of privileges at any hospital or health care institution; the cancellation or restriction of his/her liability coverage or DEA number; an adverse determination by a peer review organization or a third party payer reimbursement program concerning his/her quality of care; the commencement of a formal investigation or the filing of charges by the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or the State of Indiana, or any other state; or the filing of a claim against the practitioner alleging professional liability.

k. Violations of any of the following areas will result in review by, and potential permanent loss of clinical privileges, per MEC with Medical Staff and Board of Trustee's approval:

1. Honesty

2. Agreement to practice appropriate conduct and avoid disruptive behavior

3. Agreement to practice impairment free

4. Completion of records

5. Violation of Hospital or Medical Staff policies

6. Conviction of a felony

l. Adhere to applicable ethical standards as outlined in the Hospital's Code of Ethics and Corporate Compliance Program.

m. Failure to comply with these ethics and responsibilities may result in dismissal from the Medical Staff.

Section 4: Conditions and Duration of Appointment

a. The Board of Trustees shall make initial appointments and reappointments to the Medical Staff. The Board shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the MEC, as provided herein, except for good cause shown as determined by the Board.

b. Initial appointment shall be provisional for a period of one (l) year from the date of appointment, at which time the practitioner shall be reviewed/accepted/advanced as appropriate. Practitioner may apply for reappointment at the next Application for Reappointment deadline in September of odd number years.

c. Reappointments shall be for a period of not more than two (2) years.

d. Appointment to the Medical Staff shall confer upon the appointee only such privileges as are merited by education, training, and demonstrated current

competence. A clear distinction shall be made between an appointment to the Medical Staff and the specific privileges to attend patients.

e. Every application for Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgement of his/her obligation to provide continuous care and supervision of his/her patients, to abide by the Medical Staff Bylaws and Rules and Regulations, to accept committee assignments, participate in providing emergency services, and participate in Hospital and Medical Staff performance/quality improvement activities.

f. Appointment to or termination from employment and/or administrative responsibilities by the Hospital has no effect on an independent practitioner's Medical Staff privileges or his/her right to exercise those privileges, except as otherwise provided in the Parties agreement.

Section 5: Leave of Absence

a. The Department Chair, upon written request and notification to the Medical Staff Office, may grant a leave of absence for up to six (6) months for medical (including, but not limited to maternity leave) or personal reasons.

b. Notwithstanding the foregoing, upon the return of a physician from a medical leave of absence of six (6) months or less, the Department Chief shall determine whether the Member may continue to exercise the clinical privileges that had been granted previously. If such decision is to allow such Member to exercise the same privileges as prior to the leave of absence, the Chair's decision shall be final. In the event of any other decision by the Department Chair, the Medical Executive Committee (MEC) shall review the Department Chair's decision and make recommendations to the Governing Board for a final decision.

c. The Medical Executive Committee may grant any Member not serving a provisional staff appointment, a leave of absence, not to exceed two (2) years, for the following reasons:

- absence from the community,
- military service, or
- for other good cause shown and for a period not to exceed four (4) years, for the following reasons: to pursue post graduate medical training, official missionary work, or prolonged illness.
- A request for a leave of absence not to exceed the term of active duty due to military service may be requested by any medical staff member regardless of staff category.

A written request shall state the starting date of the leave and the reason for the request. Such leaves must be considered for renewal yearly upon written application of such Member. Failure to renew leave of absence by written application after two successive years will be considered an automatic resignation from the Medical Staff. Upon return of the applicant, Medical Staff Category and clinical privileges shall be reviewed by the Department Chair. The MEC may require a personal interview with the Applicant, and recommendations shall be made by the MEC to the Governing Board. The Department Chair may recommend granting temporary privileges to the applicant prior to the interview by the MEC.

d. During the leave of absence, the Staff Member does not pay dues, attend meetings, or in any way participate in Staff functions. During this period the member's clinical privileges are withheld. The Staff Member has five (5) working days after return to work to complete delinquent records.

Section 6: Staff Dues

a. The Medical Staff may maintain a fund, which, if so maintained, may require that all staff contribute. All members of the Staff shall pay dues ifassessed.

1. Initial statement shall be sent

2. Reminder sent in thirty (30) days

3. Automatic suspension sixty (60) days from initial statement, with a late fee assessed as determined by the Medical ExecutiveCommittee.

b. The dues structure shall be governed by the needs and requirements of the Medical Staff based upon a review by the Secretary/Treasurer of the Medical Staff, with approval ofMEC.

c. All expenditures of staff funds shall be made only with the prior approval of the MEC or the full Medical Staff.

d. Following written notification, special dues assessments may be made by a majority vote of the dues-paying members present and voting at any general or special Staff meeting.

Section 7: **Meeting Attendance Requirements**

a. The full Medical Staff and Departments shall meet quarterly.

b. Only members in good standing of the Active Medical Staff shall be eligible to vote at Medical Staff and Department meetings. All committee members may vote at Medical Staff Committee meetings.

c. The Medical Staff Departments meetings shall be scheduled the same month and prior to the Medical Staff meetings.

d. Members of the Honorary and Courtesy Staff and Allied Health Care Providers shall be encouraged to attend Medical Staff meetings.

ARTICLE IV. MEDICAL STAFF CATEGORIES

Section 1: Categories

The Medical Staff shall be divided into categories of Active, Courtesy, Locum Tenens and Honorary.

Section 2: Active Staff

a. The active staff shall consist of physicians who meet the qualifications of membership set forth in Article III and who regularly admit, or are otherwise regularly involved in the care of, Patients at the Hospital.

b. Prerogatives of the Active Staff:

I. Admit Patients without limitation in accord with individual privileges.

2. Vote on all matters presented at meetings of the Medical Staff.

3. Vote on all matters presented at Committees to which the member is appointed.

4. Hold office at any level in the Staff organization.

5. Exercise such clinical privileges as are specifically granted.

c. Obligations of the Active Staff

1. Provide leadership within the organization.

2. Collaborate within the Hospital organization to determine priorities, design new processes, assess performance, and implement change to improve performance.

3. Provide leadership for measurement, assessment, and improvement of clinical processes, where the process is the primary responsibility of physicians and/or other individuals with clinical privileges.

4. Contribute to the organization of administrative affairs in clinical services.

5. Serve on Hospital and Medical Staff Committees and faithfully perform the duties of any office or position to which (s)he is elected or appointed.

6. Discharge the recognized functions of Staff membership by providing specialty coverage in the emergency department, admitting Patients as required, providing consultation to other Staff members consistent with delineated privileges, and fulfilling other Staff functions as may reasonably be required of Staff members.

7. Pay all staff dues and assessments promptly.

Section 3: Courtesy Staff

a. Courtesy Staff shall consist of Practitioners qualified for Medical Staff membership who only occasionally admit, or are otherwise occasionally involved in the care of, Patients.

b. Courtesy Staff members shall be appointed to a specific service but shall not be eligible to vote or hold office on the Medical Staff. They may, however, be appointed to Medical Staff Committees (on whose matters they may vote) and shall attend educational conferences and peer review conferences when appropriate.

c. Members who ordinarily qualify for Courtesy Staff membership may apply for Active Staff membership if they are willing to assume the functions and responsibilities thereof.

d. Courtesy Staff members may be granted clinical privileges to admit Patients, when current clinical competence can be demonstrated to the satisfaction of the MEC and Board of Trustees. Any physicians admitting and/or performing surgery for more than fifty (50) patients per year shall be required to make application for membership on the Active Medical Staff.

e. Courtesy Staff members who have not treated Patients, either outpatient or inpatient, or served as a consultant or provided coverage for a Medical Staff member during the two-year term of membership shall not be eligible to renew his/her privileges. A physician whose practice changes to include treating Patients at the Hospital may apply for Medical Staff membership at that time.

Section 4: Honorary Staff

a. Honorary Staff shall consist of Practitioners who are not active in the Hospital and who are honored by emeritus status.

b. Members may be Practitioners who have retired from active practice or who are of outstanding reputation not necessarily residing in the community.

c. Members of the Honorary Medical Staff will be appointed by the MEC with the concurrence of the Medical Staff.

d. Honorary staff shall not be eligible to admit Patients or hold clinical privileges, vote, hold office, or serve on Standing Medical Staff Committees, nor shall they be required to pay dues or any assessment.

e. Reappointment is not required.

Section 5: Locum Tenens Staff

a. Locum Tenens Staff shall consist of Practitioners qualified for Medical Staff membership who are providing temporary coverage for members of the Medical Staff. Medical Staff Bylaws: Article III: Section 2 Qualification For Membership.

b. Indiana appointment of Locum Tenens practitioners shall be for a period not to exceed six (6) months.

c. Locum Tenens Staff members shall be appointed to a specific service but shall not be eligible to vote or hold office on the Medical Staff. They may, however, be appointed to Medical Staff Committees (in which they may vote) and shall attend educational conferences and peer review conferences when appropriate.

d. Locum Tenens Staff members may be granted clinical privileges to admit Patients, when current clinical competence can be demonstrated to the satisfaction of the MEC and Board of Trustees. Any physicians admitting and/or performing surgery for more than fifty (50) patients per year shall be required to make application for membership on the Active Medical Staff.

e. Members who ordinarily qualify for Locum Tenens Staff membership mayapply for Active Staff membership if they are willing to assume the functions and responsibilities thereof.

ARTICLE V. CATEGORIES OF THE ALLIED HEALTH STAFF

Section 1: Allied Health Staff

a. Membership on the Allied Health Staff is a privilege that shall be extended by the Board of Trustees, based upon need, only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set for in these Bylaws.

b. Allied Health Staff shall consist of those health care professionals active in the care of Patients, who are not licensed to practice medicine, dentistry, oral surgery, or podiatry.

c. The Allied Health Staff shall be divided into two categories: Independent Allied Health Professional and Dependent Allied Health Professional.

d. The Allied Health Staff shall be required to have professional liability insurance coverage.

   l. The minimum amount of insurance shall be sufficient to qualify the practitioner as a health care provider under Indiana Medical Malpractice Act, with proof of payment of the surcharge from the Indiana Department of Insurance.

   2. A carrier licensed or approved by the State of Indiana must provide the insurance.

   3. Dependent Allied Health Professionals may be covered either by inclusion on the policy of their supervisor or by a separate policy.

   4. A copy of the certificate of insurance shall be provided for the credentials file at the time of application and thereafter at the renewal date of the policy.

5. Allied Health Staff shall provide notice to the Hospital within thirty (30) days of having received notice of a final action (judgment or settlement) having been awarded against the Allied Health Staff Member in a professional liability action in which (s)he was named as a defendant.

e. Members of the Allied Health Staff shall notify the Hospital in writing within thirty (30) days of any suspension or revocation of their privileges at any health care institution, or suspension of any license.

f. Members of the Allied Health Staff shall: comply with all applicable state and federal laws and regulations; render care to Patients that are consistent with applicable standards of quality and appropriateness; and avoid personal or professional conflicts of interest in fulfilling his/ her function as an Allied Health Professional and in the provision of Patient care.

g. Although applicants to the Allied Health Staff are not eligible to be appointed to the Medical Staff, they are subject to the Medical Staff Bylaws, Rules and Regulations, and any other policies and rules of the Hospital.

h. The factors to be considered in acting on the application or renewal application of a member of the Allied Health Staff shall be the same as those set forth in these Bylaws for the appointment or reappointment, as applicable, for a Medical Staff member, modified only as necessary to reflect the particular professional field of the applicant.

i. Clinical privileges for any category shall not exceed a two-year (2) period.

j. Members of the Allied Health Staff have limited rights to a hearing.

Section 2: Categories of Allied Health Staff

Allied Health Staff shall be divided into two categories: Independent and Dependent.

a. Independent Allied Health Professional

1. This category of Allied Health Staff shall consist of those who, when practicing within the delineated privileges, provide unsupervised, independent direct Patient care. These might include:

a) Individuals with a doctorate in psychology or its equivalent from an accredited college or university and licensed in the state of Indiana.

b) Individuals with a master's degree in social work from an accredited college or university with appropriate academic and field experience.

c) Individuals with a doctorate degree in medical genetics or its equivalent from an accredited college or university.

d) Optometrists duly licensed by the State of Indiana.

2. Independent Allied Health Professionals shall:

a) Exercise independent clinical judgment in their areas of competence, provided that an Active or Courtesy member of the Medical Staff shall have ultimate responsibility for Patient care.

b) Participate directly in the management and care of Patients under the general supervision or direction of an Active or Courtesy member of the Medical Staff.

c) Record reports and progress notes on the Patients' records and write orders for treatment, provided that such orders are within the scope of his/her license, certificate or other legal credentials.

d) Not admit patients to or discharge patients from Decatur County Memorial Hospital.

e) Applications for clinical privileges as an Independent Allied Health Professional shall be processed in accordance with the procedures as set forth in Article 7 of the Medical Staff Bylaws, except as otherwise provided in these Bylaws.

f) Independent Allied Health Professionals may serve on appropriate Committees of the Medical Staff, as appointed by the Chief of the Medical Staff, and exercise voting privileges on such Committees. Such individuals are encouraged to attend Medical Staff meetings and may, as a condition of continued privileges, be required to attend meetings involving the clinical review of Patient care in which they participated.

b. Dependent Allied Health Staff

1. This category of Allied Health Staff shall consist of those professionals who, when practicing within the scope of their licenses and delineated privileges provide direct Patient care under the supervision or sponsorship of a member of the Medical Staff. These might include certified physician assistants, nurse practitioners, certified registered nurse first assistants, and certified registered nurse anesthetists.

2. Allied Health Staff must be associated with the Hospital or with a physician with active Staff membership in order to maintain staff status/privileges and the right to exercise those privileges.

3. Exception may be made to #2 when a physician on the Courtesy Medical Staff employs the dependent practitioner. The dependent practitioner, in this instance, may only exercise clinical privileges associated with care provided by

the supervising licensed independent practitioner; i.e., assist with surgery.

4. If the Medical Staff membership of the supervisor is terminated for any reason, or if the supervisor's clinical privileges are curtailed to the extent that the professional services of the Dependent Allied Health Professional within the Medical Staff are no longer necessary or permissible to assist the supervisor, the clinical duties and responsibilities of said individual shall be terminated unless supervision is transferred to another member of the Medical Staff.

5. Reappointment procedures will follow the requirement prescribed for the Medical Staff in Article VI of the Medical Staff Bylaws.

6. A written plan of supervision is required at the time the Dependent Allied Health Professional applies to the Allied Health Staff for appointment or reappointment, and must be maintained throughout the period of appointment.

7. All orders of the Dependent Allied Health Professional must be co-signed by a physician as required by Indiana Law.

c. Prerogatives: A dependent Allied Health Staff member shall:

1. Provide care in accordance with delineated clinical privileges under the supervision or direction of an active Staff physician, as authorized by law and these bylaws.

2. Write orders in accordance with delineated clinical privileges within the scope of his/her license or registration.

d. Obligations:

1. Vote on all matters presented at Committees to which the Allied Health Staff member is appointed or elected.

2. Collaborate within the Hospital organization to determine priorities, design new processes, assess performance, and implement change to improve performance.

3. Discharge other functions, which may be required by the Staff, from time to time.

ARTICLE VI. PROCEDURE FOR APPOINTMENT & REAPPOINTMENT

Section 1: Staff Membership

The mechanism described below has been developed by the Medical Staff and approved by the Board of Trustees. Criteria for Medical Staff membership and clinical privileges is specified and uniformly applied. Individuals in administrative positions who desire Staff membership and/or clinical privileges are subject to the same procedure as all other applicants.

Section 2: Appointment

a. Qualifications requiring primary source verification:

1. Education and training

a) Graduation from an accredited allopathic, osteopathic, dental, or podiatric school, or

b) Graduation from an accredited medical arts program, or

c) Successful completion of ECFMG or similar professional examination if foreign graduate.

2. Licensure history in any state or country where a license is/was held.

3. Residency training and Board admissibility/eligibility/certification. It is the intention that all applicants to the medical staff be either Board Certified or Board Eligible/admissible in their specialty. This requirement may be waived at the discretion of the Board of Trustees, upon recommendation of the Credentials Committee/MEC, for otherwise outstanding applicants. For individuals for whom this criterion has been waived, primary source verification of this status is not required. For all other applicants, primary source verification of this status is required.

4. Primary source verification of the following is required no sooner than three (3) months prior to the date of the Governing Board meeting at which the application will be acted upon. (This can be a letter, a telephone call for which the date and verifying individual are documented, a facsimile, or the use of a licensure or specialty board internet site.)

a) Current licensure in the State of Indiana (for advanced practice nurses, this means evidence of current nursing license and evidence of approval to practice as an advanced practice registered nurse by the Indiana State Board of Nursing).

b) Board certification or eligibility if claimed by the applicant.

c) Professional liability insurance to qualify the practitioner as a health care provider under Indiana Medical Malpractice Act, with proof of

payment of the surcharge from the Indiana Department of Insurance or in the case of the applicant's principal practice location being out- of-state, to maintain adequate professional liability insurance coverage that in the opinion of the Medical Staff Executive Committee and the Hospital Board to be adequate protection.

d) Current NPDB report.

5. Other documentation required:

a) DEA, if requesting privilege to prescribe medication. Must be maintained continually while appointment is in effect.

b) CME appropriate to privileges requested.

c) Ability to speak English proficiently.

d) Absence of mental or physical disabilities that would jeopardize the safe exercise of requested privileges.

e) Clinical practice history, employment history, and privileges requested.

f) All current hospital affiliations and all prior hospital affiliations for a period of ten (10) years prior to the date of the application for initial appointment

Section 3: Application - Information Requirements

a. Written application on forms prescribed by the Board of Trustees, signed by the applicant and submitted to the President.

b. Information required:

1. Challenges to or relinquishment of DEA or CSR certificate.

2. Information involving voluntary or involuntary termination of Medical Staff status or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another accredited hospital.

3. Involvement in professional liability action to include final judgments, settlements, and pending claims.

4. Challenges to or relinquishment, either voluntary or involuntary, of registration or license to practice medicine in any state or loss of ability to participate in government programs.

5. History of all past professional sanctions or discipline issued by licensing boards or specialty boards or loss of board certification.

6. Names and addresses of at least three (3) physicians who have had extensive experience observing and working with the applicant who can provide adequate references regarding ethical character, experience, judgment, and quality of clinical performance. At least two (2) persons must be outside the applicant's practice group.

7. History of any felony conviction(s).

8. Current substance abuse.

9. History of sanctions by state or federal payers.

10. History of licensure in countries other than USA.

11. Information about scope of practice and coverage arrangements.

12. Personal attestation regarding current professional liability coverage and a personal attestation regarding professional liability claims history.

13. Personal attestation regarding health status.

14. Request for scope and delineation of clinical privileges.

15. Personal attestation of past two (2) years of CMEs.

Section 4: Application Process

a. An application is considered complete when all reference materials and verifications have been received.

b. A credentials verification organization may be used to verify information.

c. The applicant shall have the burden of providing adequate information for proper evaluation of his/her:

1. Background education, training, experience, and current clinical competence,

2. Ethical character,

3. Mental and physical health status,

4. Clinical and administrative performance,

5. Any other areas of inquiry deemed appropriate by the Credentials Committee, MEC, and the Board of Trustees.

d. By applying for appointment to the Medical Staff, the applicant thereby signifies his/her agreement to:

1. Appear for interviews in regard to his/her application.

2. Authorize the Hospital's inspection of any pertinent records and documents.

3. Release the Hospital, all representatives of the Hospital, and all members of the Medical Staff from any liability for acts performed in good faith in connection with evaluating the applicant and his/her credentials.

4. Release from any liability all individuals and organizations that provide information to the Hospital in good faith and without malice concerning the applicant's qualifications for staff appointment, including otherwise privileged information.

e. The application form shall contain a statement that fully informs the applicant of the scope and extent of the above release and consent provisions and of the immunity provisions contained in Article XIII of these bylaws.

f. The application packet shall contain a statement that the applicant has read the Bylaws, Rules and Regulations of the Medical Staff, and major Medical Staff policies, and that (s)he agrees to be bound by the terms thereof.

Section 5: Credentialing Process

a. Responsibility: The Credentialing office shall be responsible for compiling and maintaining the physician files. The files will be maintained confidentially.

APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

b. The application should include the following:

1. CV (if applicable)

2. Signed confidentiality statement

3. Copy of IN license

4. ACLS/BLS/CPR as applicable

5. Copy of DEA and CSR

6. Acknowledgement of HIPAA Policy

7. Health care checklist

8. Proof of malpractice insurance coverage

9. Current PPD or completed questionnaire (as appropriate)

c. Process: On receipt of a completed application, the Credentialing office shall:

1. Verify education via Physician Profile from AMA.

2. Query Residency Program Director(s), facilities where applicant currently holds privileges, peer references, as listed on application. The query(s) will consist of:

a) Cover letter which specifically asks the opinion of the peer whether or not they feel the applicant is competent to perform the procedures requested.

b) List of privileges requested.

3. Query the National Practitioner Data Bank /Enroll in Proactive Disclosure Service.

4. Verify current license (CRS 9 Online verification).

5. Limited criminal history check (Online website query).

6. Obtain online report from Officer of Inspector General pertaining to Medicare sanction.

7. Query online Department of Insurance regarding whether or not there have been or are claims filed.

d. Approval procedure:

1. Majority of Credentials Committee (the Medical Staff Executive Committee) to review application and supporting documentation and make recommendation.

2. Board of Trustees to review application and supporting documentation and Give final decision.

• The full medical staff will be advised of approvals.

APPLICATION FOR REAPPOINTMENT TO THE MEDICAL STAFF

e. Applications for reappointment shall be sent to current Medical Staff members approximately six (6) months prior to the expiration of membership and should include:

1. CME Attestation Form

2. Confidentiality statement

3. Conflict of Interest Declaration Statement

f. Approximately one (1) month prior to the due date of September 1, a reminder will be sent to those who have not returned their Application for Reappointment.

1. A late fee may be assessed those who do not meet the September 1 deadline. The fee to be determined by the Medical Staff Executive Committee.

2. If the reappointment process cannot be completed before the expiration of the current appointment period, the Medical Staff member will be terminated from membership and must submit a new Application for Medical Staff membership.

g. On receipt of an application for reappointment (due in Credentialing office by September 1), the following will occur:

1. Correspondence/online verification of staff affiliations.

2. Limited criminal history check.

3. Online report from Office of Inspector General pertaining to Medicare sanctions.

4. The Ongoing Professional Proficiency Evaluation (OPPE) will be completed every 6 months by all applicable departments and reported at appropriate Clinical department meetings. OPPEs will be utilized for the recredentialing process.

h. Approval Process:

1. Applicable Department Chief to review Application for Reappointment (Medicine, Surgery, OB/Peds), supporting documentation, and Assessment and make a recommendation.

2. Medical Executive Committee will review application, supporting Documentation and recommendation and make a recommendation.

3. Board of Trustees to review application and supporting documentation and make final reappointment decision.
   - The full Medical Staff will be advised of reappointments.

Section 6: Appointment Process

When the application is deemed complete, it will be made available to:

a. The Department Chief in the area of the requested privileges who will, prior to the next scheduled MEC meeting:

1. Evaluate the contents of the credentials file to assess the applicant's entry- level qualifications in relation to the clinical privileges requested.

2. Interview the applicant either in person or by telephone if appropriate. A permanent record of the interview will be made and retained in the credentials file.

3. Make a written recommendation to the MEC regarding appropriateness of requested clinical privileges in relation to entry-level qualifications and the need for supervision or limitation of privileges, if indicated.

b. The Department Chiefs of other areas of requested privileges, who would then evaluate the contents of the credentials file to assess the applicant's entry-level qualifications in relation to the clinical privileges requested.

I. A written recommendation will be made to the MEC as to the findings of each Department Chief.

2. A second interview is not required but may be performed at the discretion of any Department Chief.

3. If additional interviews are performed, a permanent record will be made and retained in the credentials file.

c. When all Department Chiefs have completed their assessment of the application, the Medical Executive Committee (MEC) chairperson will be notified that the file is complete.

1. The chairperson of the MEC will review the applicant's file and all supporting documentation.

2. The file will be presented to and reviewed by the MEC at their next regularly scheduled meeting after receipt of the file by the chairperson.

a) When the MEC's recommendation is favorable to the applicant in all respects, it shall promptly be forwarded with all supporting documentation to the MEC for their review and action.

b) When the MEC's action is to defer the application for further consideration, it must be followed within thirty-one (31) days by a subsequent review and recommendation within 31 days.

c) Recommendation for approval, modification, or denial of staff appointment, category of staff and prerogatives, department affiliations, and scope of clinical privileges.

d) When the MEC's recommendation is adverse to the applicant, the file, with written determination and supporting documentation, will be forwarded to the MEC.

e) An adverse determination must be directly related to quality of care issues.

f) When the MEC's recommendation is adverse to the applicant and the MEC has determined to forward the recommendation to the Board of Trustees as its own recommendation, special notice will be sent to the applicant, who shall be entitled to procedural rights as provided in the fair hearing plan (see Article VIII, Section 5).

g) An adverse recommendation is defined as a recommendation to deny appointment, or to deny or restrict any substantive request for clinical privileges in excess of fifteen (15) days, which is directly related to competence or professional conduct.

3. At the next regularly scheduled meeting of the Board of Trustees, the Chief of the Medical Staff will present a summary of the applicant's file, the Department Chiefs findings, and the MEC's recommendation.

h) The Board of Trustees, or its authorized representative, may adopt or reject, in whole or in part, the MEC's favorable recommendation, or may refer the recommendation back to the Committee for further consideration.

1) The Board of Trustees must state the reasons for such referral.

2) The Board of Trustees must set a time limit for the MECto make a subsequent recommendation.

i) Favorable action by the Board of Trustees is effective as its final decision.

j) In the case of an adverse MEC recommendation, the Board of Trustees shall take action in the matter as provided in the fair hearing plan.

1) If, after complying with the requirements, the Board's action is adverse to the applicant, special notice will be sent to the applicant, who shall be entitled to the procedural rights provided in the fair hearing plan.

2) "Adverse action" by the Board of Trustees means action to deny appointment or to deny or restrict requested clinical privileges.

4. Each individual's or group's report, including the Board of Trustees', must state the reasons for each recommendation or action taken, with specific reference to the completed application and any other documentation that was considered. Any dissenting views, at any point in the process, must be documented, supported by reasons and references, and transmitted with the majority report.

5. In any case, where the Board of Trustees' decision on a matter is contrary to the MEC's, or Department Chair's recommendation, the matter will be submitted to an Ad Hoc Committee on Quality Care and Professional Performance for review and recommendation before the Board of Trustees makes its final decision.

6. In addition to notifying the applicant, the President shall notify each applicable Department Chief and the MEC of the Board's final decision

Section 7: Provisional Status

a. All initial appointments to any category of the Medical or Allied Health Staff shall be provisional for a period of at least 1 year, excepting cases where an Active Staff member is transferring to the Courtesy Staff and further excluding appointments to the Honorary Staff.

b. During provisional status, a provisional appointee may not chair a Committee, serve as an officer, or serve on the MEC, except where appointed by the Medical Staff Chief or elected to the position to fill that position which would otherwise remain unfilled.

c. Provisional appointees shall be assigned to an appropriate service where their performance can be reviewed and precepted in accordance with the provisions of Article VIII. Section I.f. The purpose of such observation shall be to determine eligibility for regular membership and current clinical competence and quality of performance for exercising the clinical privileges provisionally granted.

1. Follow-up: prior to the end of the initial twelve (12)-month period, the provisional appointee will be evaluated. The MEC utilizing the recommendation of the Department Chiefs will make one of the following determinations:

a) A change in status to full appointment to the Staff.

b) Renew provisional status for no more than one (1) additional twelve (12)-month period with written recommendations in regard to additional training, modification of conduct, or specific privilege changes.

c) Denial of appointment and revocation of privileges (see "d" below).

d. Termination:

1. Appointment to provisional membership may not exceed two (2) full years, at which time the failure to advance to regular Staff status shall be deemed a termination of Staffappointment.

2. A provisional appointment whose membership is so terminated shall be afforded the same rights accorded by these Bylaws to a member of the

Medical Staff who has failed to be reappointed.

e. Throughout the provisional period, the applicant will provide any renewal information received (license, DEA, insurance) to keep the file current.

Section 8: Reappointment Process

a. Each Medical Staff member will be reappointed no less frequently than every two (2) years.
   1. For Locum Tenens practitioners, the standard reappointment will be for a period of not more than six (6) months.

b. An application for reappointment will be sent to the incumbent Staff member approximately six (6) months prior to the expiration of the reappointment period.
   1. Locum Tenens reappointment application will be sent to the Locum Tenens practitioner two (2) months prior to the expiration of the six-month reappointment period.

c. The completed application must be received by the Credentialing office by September 1 in order to avoid imposition of a late filing fee as determined by the MEC. The completed application must be received by September 1 to facilitate smooth transition from one reappointment period to the next.

d. If the reappointment process cannot be completed before the expiration of the current appointment period, the Medical Staff member will be terminated from membership on the Staff and must submit a new application for Medical Staff membership.

e. The Staff member will provide copies of all documents renewed between reappointments; i.e., license, DEA, insurance at the time of renewal, any requested change in clinical privileges. All requests for new or expanded privileges must be accompanied by evidence of sufficient training and experience in the performance of such privileges. At the time of reappointment, the Credentialing office will verify current licensure in the State of Indiana (for advanced practice nurses, this means evidence of current nursing license and evidence of approval to practice as an advanced practice registered nurse by the Indiana state board of nursing), insurance, currency of Board certification, eligibility or admissibility, and will query the NPDB. Each recommendation concerning the reappointment of a Medical Staff member and clinical privileges to be granted upon reappointment shall be based upon such member's:

   I. Mental and physical health status.

   2. Professional competence and clinical judgment in the treatment of Patients based on current performance data and daily observation of treatment outcomes and conclusions from performance improvement activities.
   3. His/her ethics and conduct.

4. Current report from the NPDB.

5. Compliance with Article III, Section 3, Ethics and Responsibilities, and meeting attendance requirements, etc.

6. His/her compliance with the Medical Staff Bylaws, Rules and Regulations.

7. His/her use of the Hospital facilities for Patients.

8. His/her general conduct toward Patients, Staff, colleagues, and the Hospital.

9. Information as to whether the applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily reduced, suspended, revoked, or not renewed in any other hospital or institution during the time since the last reappointment.

10. Information as to whether the applicant's license to practice medicine or other professional license has ever been voluntarily relinquished, or involuntarily reduced, revoked, suspended, or not renewed in any state or country during the time since the last reappointment.

11. Attestation of CME obtained as related to the type/nature of the care provided, findings of performance improvement activities, and clinical privileges requested.

12. Input from affiliated hospital's medical staff office and the appropriate Department Chief(s).

13. History of felony conviction.

14. Attestation regarding current health status.

15. Current substance abuse.

16. Sanctions by state or federal payers.

17. Verification of current Board Certification, admissibility/eligibility, unless this requirement has been waived by the Board of Trustees.

18. In the case of an applicant for reappointment who has not treated at least two (2) patients, either outpatient or inpatient, or served as a consultant or provided coverage for a Medical Staff member during the two-year term of membership shall not be eligible to renew his/her privileges. A physician whose practice changes to include treating Patients at the Hospital may apply for Medical Staff membership at that time. Being ineligible to reapply because of little activity will not automatically trigger reporting under the terms of public law 99-660, the Healthcare Quality Improvement Act of 1986, as amended.

19. Primary source verification of the following is required no sooner than three

(3) months prior to the date of the Governing Board meeting at which the application will be acted upon. (This can be a letter, a telephone call for which the date and verifying individual are documented, a facsimile, or the use of a licensure or specialty board internet site). Current licensure in the State of Indiana (for advanced practice nurses, this means evidence of current nursing license and evidence of approval to practice as an advanced practice registered nurse by the Indiana state board of nursing).

- Board certification or eligibility if claimed by the applicant.

- Professional liability insurance to qualify the Practitioner as a health care provider under Indiana Medical Malpractice Act, with proof of payment of the surcharge from the Indiana Department of Insurance or in the case of the applicant's principal practice location being out-of-state, to maintain adequate professional liability insurance coverage that in the opinion of the Medical Staff Executive Committee and the Hospital Board to be adequate protection.

- Complete malpractice claims history report for at least the past five (5) years. In the event that a physician has not been in practice for at least five (5) years, then the complete history for the entire duration of practice is needed.

- Current NPDB report.

20. Prior to recommending an applicant for reappointment to the Medical Staff and Allied Health Staff, the Hospital must send queries to all hospital affiliations listed by the applicant with specific questions about the applicant clinical skills and competence, ethics, professional conduct and citizenship.

f. Once all verifications, queries, and peer references have been received, the file will be made available to the appropriate Department Chief(s). The Department Chief will also review the individual practitioner's performance profile.

g. When each appropriate Department Chief is satisfied with the content and quality of the application, the file will be forwarded to the MEC.

h. The MEC will review the applicant's file, Department Chiefs reports, and all relevant information and will forward to the Board of Trustees a written report with recommendations for reappointment including Staff category, department assignment, and clinical privileges - or non-reappointment. Only the Governing Board may reappoint a member of the Medical Staff or Allied Health Staff.

1. If the recommendation of the MEC is deemed adverse under the terms of the fair hearing plan, the provisions of the fair hearing plan will become effective.
2. The final processing of reappointment requests follows the same procedure as initial appointment.

1. If a member of the Medical Staff or Allied Health Staff is not reappointed within two (2) years of the last appointment or reappointment, regardless of fault or reason, the member may no longer admit or attend Patients in the Hospital. In this circumstance, the care of Patients already admitted will be transferred by the Department Chief to other physicians with appropriate clinical privileges.

    1. If a member of the Medical Staff or Allied Health Staff who fails to be reappointed within two (2) years of the last appointment or reappointment elects to apply again for Medical Staff or Allied Health Staff membership, that application shall be treated as an initial application.

    2. Temporary appointments, extensions, and similar mechanisms may not be used to permit members to retain their membership and privileges for more than two (2) years since the last appointment or reappointment.

ARTICLE VII. CLINICAL PRIVILEGES

Section 1: Granting Clinical Privileges

a. Restrictions -

Every Practitioner practicing at the Hospital by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Board of Trustees, except as provided in Sections 2 and 3 of this Article.

b. Providing Evidence of Qualifications and Competency -

Every application for Staff appointment or re-appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests or requests for additional privileges shall be based upon the applicant's education, training, experience, demonstrated current competence, references and other relevant information, including an appraisal by the clinical service in which such privileges are sought. Such evaluation shall also include an analysis of the ability of the Hospital to provide adequate facilities and supportive services in regards to the clinical privileges sought. The applicant shall have the burden of establishing his/her qualifications and current competency in the clinical privileges (s)he requests.

c. Modification of Clinical Privileges

1. Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of Patients treated in this or other hospitals and review of the records of the Medical Staff which document the

evaluation of the member's participation in the delivery of medical care.

2. On its own motion or upon recommendation of the applicable department(s), the MEC may recommend a change in the clinical privileges of a member. The MEC may also recommend that the granting of additional privileges to a current member be made subject to monitoring. Any reduction in clinical privileges is subject to the due process provisions of Article VIII.

3. A request by a member for a modification of clinical privileges may be made at any time, but requests for additional privileges must be supported by documentation of training and experience supportive of the request and will be evaluated on the same criteria as requests for initial privileges, and will be treated procedurally the same as initial requests for clinical privileges.

d. Dentists/Podiatrists

1. Privileges granted to dentists/podiatrists shall be based on their training, experience, demonstrated competence, and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists/podiatrists shall be under the overall supervision of the Chief of the Surgical Service. All dental/podiatry Patients shall receive the same basic medical appraisal as Patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

e. Precepting

1. All Practitioners to whom new clinical privileges have been granted, whether such privileges are temporary, initial, or additional, shall be subject to precepting as to such new privileges. Each recipient of new clinical privileges shall be assigned to a department where clinical performance shall be reviewed and monitored by the Department Chief or the Chiefs designee during the period of precepting. The purpose of such precepting shall be to determine the recipient's suitability to continue to exercise those clinical privileges. The exercise of clinical privileges on any other Service shall also be subject to review and monitoring by the Department Chief of such other Service(s) or his/her designee.

2. The recipient shall remain subject to such precepting until the MEC has been furnished with a report(s) in writing from the Department Chief(s) of the Service(s) in which the recipient has new privileges, describing types and numbers of cases observed/reviewed, an evaluation of the recipient's performance, a statement that the recipient appears to meet all of the qualifications for unsupervised practice on that Service, has discharged all of the applicable responsibilities of Staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made.

3. In the event that the recipient shall fail to qualify during the period of preceptorship for the issuance of an affirmative report as described in the foregoing paragraph, then the provisions of these Bylaws pertaining to the extension of probationary period, reappraisal of clinical privileges, reappointment, formal corrective action, and due process, as appropriate and applicable in a given case, shall apply.

Section 2: Temporary Privileges

The granting of temporary privileges is a courtesy on the part of the Hospital, and the granting, denial or termination of such temporary privileges does not entitle the Practitioner to any of the procedural rights in these Bylaws with respect to hearings or appeals. Temporary privileges shall not exceed one-hundred (100) days with no renewal period.

a. The Chief of the Medical Staff (in his/her absence the Vice Chief) with the concurrence of the President (or designee in his/her absence) may grant temporary privileges to a new applicant for Medical or Allied Health Staff membership, a Practitioner who is uniquely qualified for a particular patient or group of patients, or to a locum tenens Practitioner.

b. The applicant for temporary privileges must provide the same information as applicants for initial appointment to the Medical Staff and Allied Health Staff.

c. Applicants for temporary appointments and privileges must have the same verifications as required as applicants for initial appointment to the Medical Staff and Allied Health Staff, and a query must be made to the NPDB. Verifications and the results of the NPDB query must be in the Hospital's possession before temporary privileges are granted. Any Practitioner granted temporary privileges shall act under the supervision of the Department Chief of the Service to which (s)he is assigned. Persons holding temporary appointments and privileges will be subject to all provisions of the Bylaws, Rules and Regulations, and policies while exercising those privileges. Temporary privileges are not intended or designed as a means by which to circumvent, postpone, or delay the usual application and review process.

d. Supervision and reporting - special requirements of supervision and reporting may be imposed by the Department Chief concerned as to any Practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the President upon notice of any failure by the Practitioner to comply with such special conditions.

e. Termination - The President may, upon recommendation of the Department Chief involved or of the Chief of the Medical Staff, terminate a Practitioner's temporary privileges effective as of the discharge from the Hospital of the Practitioner's Patient(s) then under his/her care in the Hospital. However, when the President, based on the recommendation of the Department Chief or the Chief of the MEC, concludes, in addition, that the life or health of a Patient(s) would be endangered by continued treatment by the Practitioner, such termination shall become effective immediately and the Department Chief, or, in his/her absence, the Chief of the MEC, taking into consideration the wishes of the Patient(s), shall assign a member(s) of the Medical Staff to assume responsibility for the care of the Patient(s). A Practitioner whose request for temporary privileges is refused or whose temporary privileges are terminated or limited, is not entitled to the procedural rights afforded by the fair hearing process.

Section 3: Emergency Privileges

a. In the case of an emergency, in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a Patient is in immediate danger, and any delay in administering treatment could add to the danger, any Practitioner on the Medical or Allied Health Staff, to the degree permitted by his/her license and regardless of service or Staff status, shall be permitted and assisted to do everything possible to save the life of a Patient, using every facility of the Hospital necessary. Emergency privileges exercised under this provision shall be for a maximum of seventy-two (72) hours and are not renewable.

b. When an emergency is declared and the Hospital's disaster or emergency management plan has been activated and the Hospital is unable to handle immediate Patient needs without additional support, qualified licensed healthcare professionals, who are not currently members of the Medical or Allied Health Staff, may be granted emergency privileges to assist appointed Staff in Patient care.

c. The person(s) authorized to grant such emergency privileges include the President, Medical Staff Chief or their designees as specified in the disaster plan.

d. An individual seeking an emergency appointment must present some form of identification prior to an appointment. Examples of acceptable identification include a copy of their medical license, a personal attestation by a member of the medical or allied health staff to whom they are personally known, and a photo ID that can be used in conjunction with an internet search to verify current medical licensure. For all applicants for emergency privileges, verification of current licensure must begin as soon as possible, ideally before the healthcare professional begins to render Patient care.

e. Verification of credentials of any person granted emergency privileges shall be done as soon as feasible and no later than seventy-two (72) hours of granting the emergency privileges.

f. Emergency privileges expire once the immediate situation is under control. Individuals holding emergency privileges who wish to continue providing Patient care must apply for regular or temporary staff appointment.

Section 4: New Technology Privileges

a. If new technology or equipment becomes available which warrants a request for new privileges, the interested Staff member(s) must notify the MEC.

b. The MEC will determine requirements necessary to establish adequate training and current clinical competence based on objective professional criteria and shall forward its recommendation to the MEC, who will then forward its recommendation to the Board ofTrustees.

c. Temporary privileges may be granted accordingly for Practitioners who have satisfied the requirements of "b" above.

d. Full privileges require approval of the MEC and the Board of Trustees, processed through established channels.

Section 5: Telemedicine Privileges

a. Definitions: Originating site: the site where the patient is located at the time services are provided. Distant site: the site where the practitioner is located at the time the service is provided.

b. Practitioners providing telemedicine services to patients in the Hospital must have a current, valid Indiana license. Licensed Independent Practitioners who are responsible for the care, treatment or services of the Patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.

c. If the Hospital has a pressing clinical need and a Practitioner can supply that service through telemedicine, the Hospital can evaluate the use of temporary privileges for this situation.

d. Credentialing and privileging to provide telemedicine services at the Hospital may be through one of the following mechanisms:

I. The Hospital fully privileges and credentials the Practitioner as per Article VI Section 1 of the Hospital Medical Staff Bylaws.

2. The Hospital credentials and privileges the Practitioner using information from the distant site provided that site is approved by a CMS-approved credentialing body.

3. The Hospital uses the credentialing and privileging decision of the distant site to make the final privileging decision if the following conditions are met:

a) The distant site is a CMS-approved credentialed organization.

b) The Practitioner is privileged at the distant site for those services to be provided at the Hospital.

Section 6: Patient Specific Temporary Privileges

a. Patient-specific temporary admitting and clinical privileges to care for a specific Patient, and limited to the duration of that Patient's stay in the Hospital, may be requested by a physician who is not a member of the Medical Staff. Such a request may be granted by the President upon receiving the recommendations of the Chief of Staff and the Chairperson of the relevant clinical departments involved.

Section 7: **Organ Procurement**

Temporary privileges may be extended to non-physician medical personnel provided by the Indiana Organ Procurement Organization, Inc. under its contract with the Hospital to assist in human organ procurement procedures in reliance of 1.0.P.O.'s representations in its contract with the Hospital that such personnel have had specialized training in transplantation, donor evaluation and management, and organ recovery and preservation. They may perform their services only under the supervision of a physician or surgeon who is a member of the Hospital Medical Staff or has been granted temporary privileges pursuant to Section 6-5-1.

Temporary privileges may be extended to the following for removal of an eye or part of an eye gifted in accordance with the Indiana Uniform Anatomical Gift Act:

a. A surgeon or physician licensed in the State of Indiana or another state;

b. An embalmer or a funeral director who before September 1, 1983 completed a course in eye enucleation and was certified as competent to enucleate eyes by an accredited school of medicine; or,

c. A person who is registered with the Indiana State Department of Health as an eye enucleator and is able to furnish satisfactory written evidence that he or she has been approved by the Indiana State Board of Health for enucleation ofeyes.

Privileges extended to non-physician personnel for organ procurement as provided hereunder may be terminated summarily by the President, the Chief or Vice Chief of the Medical Staff at any time should it be determined or should there be reasonable belief that such person is not qualified to perform such organ procurement activities and such termination shall not entitle such person to any due process or hearing rights.

Section 8: History and Physicals

a. The History and Physical ("H&P") for an observation or inpatient admission will be completed no more than thirty (30) days prior to or twenty-four (24) hours after patient arrives and will be placed in the patient's medical record. Provided however, no procedure requiring anesthesia will be performed until the H&P is first completed.

b. The H&P is the responsibility of the admitting physician.

c. If the history and physical has been completed and documented within thirty (30) days prior to admission, when appropriate, a durable, legible copy of the report may be used in the Hospital medical record with the signed notation on the day of admission/procedure of any changes in the patient's condition. If none, then "reviewed with no change" shall be noted with signature, date and time.

d. H&P's may be completed, documented, signed, dated and timed by the following:

1. Physicians

2. Podiatrists with privilege to do history and physicals

3. Advance Practice Nurses including CRNAs

4. Physician Assistants – must be co-signed by their collaborating physician.

5. Nurse Practitioners – must be co-signed by collaborating physician.

e. A current, updated H&P is required on all acute care admissions, all surgical procedures including those done under local anesthesia, an updated H&P on all swing bed admissions, and any potentially hazardous diagnostic procedure (see Medical Staff Policy: Medical Records).

ARTICLE VIII. CORRECTIVE ACTION, FAIR HEARING & APPELLATE REVIEW

Section 1: Corrective Action Review Status

a. Any Practitioner with clinical privileges may be placed on review status when their activities or professional conduct are considered not to meet the standards or aims of the Medical Staff or to be disruptive to the operation of the Hospital, but are not of such a nature to warrant the taking of corrective action (Article VIII, Section 2). The MEC may receive a request from a Committee, a member of the Medical Staff, the President, or the Board of Trustees for review of the activities or conduct of a particular Practitioner. This request must be supported by references to the specific activities or conduct, which constitutes grounds for the request.

b. When a request that a Practitioner be placed on review status is received, that request shall immediately be forwarded to the Chief of the Medical Staff. S(he) will call a meeting of the MEC within ten (10) calendar days to review the grounds for the request. The Chief of the Medical Staff and/or the President has the right to inquire about potential conflicts of interest in order to assure the objectivity of the investigation process.

c. The MEC will then make a report of its investigation, which will include its recommendation about placing the Practitioner on review status, to the Chairman of the Board of Trustees, within fifteen (15) calendar days of receipt of the request.

I. During the investigation stage, the Practitioner involved shall be given the opportunity for an interview with the MEC.

2. During this interview (s)he shall be invited to discuss, explain, and refute any allegations.

3. This appearance by the Practitioner shall not be a formal hearing and no formal procedural rules shall be used.

4. A record of the interview shall be included with the MEC's report to the Board of Trustees.

d. The MEC shall take action upon the request within fifteen (15) calendar days of concluding their deliberation.

e. Whether the MEC decides to place the Practitioner on review status or not, the Practitioner will be provided with written notice of the decision, to include the items detailed in (g) of this section.

f. If the MEC determines that the Practitioner in question will be placed on review status they will also define:

I. Duration of review status.

2. Intervals at which the activities and professional conduct of the Practitioner will be reviewed.

3. Who will be charged with monitoring/assessing the Practitioner's progress.

4. The date upon which the final report will be due to the MEC.

g. When the MEC receives and reviews the results of the monitoring and assessment of the Practitioner's activity or conduct, they shall take one of the following actions:

I. Accept the report and notify the Practitioner that (s)he has completed the requirements of the review status procedure and that, as a result of his/her action to correct his/her activities or professional conduct, he/she is no longer on review status,

2. Extend and/or continue the review status of the Practitioner for an additional period of time; or

3. Make a determination that the activities or professional conduct

which constituted grounds for the original request for review status have not been corrected satisfactorily, and institute the appropriate procedures under Article VIII.

Section 2: Corrective Action

a. Whenever the activities or professional conduct of any Practitioner with clinical privileges are considered not to meet the standards or aims of the Medical Staff or to be disruptive to the operations of the Hospital, corrective action against such Practitioner may be requested by any member of the Medical Staff, by the President, or by the Board of Trustees.

b. Whenever the corrective action could be a reduction or suspension of clinical privileges, the MEC will forward such a request to the Chief of the Medical Staff. Upon receipt of such request, the Chief of the Medical Staff shall immediately appoint an ad hoc committee of three (3) active Medical Staff members to investigate the matter.

c. Within fifteen (15) days after the receipt of the request for corrective action, the ad hoc committee shall make a report of its investigation to the MEC.

I. Prior to the making of such a report, the practitioner against whom the corrective action has been requested shall have an opportunity for an interview with the ad hoc investigating committee.

2. At such interview, (s)he shall be invited to discuss, explain or refute any allegation.

3. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto.

4. A record of such interview shall be made by the ad hoc committee and included with its report to the MEC.

d. Within thirty (30) days following the receipt of the request for corrective action, or following receipt of a report from the ad hoc committee following the committee's investigation of a request for corrective action involving reduction or suspension of clinical privileges, the MEC shall take action upon the request.

1. If the corrective action could involve a reduction or suspension of the affected Practitioner's clinical privileges, or a suspension or expulsion from the Medical Staff, the affected Practitioner shall be permitted to make an appearance before the MEC prior to its taking action on the request.

2. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto.

3. A record of such appearance shall be made by the MEC.

e. The action of the MEC on a request for corrective action may be to:

1. Reject or modify the request for corrective action,

2. Issue a warning, a letter of admonition, or a letter of reprimand,

3. Impose terms of probation or a requirement for consultation,

4. Recommend reduction, suspension or revocation of clinical privileges,

5. Recommend that an already imposed summary suspension of clinical privileges be terminated, modified, or sustained, or

6. Recommend that the Practitioner's staff membership be suspended or revoked.

f. Any recommendation by the MEC for reduction, suspension or revocation of clinical privileges or for suspension or expulsion from the Medical Staff for more than fourteen (14) days which is based on competence or professional conduct shall entitle the affected Practitioner to procedural rights, and a fair hearing as set forth in Section 5 below.

g. The chairman of the MEC shall promptly notify the President, in writing, of all requests for corrective action received by the MEC and shall continue to keep the President fully informed of all action taken in connection therewith. After the MEC has made its recommendation in the matter, the procedure to be followed shall be as provided in this fair hearing process.

Section 3: Summary Suspension

Indications for summarily suspending a Practitioner's clinical privileges include but are not limited to:

1. Exhibiting behavior which could or does put patients or staff in immediate danger,
2. Being under the influence of drugs or alcohol.

Procedure:

a. Any one of the following - the President and either the Chief of the Medical Staff or the Executive Committee of the Board of Trustees - shall have the authority, acting singly, whenever action must be taken immediately in the best interest of patient care in the Hospital, to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition.

b. A Practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the MEC hold a hearing on the matter within two (2)

weeks.

c. The MEC may recommend modification, continuance or termination of the terms of the summary suspension.

1. If, as a result of such hearing, the MEC does not recommend immediate termination of the summary suspension, the affected Practitioner shall be entitled to request a hearing.

2. The terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision thereon by the Board.

d. Immediately upon the imposition of a summary suspension, the chairman of the MEC shall have authority to provide for alternative medical coverage for the Patient(s) of the suspended Practitioner still in the Hospital at the time of such suspension. The wishes of the Patient(s) shall be considered in the selection of such alternative Practitioner.

e. Notification to the Practitioner of summary suspension shall be made as follows:

1. A letter from the President addressed to the Practitioner will be sent to the Practitioner by certified mail.

Section 4: Automatic Suspension

1. Indications:

a. Delinquent Records

I. A temporary suspension in the form of withdrawal of a Practitioner's privileges, effective until medical records are completed, shall be imposed automatically after warning of delinquency, for failure to complete medical records within the time frames specified in the Rules and Regulations.

2. Admission of patients, acceptance of transfer patients, assignment to service and committees as well as the professional use of the operating room by a physician or dentist either as surgeon or assistant, will be denied until privileges have been reinstated.

3. It is the physician's responsibility to arrange coverage for ER call and private admissions, and his/her private patients already in the Hospital.

4. Suspension will be maintained until records are dictated, transcribed, signed, and completed to the satisfaction of the MEC and Board of Trustees.

b. Lapse of Professional Liability/Insurance

1. A temporary suspension will automatically be imposed for failure to maintain and provide evidence of adequate professional liability insurance, as established by the Board of Trustees.

2. Admission of Patients, acceptance of transfer patients, assignment to service and committees as well as the professional use of the operating room by a physician, dentist or podiatrist either as a surgeon or assistant, will be denied until privileges have been reinstated.

3. Suspension shall be maintained until the Practitioner provides the Hospital with evidence of adequate professional liability insurance, as established by the Board of Trustees.

c. Action by the State Board of Medical Examiners revoking or suspending a Practitioner's license or placing him upon probation, shall automatically suspend all of his/her Hospital privileges.

d. It shall be the duty of the Chief of the Medical Staff to cooperate with the President to enforce all automatic suspensions.

2. Process for Notification of automatic suspension

a. The Practitioner's office will be notified by phone of pending suspension

b. A letter from the President addressed to the Practitioner will be faxed to the Practitioner's office address upon automatic suspension.

c. If the indication for suspension is not corrected within twenty-four (24) hours, a letter addressed to the Practitioner will be sent by certified mail.

d. Notification will be made in writing to all hospital departments.

Section 5: Hearing and Appellate Review Procedure

a. Right to Hearing and to Appellate Review

1. When any Practitioner receives notice of a recommendation of the MEC that, if ratified by decision of the Board of Trustees, would adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, then (s)he shall be entitled to a hearing before an Ad Hoc Hearing Committee of the Medical Staff ("Medical Staff Ad Hoc Hearing Committee"). If the recommendation of the MEC following such hearing is still adverse to the Practitioner, (s)he shall then be entitled to an appellate review by the Board of Trustees in accordance with these Bylaws before the Board of Trustees makes a final decision on the matter. Notwithstanding anything in these Bylaws to the contrary, a

Practitioner does not have a right to a hearing if the Practitioner does not satisfy eligibility requirements of the Medical Staff, including but not limited to, maintaining evidence of: professional liability insurance, required licenses, board certification (if applicable), or any minimum volume requirements to demonstrate quality of care.

2. When any Practitioner receives notice of a vote by the Board of Trustees, based on his/her competence or professional conduct that will affect his/her appointment to or status as a member of the Medical Staff for more than fourteen (14) days, or his/her exercise of certain clinical privileges, and such decision is not based on a prior adverse recommendation by the MEC with respect to which (s)he was entitled to a hearing and appellate review, (s)he shall be entitled to a hearing by an Ad Hoc Hearing Committee appointed by the Board of Trustees ("Board Ad Hoc Hearing Committee"). If the Board does not change its vote after it receives the report and recommendation of the Board Ad Hoc Hearing Committee, then the Practitioner shall have the right to request an appellate review of such action of the Board of Trustees, before the Board of Trustees vote becomes a final decision on the matter.

3. A Practitioner who receives notice of a right to a Hearing from the MEC or the Board of Trustees pursuant to Section 5 a. 1. or 2 above shall be referred to as the Affected Practitioner.

4. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in these Bylaws to assure that the Affected Practitioner is accorded all rights to which (s)he is entitled.

b. Request for Hearing

1. The President shall be responsible for giving prompt written notice of an adverse recommendation or vote to any Affected Practitioner who is entitled to a hearing or to an appellate review, by certified mail, return receipt requested.

2. The failure of a Affected Practitioner to request a hearing to which (s)he is entitled by these Bylaws within thirty (30) days and in the manner herein provided shall be deemed a waiver of his/her right to such hearing and to any appellate review to which (s)he might otherwise have been entitled, on the matter.

3. When the waived hearing or appellate review relates to an adverse recommendation of the MEC, the same shall thereupon become and remain effective against the Practitioner pending the Board of Trustees' decision on the matter.

4. When the waived hearing or appellate review relates to an adverse vote by the Board of Trustees, the same shall thereupon become and remain effective and final against the Affected Practitioner in the same manner as a final decision of the Board of Trustees.

c. Notice of Hearing

1. Within fifteen (15) days after receipt of a request for hearing from an Affected Practitioner entitled to the same, the MEC or the Board of Trustees, whichever is appropriate, shall use its best effort to schedule and arrange for such a hearing and shall, through the President, notify the Affected Practitioner of the time, place, and date so scheduled, by certified mail, return receipt requested.

2. The hearing date shall not be less than thirty (30) days from the receipt of the request for hearing.

3. If requested by the Affected Practitioner and if the hearing is for an Affected Practitioner who is under suspension, it shall be held as soon as arrangements may reasonably be made, but not later than fifteen (15) days from the date of receipt of such Affected Practitioner's request for hearing.

4. The notice of hearing shall state, in concise language, the acts or omissions with which the Affected Practitioner is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.

d. Composition of Hearing Committee

1. When a hearing relates to an adverse recommendation of the MEC, an Ad Hoc Hearing Committee of not less than three (3) members of the Medical Staff shall conduct such hearing.

a) The members of the Medical Staff Ad Hoc Hearing Committee will be appointed by the Chief of the Medical Staff in consultation with the MEC and one of the members so appointed will be designated as chairman by the Chief of the Medical Staff. At the sole discretion of the Chief of the Medical Staff, a hearing officer may be appointed to facilitate the conduct of the hearing.

b) No Staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of the Medical Staff Ad Hoc Hearing Committee unless it is otherwise impossible to select a representative group due to the size of the Medical Staff.

c) No member of the Medical Staff Ad Hoc Hearing Committee may be in direct economic competition with the Affected Practitioner. If there are not sufficient members who meet the criteria for peer review, Medical Staff Ad Hoc Hearing Committee members may be selected from other accredited

hospital medical staffs.

d) When a hearing relates to an adverse decision of the Board of Trustees that is contrary to the recommendation of the MEC, the Board of Trustees shall appoint a Board Ad Hoc Hearing Committee to conduct such hearing and shall designate one (1) of the members of this Committee as chairman. At least two (2) representatives of the Medical Staff shall be included on this Board Ad Hoc Hearing Committee when feasible, and the representatives of the Medical Staff so appointed shall not be in direct economic competition with the Affected Practitioner. If there are not sufficient members who meet this criteria, Board Ad Hoc Hearing Committee members may be selected from other accredited hospital medical staffs. At the sole discretion of the Chairman of the Board of Trustees, a hearing officer may be appointed to facilitate the conduct of the hearing by the Board Ad Hoc Hearing Committee.

e) The term "Ad Hoc Hearing Committee" shall refer to either the Medical Staff Ad Hoc Hearing Committee, the Board Ad Hoc Hearing Committee, or both as appropriate.

e. Conduct of Hearing

1. There shall be at least a majority of the members of the Ad Hoc Hearing Committee present when the hearing takes place, and no member may vote by proxy.

2. An accurate record of the hearing must be kept. The mechanism shall be established by the Ad Hoc Hearing Committee, and may be accomplished by the use of a court reporter, an electronic recording unit, detailed transcription, or by the taking of adequate minutes.

3. The personal presence of the Affected Practitioner for whom the hearing has been scheduled shall be required. An Affected Practitioner who fails, without good cause, to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 2, and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Section 2.

4. Postponement of hearings beyond the time set forth in these bylaws shall be made only with the approval of the Ad Hoc Hearing Committee for good cause shown. Granting of such postponements shall only be for good cause shown and is the sole discretion of the Ad Hoc Hearing Committee.

5. The Affected Practitioner shall be entitled to be accompanied by and/or represented at the hearing by an attorney at his/her expense.

6. The Affected Practitioner shall be informed of the names of the members of the Ad Hoc Hearing Committee at least fourteen (14) days before a scheduled hearing and provided five (5) days after receipt of such names to raise any objections about conflicts with explanation and details of such objection. Failure to raise an objection within the five (5) day time period shall be deemed to be a waiver of any right of objection and acceptance of the members of the Ad Hoc Hearing Committee. The MEC or the Board Chair, as appropriate, shall promptly consider any such objection and make a timely determination whether to remove and replace such member. The Affected Practitioner shall have the same right to object to replacement members. The deadlines, rights and processes shall be same as if the replacement member were one of the original members of the Ad Hoc Hearing Committee.

7. After discussion input from the parties, either a hearing officer, if one is appointed, or the Chairman of the Ad Hoc Hearing Committee, or his/her designee, shall preside over the hearing and maintain decorum and establish and address, in his or her sole discretion, the following:

   a) fair procedures before and during the hearing, including whether there will be opening and closing oral statements and time limitations;

   b) what documents are relevant to the hearing;

   c) assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence;

   d) the role of the attorneys for the parties before and during the hearing;

   e) whether the parties will be invited to prepare and share statements of their positions to be submitted to the Ad Hoc Hearing Committee in advance of the hearing, and, if invited, then establish the deadlines for such submissions;

   f) whether the parties have the right to see the statement of the other party prior to the hearing and raise any objections to the content before the statements are submitted to the Ad Hoc Hearing Committee;

   g) when the parties must identify witnesses they intend to present during the hearing and whether the parties must summarize in advance of the hearing what the witnesses will testify to;

   h) whether parties should be required to share evidence with each other and the Hearing Committee prior to the hearing and if so required then a right to object to such evidence prior to the hearing;

i) what limitations, if any, should be imposed on any witnesses hearing testimony of other witnesses;

j) rulings on objections of either party before and during the hearing, including but not limited to rulings about what information is relevant and not relevant; and

k) whether the parties may be permitted to submit written statements after the testimony during the hearing.

8. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence.

a) Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule, which might make evidence inadmissible over objection in civil or criminal action.

b) The Affected Practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact, and such memoranda shall become a part of the hearing record.

1) The MEC or the Board, when its action has prompted the hearing, shall retain legal counsel to represent it at the hearing, to present the facts in support of its adverse recommendation of the MEC or adverse action of the Board, and to examine and cross examine witnesses.

2) It shall be the obligation of such representative of the MEC or the Board to present appropriate evidence in support of the adverse recommendation or adverse action, but thereafter the Affected Practitioner shall have the burden of proof for supporting his/her challenge to the adverse recommendation or adverse action by demonstrating by clear and convincing evidence that the adverse recommendation or adverse action was arbitrary, unreasonable, capricious, and/ or not sustained by credible evidence.

9. The Affected Practitioner shall have the following rights in accordance with rules established by the Hearing Officer or the Chairman of the Ad Hoc Hearing Committee:

a) To call and examine witnesses on any matter relevant to the issue of the hearing,

b) To challenge any witness and to rebut any evidence,

c) To inspect all pertinent, non-privileged information in the

Hospital's possession and relied upon with respect to the adverse recommendation or adverse action,

d) To introduce relevant evidence,

e) To obtain a copy of the transcript at his/her expense,

f) To submit a written statement at the close of the hearing.

10. The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. Accordingly, the Affected Practitioner, the MEC, or the Board of Trustees may be represented at any phase in the hearing procedure by an attorney at law. If any of these parties choose to be represented by an attorney, they must give adequate notice to the other affected parties.

11. The Ad Hoc Hearing Committee, in its sole discretion, may, without special notice, recess the hearing and reconvene the same at the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

a) Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

b) The Ad Hoc Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Parties for whom the hearing was convened.

c) During its deliberations, the Ad Hoc Hearing Committee shall be charged with the duty to determine if the Affected Practitioner satisfied his/her burden to establish, by clear and convincing proof, that the adverse recommendation was arbitrary, unreasonable, capricious and/or not sustained by credible evidence.

12. Within fifteen (15) days after final adjournment of the hearings, the Ad Hoc Hearing Committee shall make a written report and recommendation to either the MEC or the Board, as applicable, about its determination and shall forward the same together with the hearing record and all other documentation to the MEC or to the Board of Trustees, whichever appointed it.

a) The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the MEC or adverse action of the Board of Trustees, supported by a statement of the basis for such recommendation

b) The MEC shall evaluate and vote to accept, modify or reject the report and recommendation of the Medical Staff Ad Hoc Hearing Committee. The MEC shall forward the results of its vote to the Board of Directors and the Affected Practitioner who is the subject of the adverse recommendation along with a copy of the report and recommendation of the Medical Staff Ad Hoc Hearing Committee.

c) The Board shall evaluate and vote to accept, modify or reject the report and recommendation of the Board Ad Hoc Hearing Committee. The Board shall forward the results of its vote to the Affected Practitioner along with a copy of the report and recommendation of the Board Ad Hoc Hearing Committee.

13. An Affected Practitioner shall have a right to only one hearing by either the Medical Staff Ad Hoc Hearing Committee or the Board Ad Hoc Hearing Committee and shall have right to only one review by the Ad Hoc Review Committee of the Board ("Ad Hoc Review Committee").

f. Appeal to the Board of Trustees

1. Within fifteen (15) days after receipt of a notice of either (i) the MEC's adverse recommendation following the Medical Staff Ad Hoc Hearing Committee's report and recommendation or (ii) the Board Ad Hoc Hearing Committee recommendation to support the adverse action taken by the Board, the Affected Practitioner may, by written notice to the Board of Trustees by delivery to the President, or by certified mail, return receipt requested, request an appellate review by the Board of Trustees. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or adverse action is based, (as supported by the Affected Practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review. The Affected Practitioner shall state the rationale for a request for an oral argument but the Affected Practitioner shall have no right to make an oral argument or to attend meeting of the Ad Hoc Review Committee.

2. If such appellate review is not requested within fifteen (15) days, the Affected Practitioner shall be deemed to have waived his/her right to same, and to have accepted such adverse recommendation or adverse action. The Board shall then proceed to vote on the adverse recommendation of the MEC and such vote shall be final with no right of appeal. If the Affected Practitioner has deemed to have accepted the adverse action of the Board and the Board Ad Hoc Hearing Committee, then the initial adverse action of the Board shall be deemed final and without need for further vote by the Board and without further right of appeal effective as of the end of the fifteen (15) day time period to request a hearing.

3. Within fifteen (15) days after receipt of such notice of request for appellate review, the Board of Trustees shall schedule a date for the Ad Hoc Review Committee to conduct such review. If the Affected Member requested an oral argument, then the Board shall determine in its sole discretion whether to honor such a request. The Board reserves the right to call for oral arguments even if the Affected Practitioner did not make such a request.

   a) The Ad Hoc Review Committee shall set a time, date and place for its meeting, and

   b) The President shall, by written notice, certified mail, return receipt requested, notify the Affected Practitioner of the same along with a decision regarding any request for oral arguments.

   c) The date of the meeting of the Ad Hoc Review Committee shall not be less than fifteen (15) days, nor more than sixty (60) days, from the date of receipt of the notice of request for appellate review, except that when the Affected Practitioner requesting the review is under suspension which is then in effect, such review shall be scheduled as soon as the arrangements of it may reasonably be made, but not more than fifteen (15) days from the date of receipt of such notice.

4. The appellate review shall be conducted by a duly appointed Ad Hoc Review Committee of the Board of Trustees of not less than three (3) members. The Board is under no obligation to inform the Affected Practitioner of the names of the members of the Appellate Review Committee. If the Board agrees to schedule an oral argument, then the President shall inform the Affected Practitioner of the names of the members of such committee. The Affected Practitioner shall have no right to object to any member of the Appellate Review Committee.

5. The Affected Practitioner shall have access to the report and record of the Ad Hoc Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or adverse action against him/her.

   a) (S)he shall have fifteen (15) days from date of request for appellate review to submit a written statement in his/her own behalf, in which those factual and procedural matters with which there is disagreement, and the reasons for such disagreements shall be specified.

   b) The written statement shall present compelling arguments demonstrating (i) the details about a material failure to comply with the Bylaws during or prior to the hearing so as to deny a fair hearing or (ii) why the recommendations of the MEC and/or

the Ad Hoc Hearing Committee were arbitrary, unreasonable, capricious and/or unsupported by any credible evidence.

c) Such written statement shall be submitted to the Ad Hoc Review Committee through the President, by certified mail, return receipt requested, at least fifteen (15) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the MEC or by the chairman of the Ad Hoc Hearing Committee appointed by the Board of Trustees, and if submitted, the President shall provide a copy thereof to the Affected Practitioner at least fifteen (15) days prior to the date of such appellate review by certified mail, return receipt requested.

6. Ad Hoc Review Committee shall act as an appellate body.

a) The Ad Hoc Review Committee shall review the record created in prior proceedings and shall consider the written statements submitted by the parties. It shall not consider additional evidence. The Affected Practitioner shall have the burden of proof to demonstrate (i) whether there was a material failure to comply with the Bylaws during or prior to the hearing so as to deny a fair hearing or (ii) whether the recommendations of the MEC and/or the Ad Hoc Hearing Committee were arbitrary, unreasonable, capricious and/or unsupported by any credible evidence.

b) If oral argument is granted as part of the review procedure, the Affected Practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or adverse action, and shall answer questions put to him/her by a member of the Ad Hoc Review Committee.

c) The MEC or the Board of Trustees may be represented by an attorney who shall be permitted to speak in favor of the adverse recommendation or adverse action, and shall answer questions put to him/her by the members of the Appellate Review Board.

d) The determination of the Board of Trustees is final.

ARTICLE IX. OFFICERS OF THE MEDICAL STAFF

Section 1: Officers of the Medical Staff shall be:

a. Chief of Staff

b. Vice Chief

c. Secretary/Treasurer

Section 2: Qualifications of Officers

a. Officers must be members of the Active Staff at the time of nomination and election and must remain members in good standing during the term ofoffice.

b. Failure to maintain such status shall immediately create a vacancy in the office involved.

c. Automatic suspension by reason of incomplete records will not be deemed to create a vacancy in the office of the Medical Staff.

Section 3: Election of Officers

a. Officers shall be elected in odd numbered years, traditionally at the November meeting of the Staff. Only members of the Active Staff are eligible tovote.

b. The Nominating Committee shall consist of the three past Chiefs of Staff with the current Chief serving as chairperson.

1. If any one of these Physicians is unable to serve, the MEC shall name a replacement.

2. The Nominating Committee shall meet at least two months before elections, and shall issue its report, nominating two (2) or more physicians qualified as defined in these Bylaws, for each office.

3. All nominees shall be contacted by the Nominating Committee regarding their willingness to serve.

4. The list of the nominees shall be communicated to the Active Medical Staff members at least 30 days prior to the annual meeting of the Medical Staff, held in November of the odd numbered years.

5. The Nominating Committee shall submit the slate of nominees at the annual meeting following which nominations may be made from the floor.

6. In the event of a required absence of a member of the Active Medical Staff, he or she may place a candidate in nomination by signing a petition to the effect and presenting the petition to the Chief of Staff at least two (2) days prior to the annual meeting.

c. The ballots shall be written. Proxies shall be accepted. No individual may hold more than two (2) proxies.

d. The candidate for each office receiving the majority of votes for that office shall be thereby elected to that office. In the event there are three or more nominees for an office and no nominee receives a majority, the name of the nominee receiving the fewest votes is omitted from each successive ballot until one candidate obtains a majority.

e. The Chief or his/her designee will be moderator of the tabulation of votes.

Section 4: Term of Office

a. All officers shall serve for a period of two years or until a successor is elected.

b. Officers shall take office on the first day of the calendar year following elections.

c. In order to promote the development of leadership skills and physician leaders within the ranks of the Medical Staff, it is the intention of this Staff that no individual will serve for more than two consecutive terms as Medical Staff Chief. However, in the event that the then-current composition of the staff is such that there is no clear willing successor capable of serving as Chief, when an individual would otherwise be unable to serve due to these term limits, the Medical Staff shall have a right to vote to override this provision of the Bylaws to ensure the presence of trained and capable leadership for the Staff and the Hospital community.

Section 5: Resignation and Removal from Office

a. Resignation

1. Any general staff officer may resign at any time by giving written notice to the MEC.

2. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified in it.

b. Removal

1. Removal of a Medical Staff officer may be effected upon a two-thirds (2/3) vote, by secret ballot, of the Active Staff members present at a mandatory special meeting called for that purpose by the MEC.

2. Permissible basis of removal of a Medical Staff officer include, without limitation:

a) Failure to perform the duties of position in a timely and

appropriate manner.

b) Having an unresolved conflict of interest with the Hospital.

c) Conduct or statements unfavorable or damaging to the best interests of the Hospital or Medical Staff or to their goals, programs, or public image.

d) Failure to continuously satisfy the qualifications of the position.

e) Physical or mental infirmity that renders the physician incapable of fulfilling his/her duties.

Section 6: Vacancies in Office

a. Vacancies in office during the staff year, except for the Chief, shall be filled by an election at the next staff meeting.

b. If there is a vacancy in the Office of the Chief, the Vice Chief shall serve out the remaining term, and the staff shall elect a new Vice Chief.

Section 7: **Duties of the Officers**

a. Chief

Shall serve as the presiding officer of the Medical Staff to:

I. Act in coordination with the President in all matters of clinical concern within the Hospital.

2. Preside at all meetings of the staff, chair of the MEC and attend all regularly scheduled meetings of the Board of Trustees.

3. Preside at all meetings of the MEC.

4. Serve as the ex-officio member of all other Medical Staff Committees. Attendance at these meetings is not mandatory.

5. Be responsible for enforcement of Medical Staff Bylaws, Rules and Regulations; for implementation of sanctions where indicated; and for the staff's compliance with the procedural safeguards where corrective action has been requested against a practitioner.

6. Appoint committee members, Department Chiefs, and appoint committee chairpersons.

7. Present the views, policies, needs and grievances of the staff to the President and to the Board of Trustees.

8. Receive and interpret the policies of the Board of Trustees to the staff.

9. Be spokesperson for the staff in its external professional and public relations.

10. Supervise the clinical work and be responsible for the organization of the Medical Staff.

b. Vice Chief

1. In the absence or disability of the Chief, discharge the functions and authority of the Chief.

2. Serve as a member of the MEC.

3. Keep an account of the financial transactions of the staff organization.

4. Render financial reports at the annual meeting of the staff.

5. Be responsible for the collection of any staff dues or assessments,

6. Carry out such duties as are assigned to him/her by the Chief.

7. Automatically succeed the Chief when the latter ceases to serve for any reason.

8. In the event that the Vice-Chief is anticipated to progress to the position of Chief in the next election cycle, the Medical Staff strongly encourages that physician to seek formal training in health management issues and/or attend a forum for effective leadership of Medical Staffs and Medical Executive Committees. The Hospital shall provide resources to assist with the cost of such training.

c. Secretary/Treasurer

1. The Secretary/Treasurer shall be a member of the MEC.

2. The Secretary shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the Chief of Staff, attend to all correspondence, and perform such duties as ordinarily pertain to his or her office.

3. The Secretary/Treasurer shall be in charge of corresponding to parties outside the Hospital regarding credentialing and privileges and shall assist the Chief in securing necessary information.

4. The Secretary/Treasurer will make an annual financial report of the Medical Staff receipts and disbursements of funds.

ARTICLE X. STRUCTURE OF THE MEDICAL STAFF

Section 1: The Medical Staff of the Hospital functions as a committee of the whole

a. The full Medical Staff meets, at a minimum, four times per year.

b. Business at the Medical Staff meeting includes but is not limited to:

1. Discussion of policy development or revisions as it relates to the care of patients from a Medical Staff standpoint, including but not limited to:

a) Protocols

b) Recommendations of other Committees

c) Quality of the medical record

d) Review of patient care as appropriate

2. Financial matters as appropriate

c. A quorum at the full Medical Staff meeting is defined as thirty percent (30%) of the voting membership of the Active Medical Staff, except that for the biannual meeting for the purpose of election of officers is fifty percent (50%).

d. All members of the Medical and Allied Health Staff are strongly encouraged to attend.

e. A record of the proceedings of each meeting, including conclusions, is maintained. Upon the adoption of motions at regular and special meetings of the Staff, decisions shall be forwarded as appropriate, in the form of recommendation to the Board of Trustees through the MEC for consideration.

f. The agenda of the Medical Staff meeting will include issues raised in discussions at the MEC meeting.

g. Members of the Active Medical Staff shall be privileged to vote on all matters coming before the Medical Staff and the Medical Staff Departments.

Section 2: Special Meetings of the full Medical Staff

a. Special meetings of the staff may be called at any time by the Chief of the staff, at the request of the Board of Trustees, or upon written request of any five (5) members of the active staff.

b. Written notice shall be given to each Active Staff member and such written notice shall indicate the purpose of such special meeting.

c. A special meeting shall be limited to discussion and action of the specific purpose indicated in the notice of the meeting.

d. The agenda at special meetings shall be:

1. Reading of the notice calling the meeting

2. Transaction of business for which the meeting was called

3. Adjournment

Section 3: Medical Executive Committee (MEC)

a. Membership

1. The executive authority of the staff shall be vested in an Executive Committee, which shall have the duty of coordinating the professional activities and general policies of the various departments of the Hospital and have such other functions and responsibilities as are provided in these bylaws and the Bylaws of the Hospital.

2. The MEC is responsible to the Medical Staff as a whole and to the Board of Trustees. The MEC acts for and on behalf of the Medical Staff between meetings of the staff, as described in these Bylaws.

3. It shall consist of the following voting members:

a) Chief of Staff

b) Vice Chief

c) Secretary/Treasurer

d) Chiefs of Departments

e) Immediate past Chief of Staff

4. There shall also be the following non-voting, ex officio members:

a) President of Hospital (or designee)

b) Chief Nursing Officer (or designee)

c) Quality Director

d) Compliance Officer

5. The officers of the Medical Staff shall be the officers of the MEC. The Chief of Medical Staff shall be the presiding officer. Any member of the MEC, except the Chief of Medical Staff, may hold more than one position.

b. Duties

1. To represent and to act on behalf of the Medical Staff, subject to such limitations as provided in these Bylaws. The Medical Staff has delegated the authority to adopt and amend the Medical Staff Policies, to recommend approval of applications for Medical Staff membership, and credentialing and privileging requests of physicians and allied health providers to the Hospital Board.

2. To organize and oversee Medical Staff and Allied Health Staff performance improvement and quality management activities and establish a mechanism to conduct, evaluate, and revise such activities and maintain accountability for these to the Board.

3. To coordinate the activities and general policies of the various departments.

4. To receive and act upon committee reports.

5. To implement policies of the staff not otherwise the responsibility of the various departments.

6. To provide liaison between the Medical Staff, the President, and the Board of Trustees.

7. To recommend action to the President on matters of a medical administrative nature.

8. To fulfill the staff's accountability to the Board of Trustees for the medical care rendered to patients in the Hospital.

9. To review the credentials of all applicants for appointment and reappointment to the medical staff and Allied Health Staff and to make recommendations for staff membership and delineation of privileges, assuring that privileges granted are supported by evidence of clinical experience and competence.

10. To review periodically all information available regarding the performance and clinical competence of staff members, and to make recommendations for reappointments and renewal or changes in clinical privileges.

11. Implements disciplinary processes as specified in these Bylaws and oversees any remedial actions required as a result of such processes. Investigates any reported breach of the Bylaws, Rules and Regulations, policies, professional ethics, standards of behavior, or clinical competence by any member of the Medical Staff and Allied Health Staff.

12. Report at each meeting of the full Medical Staff.

13. Review the Medical Staff Bylaws, Rules and Regulations on a biennial basis and make recommendations for approval or revision to the full Medical Staff and Board of Trustees.

14. The MEC is responsible for making Medical Staff recommendations directly to the Board of Trustees for its approval. Such recommendations shall pertain to at least the following:

    a) Medical Staff structure

    b) Mechanism used to review credentials and to delineate individual clinical privileges

    c) Recommendations of individuals for Medical Staff membership

    d) Recommendations for delineated clinical privileges for each eligible individual

    e) The participation of the Medical Staff in organizational performance improvement activities

    f) The mechanism by which Medical Staff membership may be terminated, and

    g) The mechanism for fair-hearing procedures

c. The MEC shall meet at least once a month and maintain a permanent record of its proceedings and actions.

d. A quorum shall be defined as 50% of the voting members.

Section 4: Departments of the Medical Staff

a. The Medical Staff shall be divided into three (3) Departments

    1. Medicine

2. OB - Peds

3. Surgery

b. In order to provide for an appropriate structure for Quality Improvement activities, Departments will be subdivided into seven (7) services. These services address specialty care and will have their own Medical Director. Four of these Services represent single specialty areas (Radiology, Anesthesia, Emergency Medicine and Pathology). The other services are Therapies, Cancer Care and Cardiopulmonary which represent a multidisciplinary team of staff members who provide QI oversight for care through the committee structure.

1. The Department of Medicine will include the Cardiopulmonary and Emergency Medicine.

2. The Surgery Department will include Radiology, Cancer Care, Anesthesia and Pathology.

3. Other Specialties will be housed under an appropriate department.

ARTICLE XI. DEPARTMENTS OF THE MEDICAL STAFF

Section 1: Three Departments

There shall be three (3) Departments of the Medical Staff: Medicine, OB-Peds and Surgery.

Section 2: Department Assignments

All Medical and Allied Health Staff members with delineated clinical privileges will be assigned to and have clinical privileges in at least one (1) Department. Individuals may have clinical privileges in more than one (1) Department based on education, training, and experience. The exercise of clinical privileges within any Department is subject to any rules, regulations, and policies of that service under the authority of the Department Chief.

a. Medicine Department

As well as the Internists and Family Physicians primarily assigned to this service, the Department of Medicine will include Emergency Medicine and Advanced Care Departments. The Department is directed to provide quality oversight and review for their Department, and to report findings to the Medical Staff.

b. Surgical Department

As well as the general and specialty surgeons assigned to this service, the Surgical Department will include Radiology, Anesthesia and Pathology Departments. The Department is directed to provide quality oversight and review for their Department, and to report findings to the Medical Staff.

c. OB-Peds Department

As well as Obstetricians, Pediatricians and Family Physicians will be assigned to the service. The Department is directed to provide quality oversight and review for the Department, and to report findings to the Medical Staff.

Section 3: Chiefs of Departments

a. Each Department will have a Chief, appointed by the Chief of Staff, except in the case where the Hospital hires a medical director for a service, who shall become the Chief of that Service.

b. Each Chief of Department shall be a member of the Active Staff.

c. Each Chief shall maintain and update clinical competence in the field of practice involved.

d. The Chief of each Department shall demonstrate qualifications for this position either by certification by an appropriate board or by demonstrating recognized clinical competence, training, and experience within her/his specialty area and appropriate clinical privileges delineated in the Department.

Section 4: Functions of a Chief of Department

a. The Chief will serve as chairperson of the committee for the specialty area.

b. The Chief of the Department is automatically a member of the MEC.

c. The Chief will be responsible for:

1. All clinically related activities of the service.

2. All administratively related activities of the service unless otherwise provided for by the Hospital.

3. Recommending the criteria for clinical privileges that are relevant to the care provided by each service to the Medical Staff.

4. Recommending clinical privileges for each member of the service based on qualifications and documented clinical competence.

5. The development, implementation, and enforcement of policies and procedures that guide and support the provision of services

6. Ensuring departmental compliance with Medical and Allied Health Staff Bylaws and Rules and Regulations.

7. Participating in the ongoing quality improvement activities of the Department and other organizational quality improvement activities.

8. Provision of a process, which includes, at a minimum on an annual basis, relevant documented provider specific feedback to each member of the Medical and Allied Health Staff on this Service who participates in patient care. In the case of staff members who are on one of the three specialties (Radiology, Pathology, Anesthesia), this function will be completed by the Department Chief.

9. Assessing and recommending off-site sources for needed patient care, treatment and/or services not provided by the Hospital.

10. Coordination and integration of intradepartmental services and the Department into the primary functions of the Hospital.

11. Recommendation for a sufficient number of qualified and competent staff to provide patient care, treatment and services.

12. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide care, treatment or services

13. Provide oversight for the continuous assessment and improvement of the quality of care, treatment and services. Maintain quality control programs, as applicable.

14. Responsible to assure the orientation and continuing education of all persons in the Department or service.

15. Recommending space and other resources needed for the Department or service.

Section 5: Department Meetings

a. Departments shall hold regular meetings, no less than four (4) times per year, to review and evaluate the clinical work and quality of care provided by all Practitioners working in the area/service. These will be real time meetings. Minutes shall be recorded and submitted to the Medical Executive Committee.

1. Emphasis must be placed on improving quality of care through education, systems analysis, trending and individual case review.

2. Morbidity and mortality analysis, where appropriate, with detailed consideration of particular patients selected by the Chief of Service; infections, complications, unanticipated deaths, errors in diagnosis, results of treatment with analytical reports relative to patient care within the Hospital, efficiency of clinical practice patterns, significant departure from established patterns of clinical practice, and medical assessment and treatment of patients. The Practitioner who has attended a patient, whose case is to be presented for clinical discussion, shall be notified in advance of such meeting by the Chief and shall be invited to be present for the review.

b. Departments are charged with the formulation of policies and rules and regulations as pertains to issues involving Medical Staff aspects of care for the Service.

I. Policies effecting only one service may be endorsed by that Service's Chairperson following approval in a Service meeting.

2. Policies effecting more than one service may be approved jointly by those Services or by the MEC or by the full Medical Staff.

c. Surgical Department

1 Functions

a) Surgical case review (tissue).

b) Blood usage review (transfusion).

c) Surgical occurrence screens as in Section 5A2 above.

d) Anesthesia review.

e) Policy formulation and revision for surgical and anesthesia services throughout the Hospital.

f) Dental case review.

2. All Physicians with surgical or anesthesia privileges shall be members; all practitioners with surgical or anesthesia privileges are encouraged to attend.

3. Pathologists and radiologists shall be members of the Department of Surgery.

4. A quorum shall be defined as "those present", (at least two [2] members of the Medical Staff must be present).

d. OB-Peds Department

1. Functions

a) Evaluate the appropriateness of treatment and care received by patients in the OB-Peds Department and all patients less than eighteen (18) years of age as in Section 5A2 above.

b) Formulate policies, rules and regulations, and standards of care in the unit with periodic updates to be done as needed.

2. Members

a) All Physicians assigned to the OB-Peds Service.

b) All Physicians with privileges in the area of obstetrics.

c) All non-OB docs who care for children may be members.

d) OB nurse manager.

e) Representatives from Hospital Administration, Quality/ Compliance, Cardiopulmonary, Pharmacy and OB Nursing Staff.

3. A quorum shall be defined as "those present", with at least two [2] members of the Medical Staff present.

e. Medicine (Adults and Children 18 or older)

I. Functions

a) To evaluate the appropriateness of treatment and care received by adult and pediatric patients (18 or older) admitted to the medical floor or ACU as in Section 5A2 above.

b) Review and evaluate the clinical work and quality of care provided by all practitioners working in the area/service in areas described in Section 5A2 above.

c) To formulate policies, rules and regulations, and standards of care for patients admitted to or discharged from the Medical/Surgical unit or ACU, with periodic updates to be done as needed.

2. Members

a) All Physicians assigned to the Medicine Service shall be voting members.

b) Non-voting members shall include:

1) Nursing Administration.
2) Nursing Staff.
3) Hospital Administration.
4) Quality/Performance Improvement
5) Compliance
6) Any caregiver whose input would be helpful in the review of care.

3. A quorum shall be defined as those present, with at least two [2] members of the Medical Staff present.

f. Minutes of Meetings

1. Minutes of each regular and special meeting of a Department shall be prepared and shall include a record of the attendance of members, any votes taken, discussions, conclusions, recommendations, actions, and evaluation of actions taken.

2. The minutes shall be forwarded to the MEC for discussion and action.

3. The minutes shall remain the jurisdiction of the Committee.

4. Comments, recommendations, and actions shall be documented in the minutes of the MEC and communicated to the full Medical Staff as well as to the Committee involved.

5. A permanent file of the minutes of each meeting will be maintained.

ARTICLE XII. COMMITTEES OF THE MEDICAL STAFF

Section 1: General Considerations:

Committees exist to perform such functions and carry out such business of the Medical Staff as may be outlined in these bylaws or as determined from time to time by vote of the full Medical Staff: to provide a forum for the ongoing review of care provided by staff; and to assist the Medical Staff and the Board with compliance with the goals and objectives of hospital-wide and medical staff quality improvement plan.

Section 2: Medical Staff Functions include:

a. Bylaws

b. Credentials

c. Infection Control

d. Pharmacy and Therapeutics

e. Utilization Review

f. Medical Records

g. Performance Improvement

Section 3: Minutes:

a. Minutes of each regular and special meeting of a Committee shall be prepared and filed in administration and shall include a record of the attendance of members, any votes taken, discussions, conclusions, recommendations, actions, and evaluation of actions taken.

b. The minutes shall be forwarded to the MEC for discussion and action.

c. The minutes shall remain the jurisdiction of the Committee.

d. Comments, recommendations, and actions shall be documented in the minutes of the MEC and communicated to the full Medical Staff as well as to the Committee involved.

e. A permanent file of the minutes of each meeting will be maintained.

Section 4: Pharmacy and Therapeutics Committee:

a. Membership (Voting)

1. Medical Staff (optimally 3 members)

2. Director of Pharmacy or designee

3. Director of Inpatient Nursing

4. Director of Surgery & Ambulatory Care

5. ER Director

6. Director of Physician Services

7. Member of Administration

8. Others may be invited ad hoc for their expertise, but will have no voting privileges.

b. Duties of the Committee:

I. This Committee shall serve as an advisory group to the MEC in all matters relating to the use of pharmaceuticals.

2. Duties of this Committee include the development and maintenance of a formulary (drug list) for use in the Hospital.

3. Assist in the formulation of written policies and procedures relating to the Hospital drug distribution system, including the evaluation, selection, procurement, labeling, storage, and safe administration, so as to insure optimum drug use with a minimum of potential hazard to patients.

4. Recommend such policies and procedures to ensure that the distribution and administration of controlled drugs is adequately documented.

5. Ensure that there is a drug recall procedure within the Hospital, which effectively identifies pharmaceuticals, which have been recalled.

6. Review all reports of drugs and other tissue reactions occurring within the Hospital, investigate the possible cause of these reactions and make recommendations to the MEC whenever necessary for improvement in the use of drugs and other therapeutic measures.

c. Meetings shall be held at least 4 times per year and on the call of the Chairperson.

d. A permanent record of the proceedings will be maintained as noted in Section 3 of this Article. A copy will be forwarded to the MEC for review.

Section 5: Infection Control Committee

a. Membership shall consist of at least:

1. Representative of Surgical Services

2. Infection control Practitioner

3. Pharmacy representative

4. Microbiology representative

5. Compliance and Performance Improvement

6. Hospital Administration

7. Inpatient representative

8. Cardiopulmonary representative (ad hoc)

9. Representative of the Emergency Department

10. Representative of the Laboratory

11. Representative of Facilities Management

f. The Infection Control Committee is authorized by the Medical Staff and Hospital administration to institute any surveillance, prevention, and control measures or studies when there is reason to believe that any patient or person may be in danger. The Chairman of the Infection Control Committee and the Infection Control Nurse are empowered to act on behalf of the Committee between meetings.

g. Committee Function

1. Development and implementation of a plan for the prevention and control of nosocomial infections encompassing inpatient and outpatient programs, diagnostic and service areas and support services.

2. Collaboration with the Hospital's Environment of Care (Safety) Committee on policies regarding the Hospital's employee health and waste management programs.

3. Meetings will be held at least four (4) times a year.

4. A permanent record of the proceeding will be maintained as noted in Section 3 of this Article. A copy will be forwarded to the MEC for review.

Section 6: Performance Improvement/ Utilization Review/ Health Information Management Function

a. Membership consists of at least:

1. Three (3) members of the Medical Staff, to include a representative of the surgical service and medical service

2. Hospital administration

3. Director of Inpatient Services

4. Social Work/ Discharge Planning

5. Utilization Review Coordinator

6. Risk Management representative

7. Medical Information Services

8. Representative of Nursing

9. HIM Director

10. Performance Improvement Director

11. Compliance Officer

b. Committee functions:

1. To implement a program of concurrent admission certification and continued stay of all patients in accordance with applicable statutes and regulations of Medicare, Medicaid, and Blue Cross.

2. To assure that there is appropriate discharge planning implemented early in the patients' hospital stay.

3. To address Medical Information Services issues.

4. Medical record review as needed to determine:

a) Medical necessity of Hospital admissions.

b) Appropriateness of hospitalization (level of care).

c) Possible premature discharge when patients are readmitted within three days.

5. Strive to assist individual Departments in analysis of utilization studies.

6. Provide for the medical record review function of the Medical Staff.

c. The Performance Improvement / Utilization Review / Health Information Management Committee shall meet at least four times a year.

d. Minutes of the Performance Improvement/Utilization Review/Health Information Management Committee will be maintained in accord with Section 3 of this Article.

Section 7: **Credentials Committee**

The Medical Staff Executive may function as the Credentials Committee.

a. Membership shall consist of a quorum of the MEC.

b. Function - Review and investigate credentials of applicants for initial appointment, or reappointment to the Medical Staff or Allied Health Staff.

c. Other duties as defined in the policies on credentialing.

d. A quorum is defined as those present.

Section 8: Bylaws Committee

a. Shall meet at least every other year to review the Medical Staff Bylaws, compare them with current licensure and accreditation standards, and recommend revisions to the MEC and full staff as needed,

b. Shall consist of at least three (3) Physicians on the Active Staff.

c. A permanent record of the proceedings will be maintained as noted in Section 3 of this Article. A copy will be forwarded to the MEC for review.

Section 9: Other Committees

Medical Staff participation is needed on (but not limited to) the following Hospital or Board Committees:

a. Finance

b. Ethics

c. Radiation Safety

d. Strategic Planning

e. Resuscitation

f. Disease Specific

g. Ad Hoc Committees

Section 10: Medical Directors of Hospital Sections

a. The following Hospital Sections shall have a Medical Director:

1. Laboratory (Pathologist)

2. Radiology (Radiologist)

3. Oncology

4. Cardiopulmonary

5. Rehabilitative Services

6. Occupational Medicine

7. ER and Emergency Medical Services (EMS)

8. Cardiac Rehabilitation

9. Anesthesia

b. Medical Staff participation (clinical direction) in the delivery of services in the above Departments shall be provided by a qualified Physician who is knowledgeable about the medical care provided by the Hospital Section, by reason of training and experience.

1. Each of the above Sections shall have a qualified clinical director who has administrative responsibility for the delivery of patient care and for the supervision of the service.

2. Functions of the medical/clinical director include but are not limited to:

a) Participation in the development of Section QA indicators.

b) Participation in the evaluation of QA findings, formulating conclusions, recommendations, implementing action, and evaluating the effectiveness of the action taken.

c) Participation in the formulation and approval of pertinent departmental policies.

d) Participation in the education of Section members as appropriate.

e) Participation in performance improvement regarding patient and family education, coordination of care, and accurate, timely, and legible completion of the medical record.

ARTICLE XIII. IMMUNITY FROM LIABILITY

The following shall be express conditions to any Practitioner's application for, or exercise of clinical privileges at this hospital.

First, that any act, communication, report, recommendation, or disclosure with respect to any such Practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law and shall not be the basis for any claim by a Practitioner.

Second, that such privilege shall extend to members of the Hospital's Medical Staff and to its Board of Trustees, its other Practitioners, its President and his/her representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this Article the term "third parties" means both individuals and organizations from which an authorized representative of the MEC has requested

information.

Third, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed confidential.

Fourth, that such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

1. Applications for appointment or clinical privileges
2. Periodic reappraisals for reappointment or clinical privileges
3. Corrective action, including summary suspension
4. Hearings and appellate reviews
5. Medical care evaluations
6. Utilization reviews
7. Other Hospital, Departmental, Section or committee activities related to quality patient care and inter-professional conduct

Fifth, that the acts, communications, reports, recommendations and disclosures referred to in this Article to which immunity applies, may relate to a Practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly have effect on patient care.

Sixth, that in furtherance of the foregoing, each Practitioner shall upon request of the Hospital, execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations specified in paragraph Second, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.

Seventh, that the consents, authorizations, release, right, privileges and immunities provided by Article VI, Section 4 of these Bylaws for the protection of this Hospital and its Practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article.

ARTICLE XIV. AMENDMENTS TO BYLAWS

Section 1: Review and Amendment

a. These Bylaws will be reviewed at least every two (2) years. Revisions will be

made as needed.

b. These Bylaws may be amended by a two-thirds (2/3) vote of those members of the Active Staff present and voting at any regular or special meeting of the Medical Staff,

1. Provided a quorum is present, and

2. Provided written notice of the proposed amendments have been given to each member of the Active Staff at least ten (10) days in advance of such meetings.

c. Notwithstanding Article XIV, Section 1 or any other provision in these Bylaws to the contrary, if a special meeting is called jointly by five (5) members of the Medical Staff for the express purpose of considering proposed amendments to the Bylaws, Rules and Regulations then:

a) Seventy-five percent (75%) of the Active Medical Staff must be present at this meeting for a quorum.

b) Approval will be effective upon affirmative vote of two-thirds (2/3) of the Active Staff attending.

Section 2: Effective Date

An amendment shall be effective when approved by the Board of Trustees in accordance with the Hospital Board Bylaws.

ARTICLE XV. PRECEDENT OF HOSPITAL BYLAWS

The Bylaws and Rules and Regulations of the Medical Staff shall conform to the Bylaws of the Hospital, and are adopted by the Medical Staff and approved by the Board of Trustees before becoming effective. Neither body may unilaterally amend Medical Staff Bylaws or rules and regulations.

ARTICLE XVI. ADOPTION OF AMENDMENTS TO THE MEDICAL STAFF RULES AND REGULATIONS

Amendments to the Rules and Regulations, in whole or in part, may be made by affirmative vote of two-thirds (2/3) of the Active Staff members present at a regular or special Medical Staff meeting at which there is a quorum. Amendments will take effect following approval by the Board of Trustees. Neither the Medical Staff, nor the Board of Trustees may amend these Rules and Regulations unilaterally.

DECATUR COUNTY MEMORIAL HOSPITAL
MEDICAL STAFF BYLAWS
MEDICAL STAFF RULES & REGULATIONS

MEDICAL STAFF APPROVAL:

The Medical Executive Committee approved the Medical Staff Bylaws and Rules and Medical Staff Regulations at the regular meeting on February 3, 2021.

Robert W. Perry, M.D.
Chief of Staff

, MD 3/3/21
Jami Rayles, M.D.
Vice-Chief of Staff

Anxhela Treska, MD
Anxhela Treska, M.D.
Secretary/Treasurer

The Full Medical Staff approved the Medical Staff Bylaws and Medical Staff Rules and Regulations at the regular meeting on February 19, 2021.

Robert W. Perry, M.D.
Chief of Staff

DECATUR COUNTY MEMORIAL HOSPITAL
MEDICAL STAFF BYLAWS

BOARD OF TRUSTEE APPROVAL:

The Board of Trustees of Decatur County Memorial Hospital approved the Medical Staff Bylaws at the regular Board of Trustee meeting on February 25, 2021.

Larry Rueff
Board Chair

Stephen Stringer
Vice-Chair

Mollie Fry
Secretary

Laura Johnson
Board Member

Patricia Cruser
Board Member

Bryan Robbins
Board Member

Robert W. Perry, MD
Board Member, Chief of Staff

Darren Evans
Board Member

Nicole Boersma, MD
Board Member