SAINT JOSEPH HEALTH SYSTEM

MEDICAL STAFF BYLAWS

March 14, 2023

Saint Joseph Health System:

Saint Joseph Regional Medical Center – South Bend Campus, Inc.
(a/k/a SJHS Mishawaka)

Saint Joseph Regional Medical Center – Plymouth Campus, Inc.
(a/k/a SJHS Plymouth)

MEDICAL STAFF BYLAWS:

Part I – Governance

Part II – Investigations, Corrective Action, Hearing and Appeal Plan

Part III – Credentials Procedures Manual

Part IV – Organization Manual

Separate documents maintained:

AHP Policy Manual

Rules and Regulations

Part I: Governance

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Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this Medical Staff is to organize the activities of physicians and other clinical practitioners who practice at Saint Joseph Regional Medical Center – South Bend, Inc., and Saint Joseph Regional Medical Center – Plymouth, Inc. in order to carry out, in conformity with these bylaws, the functions delegated to the Medical Staff by the hospital Board of Directors.

1.2 Authority

Subject to the authority and approval of the Board of Directors the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and associated rules, regulations, and policies and under the corporate bylaws of the Saint Joseph Regional Medical Center – South Bend, Inc. (and Saint Joseph Regional Medical Center – Plymouth, Inc.). Henceforth, whenever the term "the hospital" is used, it shall mean Saint Joseph Regional Medical Center – South Bend, Inc. (and Saint Joseph Regional Medical Center – Plymouth, Inc.).; and whenever the term "the Board" is used, it shall mean Board of Directors. Whenever the term "CEO and Hospital President" is used, it shall mean the person appointed by the Board to act on its behalf in the overall management of the hospital. The term CEO and Hospital President includes a duly appointed acting administrator serving when the CEO and Hospital President is away from the hospital.

1.3 Definitions

1.3.1 "Advanced Practice Professional" or "APP" means those individuals eligible for privileges but not medical staff membership who provide a level of service including the evaluation and treatment of patients including documentation in the medical record and the prescribing of medications. Individuals in this category are, but not limited to, clinical psychologists, physician assistants (PAs), advance practice registered nurses (APRNs), and doctors of nursing practice (DNP).

1.3.2 "Advanced Practice Registered Nurse" or "APRN" means those individuals who are doctors of nursing practice (DNP), certified nurse midwives (CNMs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists or nurse practitioners (NPs), registered nurse first assistants (RNFAs).

1.3.3 "Adverse recommendation" means a recommendation to limit, restrict, or terminate privileges due to a reason related to competence or conduct.

1.3.4 "Allied Health Professional" or "AHP" means those individuals eligible for privileges or scope of practice but not medical staff membership who provide a limited scope of activity that require them to be credentialed.

1.3.5 "Application" means an application for appointment and/or privileges to the Medical Staff as described in Part III, Section 3 of the *Medical Staff Bylaws*.

1.3.6 "Appointee" means any medical or osteopathic physician, dentist, oral and maxillofacial surgeon, or podiatrist holding a current license to practice within the scope of his or her license who is a Member of the Medical Staff.

1.3.7 "Board" means the Board of Directors of Saint Joseph Regional Medical Center and or Board of Directors of Saint Joseph Regional Center – Plymouth Campus, Inc., as applicable. currently known as "Saint Joseph Health System Mishawaka/Plymouth Consolidated Board"

1.3.8 "Chief Executive Officer and Hospital President" or "CEO and Hospital President" is the individual appointed by the Board of Directors to serve as the Board's representative in the overall administration of the Hospital. The CEO and Hospital President may, consistent with his or her authority granted by the Hospital Bylaws, appoint a representative to perform certain administrative duties identified in these Bylaws.

1.3.9 "Chief Medical Officer" or "CMO" is the individual appointed by Board to serve as a liaison between administration and the Medical Staff. This term is meant to include Chief Clinical Officers and is inclusive for the purposes of this document of both hospital level and regional positions. If there is no CMO, the CEO and Hospital President shall serve in his/her stead.

1.3.10 "Clinical Privileges" or "Privileges" mean the permission granted by the Board to a Practitioner to render specific diagnostic, therapeutic, medical, dental, or surgical services with the Hospital.

1.3.11 "Days" shall mean calendar days unless otherwise stipulated in the *Medical Staff Bylaws.*

1.3.12 "Dentist" means an individual who has received a Doctor of Dental Medicine or Doctor of Dental Surgery degree and is currently licensed to practice dentistry in Indiana. "Hospital Trained Dentist" notes trained and experienced in hospital practice.

1.3.13 "Department" means a grouping of like practitioners as note in Part I, Section 5 of the *Medical Staff Bylaws* and further defined in the *Organization and Functions Manual*.

1.3.14 "Department Chair" means an Active Medical Staff Member who has been selected in accordance with and has the qualifications and responsibilities for Department Chair as outlined in Part I, Section 5.2 of these Bylaws.

1.3.15 "Executive Committee" and "Medical Executive Committee" and "MEC" shall mean the Executive Committee of the Medical Staff provided for in Part I, Section 6 of the *Medical Staff Bylaws.*

1.3.16 "Good Standing" means having no adverse actions, limitations, or restriction on privileges or medical staff membership at the time of inquiry based on a reason of competence or conduct.

1.3.17 "Governing Body", "Board of Directors" or "Board" means the Board of Directors. Please see definition of "Board", above.

1.3.18 "Hearing Committee" means the committee appointed to conduct an evidentiary hearing pursuant to a request properly filed and pursued by a Practitioner in accordance with Part II, Section 5 of these *Medical Staff Bylaws.*

1.3.19 "Hospital" means Saint Joseph Regional Medical Center – South Bend, Inc. (and Saint Joseph Regional Medical Center – Plymouth, Inc.).

1.3.20 "Hospital Bylaws" mean those Bylaws established by the Board of Directors.

1.3.21 "Medical Center" means Saint Joseph Regional Medical Center – South Bend, Inc., and Saint Joseph Regional Medical Center – Plymouth, Inc.

1.3.22 "Medical Executive Committee" or "MEC" means the Executive Committee of the Medical Staff

1.3.23 "Medical Staff or "Staff" means an individual who is either a medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, or podiatrist who have obtained membership status and have been granted privileges by the Board that allow them to attend patients and/or to provide other diagnostic, therapeutic, teaching or research services at the Hospital.

1.3.24 "*Medical Staff Bylaws"* means these Bylaws covering the operations of the Medical Staff of Saint Joseph Regional Medical Center – South Bend, Inc. (and Saint Joseph Regional Medical Center – Plymouth, Inc.).

1.3.25 "Medical Staff Leader" means any Medical Staff officer, department chairperson, section chairperson, and committee chair.

1.3.26 "Medical Staff Rules and Regulations" means the rules and regulations adopted by the Medical Executive Committee and approved by the Board.

1.3.27 "Medical Staff Year" is defined as the 12-month time period beginning on January 1st of each year and ending December 31st.

1.3.28 "Meeting attendance" is defined as in person, secure videoconference, or telephonically from a private location.

1.3.29 "Member" is a physician, hospital-trained dentist, oral and maxillofacial surgeon, or podiatrist who has been granted medical staff appointment and/or clinical privileges by the Board of Directors of Saint Joseph Regional Medical Center – South Bend, Inc., and Saint Joseph Regional Medical Center – Plymouth, Inc. practice at this hospital.

1.3.30 "Notice" means written communication by regular U.S. mail, e-mail, facsimile, hospital mail, or hand delivery.

1.3.31 "Oral and Maxillofacial Surgeon" means a licensed dentist with advanced training qualifying him for board certification by the American Board of Oral and Maxillofacial Surgery. The term "dentist" as used in these Bylaws includes oral surgeons.

1.3.32 "Patient Contact" includes any admission, consultation, procedure (Inpatient or outpatient), in-person response to emergency call, evaluation, treatment, or service provided by the member in the hospital. It shall not include referrals for diagnostic or laboratory tests or X-rays.

1.3.33 "Physician" means an individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is currently fully licensed to practice medicine in Indiana.

1.3.34 "Podiatrist" means an individual who has received a Doctor of Podiatric Medicine degree and is currently licensed to practice podiatry in Indiana.

1.3.35 “Practitioner” means an appropriately licensed medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, podiatrist, Advanced Practice Professional, or Allied Health Professional who has been granted clinical privileges.

1.3.36 “Prerogative” means the right to participate, by virtue of Staff category or otherwise, granted to a practitioner, and subject to the ultimate authority of the Board and the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.

1.3.37 "President" means the individual appointed by the Board to act on its behalf in the overall management of the hospital.

1.3.38 "President of the Medical Staff" means the individual elected by the Medical Staff to perform the functions outlined in the Medical Staff Bylaws and related documents.

1.3.39 “Provider-based Clinic” is a clinic that is part of the Hospital by either: 1) working under the tax identification number of the Hospital, 2) working under the Medicare certification number (CCN) of the Hospital, or 3) is part of the Hospital survey by an accreditation agency.

1.3.40 “Representative” or “Hospital Representative” means the Board of Directors and any trustee or committee thereof; the CEO and Hospital President or his or her designee; other employees of the Hospital; a Medical Staff organization or any member, officer, Department or Section or committee thereof; and any individual appointed or authorized by any of the foregoing Representatives to perform specific functions related to gathering, analysis, use or dissemination of information.

1.3.41 “SJHS” means Saint Joseph Health System and refers to the combined campuses of Mishawaka and Plymouth.

1.3.42 "SJRMC” means Saint Joseph Regional Medical Center- South Bend, Inc. (or Saint Joseph regional Medical Center – Plymouth, Inc).

1.3.43 “Special Notice” means written notice sent via certified mail, return receipt requested, by overnight delivery with confirmation of delivery, or by hand delivery evidenced by a receipt signed by the Practitioner to whom it is directed.

1.4 Time Limits

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

1.5 Delegation of Functions

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

Section 2 . Medical Staff Membership

2.1 Nature of Medical Staff Membership

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

2.2 Qualifications for Membership

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

2.3 Nondiscrimination

The Hospital shall not discriminate in granting Membership and/or clinical privileges on the basis of national origin, race, gender, gender identification, sexual orientation, religion, color, age, veteran status, marital status, disability unrelated to the provision of patient care or required medical staff responsibilities, or any other basis prohibited by applicable law.

2.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the Medical Staff. The Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC) except for temporary, emergency and disaster privileges. Appointment and reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months.

2.5 Medical Staff Membership and Clinical Privileges

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

2.6 Medical Staff Members Responsibilities

2.6.1 Each staff member must provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances. This includes alternate coverage by a practitioner with similar privileges at this Hospital that can care for the practitioner's patients when the practitioner is absent.

2.6.2 Each staff member and practitioner with privileges must participate, as assigned, or requested, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions (including service on appropriate Medical Staff committees) as may be required.

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

2.6.4 Each staff member and practitioner with privileges must submit to any pertinent type of health evaluation as requested by any of the Officers of the Medical Staff, CMO (local or regional), or CEO and Hospital President if no CMO, and/or their Department Chair when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or Credentials Committee as part of an evaluation of the member's or practitioner's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and hospital policies addressing physician/practitioner health or impairment.

2.6.5 Each staff member and practitioner with privileges must abide by the Medical Staff bylaws and any other rules, regulations, policies, procedures, and standards of the Medical Staff and Hospital, including the Ethical and Religious Directives for Catholic Health Care Services.

2.6.6 Each staff member and practitioner with privileges must provide evidence of professional liability coverage of a type and in an amount established by the Board. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member and practitioner with privileges shall notify the CMO (local or regional), or designee immediately, within seven (7) days of any and all malpractice claims or notices of intent to sue against the Medical Staff member or practitioner with privileges.

2.6.7 Each applicant for privileges or staff member or practitioner with privileges agrees to release from any liability to the fullest extent permitted by law, all persons acting in good faith and without malice for their conduct in connection with investigating and/or evaluating the quality of care or professional conduct provided by the Medical Staff member and his/ her credentials.

2.6.8 Each staff member and practitioner with privileges shall prepare and complete in timely fashion, according to Medical Staff and hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the hospital, or within its facilities, Sections, or departments.

2.6.9 A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.

2.6.10 An updated examination of the patient, including any changes in the patient's condition, shall be completed, and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed, and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, APP, or other qualified licensed individual in accordance with State law and hospital policy.

2.6.11 The history and physical for inpatient admission shall include a comprehensive current physical assessment including chief complaint, admitting diagnosis, details of present illness, relevant past, social, or family histories, relevant menstrual and obstetrical histories in females, an inventory of body systems, active medication list, and drug and food sensitivities/allergic history, and report of a physical examination (including, but not limited to vital signs, heart, lungs, neuro and mental status, head, chest, abdomen and extremities – *per policy*), and include the impression or reason for hospitalization/ procedure/surgery as well as the plan for treatment – *per policy*.

2.6.12 The H&P for an outpatient procedure or outpatient surgery, a short stay H&P is acceptable and includes a current physical assessment of pertinent systems of the body and must also include the impression or reason for hospitalization/procedure/surgery as well as the plan for treatment.

2.6.13 All H&Ps shall be written or dictated by a Medical Staff member or appropriate Allied Health Professional who has been granted privileges or given permission by SJRMC to perform History and Physicals. Oral and maxillofacial surgeons may be allowed to perform history and physical examinations by the granting of specific privileges to do so based on training, competence, and experience respective to their areas of expertise only. Dentists are responsible for the part of their patients' history and physical examinations that relate to dentistry. Podiatrists may be allowed to perform history and physical examinations for ASA class 1 and 2 patients by the granting of specific privileges to do so based on training, competence, and experience respective to their areas of expertise only. For non-ASA class 1 and 2 patients, Podiatrists are responsible for the part of their patients' history and physical examinations that relate to podiatry. For dental admissions, the full H&P examination must be completed by the appropriately qualified and privileged physician member of the Medical Staff.

2.6.14 The supervising physician may authorize residents, approved medical students, and allied health providers to take a history and perform a physical examination, record pertinent data, and write Progress Notes in the medical record. Minimal requirements for authentication by a counter signature are: history and physical examinations, final progress notes, operative reports, and discharge summaries. The supervising physician, in addition to countersigning all of the above referenced reports, should complete any-and-all orders, notes, summaries, and documents required by third party payers.

2.6.15 Additional requirements and exceptions regarding histories and physicals are contained in the Medical Staff Policy. The quality of medical histories and physicals are monitored by the Medical Staff according to this Bylaw Article (2.6.8).

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

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

2.6.18 Each Medical Staff leader shall disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or hospital. Medical Staff leadership will deal with conflict of interest issues per the Trinity Health System Conflict of Interest policy.

2.7 **Acceptance of a unified medical staff.**

2.7.3 If the SJHS Board of Directors elects to have a unified medical staff, then the medical staff of each affected separately certified Hospital must vote, by majority, in accordance with medical staff Bylaws, whether to accept unification or remain a separate Medical Staff. Each Active member of the medical staff will be eligible to vote on the proposed unification via printed or secure electronic ballot in a manner determined by the MEC. All Active members of each medical staff shall receive at least thirty (30) days advance notice of the proposed unification. The proposed unification shall be considered approved by each medical staff:

(a) If the vote is taken at a meeting, when the proposed unification amendment receives a simple majority (fifty percent plus one) of those present and eligible to vote, or

(b) If the vote is taken solely by ballot, unless thirty-three percent (33%) of those members eligible to vote returns a ballot marked "no".

2.7.4 Once there is a unified medical staff, the Active members at each Hospital in which the Members have clinical privileges, have the ability to vote to "opt out" of the unified medical staff. This would require a petition signed by ten percent (10%), but not less than two (2), of the members who would qualify for voting privileges at that Hospital. Upon presentation of such a petition, a medical staff meeting will be scheduled. Each Active member who would qualify for voting privileges at that Hospital will be eligible to vote on the proposed "opt out" proposal. Each Active member of the medical staff at each Hospital will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active members of each Hospital's medical staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by each Hospital's medical staff:

(a) If the vote is taken at a meeting, when the proposed unification amendment receives a simple majority (fifty percent plus one) of those present and eligible to vote, or

(b) If the vote is taken solely by ballot, unless thirty-three percent (33%) of those members eligible to vote returns a ballot marked "no".

2.8 Medical Staff Member Rights

2.8.1 Each staff member in the Active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with his/her Department Chair or other appropriate Medical Staff leader(s), that practitioner may, upon written notice to the President of the Medical Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

2.8.2 Each staff member in the Active category has the right to initiate a recall election of a Medical Staff officer by following the procedure outlined in Part I Section 4.7 of these bylaws, regarding removal and resignation from office.

2.8.3 Each staff member in the Active category may initiate a call for a general staff meeting to discuss a matter relevant to the Medical Staff by presenting a petition signed by twenty percent (20%) of the members of the Active category. Upon presentation of such a petition, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

2.8.4 Each staff member in the Active category may challenge any rule, regulation, or policy established by the MEC exempting those policies mandated by Trinity Health System, law, or regulatory standard. In the event that a rule, regulation, or policy is thought to be inappropriate, any Medical Staff member may submit a petition signed by twenty percent (20%) of the members of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Part I Section 9.3 will be followed.

2.8.5 Each staff member in the Active category may call for a Department meeting by presenting a petition signed by twenty percent (20%) of the members of the Department. Upon presentation of such a petition the Department Chair will schedule a Department meeting.

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

2.8.7 Any practitioner eligible for Medical Staff appointment has a right to a hearing/appeal pursuant to the conditions and procedures described in the Medical Staff's hearing and appeal plan (Part II of these bylaws).

2.9 Staff Dues

2.9.1 Annual Medical Staff dues, if any, shall be determined by the MEC. Failure of a Medical Staff member to pay dues shall result in ineligibility to apply for Medical Staff reappointment and be considered a voluntary resignation from the Medical Staff.

2.9.2 Any staff member who attains the age of 60 may opt not to pay dues (Active Senior). However, upon doing so, such member shall not be eligible to vote, hold office, or accept Medical Staff committee assignments.

2.10 Indemnification

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

2.10.2 Subject to applicable law and policy, the hospital shall indemnify against reasonable and necessary expenses, costs, and liabilities incurred by a Medical Staff member in connection with the defense of any pending or threatened action, suit, or proceeding to which he or she is made a party by reason of his or her having acted in an official capacity in good faith on behalf of the hospital or Medical Staff. Official capacity for purposes of this provision means any instance wherein the member is:

(a) acting in his/her official capacity as an Officer of the Medical Staff; or

(b) a duly appointed member of a medical staff committee; or

(c) a member of a peer review investigatory process; or

(d) requested by an Officer/Chair or duly charged member to:

i) participate in a peer review investigation;
ii) consult on a credentialing matter; or
iii) participate on an ad hoc or support basis to a medical staff committee.

2.10.3 However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

Section 3. Categories of the Medical Staff

3.1. Nature of Categories of the Medical Staff

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentials Manual of these Bylaws (Part III) are eligible to apply for appointment to one of the following categories:

3.2. The Active (and Voting) Category

3.2.1. Qualifications

3.2.1.1. The Active Staff shall consist of physicians, hospital-trained dentist, and podiatrists who:

(a) Are regularly involved in patient care activities at the Medical Center; and/or

(b) Actively participate in Medal Staff functions and responsibilities, such as committee assignments.

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

3.2.1.3. If a practitioner does not have any activity for two consecutive OPPE cycles (12 months), they will automatically move to Affiliate Medical Staff Status for administrative purposes per policy.

3.2.2. Prerogatives

Members of this category may;

(a) Attend Medical Staff, Department, and Section meetings of which s/he is a member and any Medical Staff or hospital education programs;

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

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

3.2.3. Responsibilities

Members of this category shall:

(a) Contribute to to the organizational and administrative affairs of the Medical Staff;

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

(c) Fulfill or comply with any applicable Medical Staff or hospital policies or procedures;

(d) Assume all all responsibilities of membership on the Active Staff, including committee service, emergency call, and care of unassigned patients;
(e) Accept consultations when requested;
(f) Attend applicable meetings;
(g) Participate in teaching activities with residents as may be assigned;
(h) Pay applicable fees, dues, and assessments;
(i) Perform assigned duties.

3.2.4. Members of the Active Staff who are at least 60 years of age may request removal from emergency call and other rotational obligations, including monitoring initial appointees. The MEC shall recommend whether to grant these requests based on need and the effect on others who serve on the call roster of that specialty. The MEC's recommendation shall be subject to final action by the Board.

3.3. The Nonvoting Category

3.3.1. Qualifications

The Nonvoting category is reserved for Medical Staff members who do not meet the eligibility requirements for the Active category.

3.3.2. Prerogatives

Members of this category may:

(a) Attend Medical Staff, Department, and Section meetings of which s/he is a member and any Medical Staff or hospital education programs;
(b) Not vote on matters presented by the entire Medical Staff, Department, or Section or be an officer of the Medical Staff; and
(c) Serve on Medical Staff committees, other than the MEC, and may vote on matters that come before such committees.

3.3.3. Responsibilities

Members of this category shall have the same responsibilities as Active Category Members.

The sub-categories of the Nonvoting Category consist of the following groups with unique Qualifications, Prerogatives, and Responsibilities as specifically delineated in the following sections:

3.3.3.1. Limited Staff

(a) Qualifications

Shall consist of physicians who soley:

i. Are involved in patient care activities as a volunteer at the Sister Maura Brannick Health Center through Mishawaka, or
ii. Provide telemedicine serices at SJHS.

(b) Prerogatives and Responsibilities

i. May exercise clinical privileges as granted;
ii. May not hold office or serve as department chairs or committee chairs;

iii. May attend meetings of the Medical Staff (without vote) and applicable department meetings (without vote) and may be invited to serve on committees (with vote);
iv. Are excused from emergency call and the care of unassigned patients;
v. Shall pay application fees, dues, and assessments, as applicable.

3.3.3.2. Consulting Staff

(a) Qualifications

The Consulting Staff shall consist of those physicians, hospital-trained dentists, and podiatrists who:

i. Are of recognized professional ability and expertise who provide a service not otherwise available on the Active Staff;
ii. Provide services at SJRMC only at the request of other members of the Medical Staff;
iii. Are members in good standing of the Active Staff at another hospital where they are currently practicing (unless this requirement is waived by the Board after considering the recommendations of the Credentials Committee and the MEC;
iv. At each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

(b) Prerogatives and Responsibilities

The Consulting Staff members:

i. May evaluate and treat patients at the request of a physician on the Medical Staff;
ii. May not hold office or serve as department chairs or committee chairs;
iii. May attend meetings of the Medical Staff (without vote) and applicable department meetings (without vote) and may be invited to serve on committees (with vote);
iv. Are ecused from emergency call and the care of unassigned patients;
v. Shall pay application fees, dues, and assessments, as applicable

3.3.4. Affiliate Staff

(a) Qualifications

The Affiliate Staff shall consist of those physicians, dentists (whether hospital-trained or not), and podiatrists who desire to be associated with, but who do not intend to establish a practice at, SJRMC. The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, including continuing medical education, and to permit

these individuals to access SJRMC services for their patients by referral of patients to other Medical Staff members for admission and care.

Individuals requesting appointment to the Affiliate Staff must submit an application as prescribed by the Credentials Committee. They shall not, however, be required to satisfy the qualifications set forth in Section 2.A.1 (b), (c), (i), (k), (l), and (m) of the Credentials Manual.

(b) Prerogatives and Responsibilities
Members of the Affiliate Staff:

i. May attend meetings of the Medical Staff and applicable departments (all without vote);
ii. Shall generally have no staff committee responsibilities, but may be assigned to committees (with vote);
iii. May attend educational activities of the Medical Staff and SJHS;
iv. May refer patients patients to other members of the Medical Staff for admission and care;
v. May visit their patients and review their medical records via Epic Care Link, but may not write orders or progress notes, make notations in the medical record, or actively participate in the provision or management of care to patients at SJRMC;
vi. May refer patients to SJRMC diagnostic facilities;
vii. May not be granted clinical privileges and may not admit or treat patients at SJRMC; and
viii. Shall pay application fees, dues and assessments.

(c) The grant of Affiliate Staff appointment is a courtesy only, which may be terminated by the Board upon recommendation of the MEC, with no right to hearing or appeal.

3.3.5. Emeritus Staff

Emeritus Staff inclusion is restricted to those individuals recommended by the MEC and approved by the Board. This recognition is entirely discretionary and may be rescinded at any time. Practitioners granted Emeritus Staff shall be those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend Medical Staff and Department meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote on Medical Staff or Department matters although they may vote on matters in committees to which they are assigned, or pay dues. Honorary recognition does not require recredentialing

Section 4. Officers and At-Large Members of the Medical Staff

4.1 Officers of the Medical Staff

4.1.2 President of the Medical Staff

4.1.3 Vice President of the Medical Staff

4.1.4 Secretary/Treasurer Mishawaka Only

4.1.5 Three At-Large members (no Secretary-Treasurer at Plymouth)

4.2 Qualifications of Officers

4.2.1 Officers must be members in good standing of the Active category [and be actively involved in patient care in the hospital]; indicate a willingness and ability to serve; have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges; have previous leadership experience either as a Department Chair/Section Chief or membership on a committee or other involvement in performance improvement functions; and be in compliance with the professional conduct policies of the hospital. The Medical Staff Nominating committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

4.2..2 Officers and MEC at-large members may not simultaneously hold a leadership position (position on the MEC or Board) on another hospital's medical staff or in a facility that is directly competing with the hospital. Noncompliance with this requirement will result in the officer being automatically removed from office.

4.2.3 In addition, they must be committed to attend continuing medical education relating to Medical Staff leadership and/or credentialing functions prior to and during the term of the office and have demonstrated an ability to work well with others.

4.2.4 The above criteria must be met initially and continuously to maintain eligibility to serve as an officer of the Medical Staff.

4.3 Election of Officers

4.3.1 The Nominating Committee shall consist of the three physicians who served as President of the Medical Staff for the three terms immediately preceding, or successively preceding if any of the immediately preceding are no longer in the medical community, that of the current President. The Committee shall convene at least 45 days prior to the election and shall submit to the President of the Medical Staff the nominations of at least one (1) candidate for each of the positions of President of the Medical Staff, Vice President of the Medical Staff, and Secretary/Treasurer (Mishawaka) or the three at-large members (Plymouth). Nominations must be announced, and the names of the nominees announced thirty (30) days prior to the election.

4.3.2 A petition signed by at least twenty percent (20%) Members of the Active staff may add nominations to the ballot, with written consent of the individuals being nominated. The Medical Staff must submit such a petition to the Medical Staff Office at least fifteen (15) days prior to the election for the nominee(s) to be placed on the ballot. The Nominating committee must determine if the candidate meets the qualifications in section 4.2 above before he/she can be placed on the

ballot. Nominations from the floor shall not be accepted.

4.3.3 Ballots will be mailed or delivered electronically to all Active Members at least 14 days prior to the election. Elections shall take place by ballots cast by Active Medical Staff Members returned to the Medical Staff Office on or before [date]. The nominee(s) who receives a plurality of votes cast will be elected.

4.3.4 In the event that a Member is elected to two positions, the elected Member shall choose one position and a second election shall be held to fill the vacated position.

4.4 Term of Office

4.4.1. All officers serve a term of two (2) years. They shall take office on January 1st following their election. An individual may be re-elected to a successive term but no more than one additional 2-year term. An officer may run again for the same position after having not been an officer for one two-year cycle. Each officer shall serve in office until the end of his/her term of office or until a successor is appointed/elected or unless s/he resigns sooner or is removed from office.

4.4.2 [Plymouth only] The at-large members of the Plymouth MEC shall serve for a term of one year but may be elected for an additional one-year term.

4.5 Vacancies of Office

The MEC shall fill vacancies of office via appointment during the Medical Staff year, except the office of the President of the Medical Staff. If there is a vacancy in the office of the President of the Medical Staff, the Vice President of the Medical Staff shall serve the remainder of the term. A non-Presidential office vacancy will be filled by appointment by the MEC.

4.6 Duties of Officers

4.6.1 **President of the Medical Staff:** The President of the Medical Staff shall represent the interests of the Medical Staff to the MEC and the Board, and act in coordination and cooperation with the President and Board in matters of mutual concern involving the care of patients in SJRMC. The President of the Medical Staff is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the Board and the administration of the hospital. The President of the Medical Staff, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in the Medical Staff bylaws, rules, regulations, and policies. Specific responsibilities and authority of the President of the Medical Staff, or designee, are to:

(a) Call and preside over all general and special meetings of the Medical Staff;

(b) Serve as chair of the MEC (with vote, as necessary) and as ex officio member of all other Medical Staff standing committees without vote, and to participate as invited by the CMO (local or regional), or CEO and Hospital President if no CMO, or the Board on hospital or Board committees;

(c) Serve as the individual assigned the responsibility for the organization and conduct of the hospital's medical staff;

(d) Enforce Medical Staff bylaws, rules, regulations, and Medical Staff/hospital policies;

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

(f) Support and encourage Medical Staff leadership and participation in interdisciplinary clinical performance improvement activities;

(g) Report to the Board the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the hospital;

(h) Continuously evaluate and periodically report to the hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;

(i) Review and enforce compliance with standards of ethical conduct and professional demeanor among the practitioners on the Medical Staff in their relations with each other, the Board, hospital management, other professional and support staff, and the community the hospital serves;

(j) Communicate and represent the opinions and concerns of the Medical Staff and its individual members on organizational and individual matters affecting hospital operations to hospital administration, the MEC, and the Board;

(k) Attend Board meetings and Board committee meetings as invited by the Board;

(l) Ensure that the decisions of the Board are communicated and carried out within the Medical Staff;

(m) Perform such other duties and exercise such authority commensurate with the office as are set forth in the Medical Staff bylaws and applicable SJHS and Medical Staff policies, including the collegial intervention steps outlined in the Credentials Manual;

(n) Be responsible for the collection of, and accounting for, and disbursement of any funds collected, donated, or otherwise assessed and present in the Medical Staff Fund. The President may also delegate this duty to a responsible person or body. The President will report the financial status to the Medical Staff.

4.6.2 Vice President of the Medical Staff: In the absence of the President of the Medical Staff, the Vice President of the Medical Staff shall assume all the duties and have the authority of the President of the Medical Staff. S/he shall perform such further duties to assist the resident of the Medical Staff as the President of the Medical Staff or the MEC may request from time to time. S/he will serve on the MEC.

4.6.3 Secretary/Treasurer: This officer will collaborate with the hospital's medical staff office, assure maintenance of minutes, attend to correspondence, act as medical staff treasurer, by assuming the responsibility for the collection of, accounting for, and disbursements of any funds collected, donated, or otherwise assessed and present in the Medical Staff Fund and report to the Medical Staff and coordinate communication within the medical staff and assume the responsibility for providing any other notices as specified in these bylaws. S/he shall serve on the MEC and perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff or the MEC may request from time to time.

4.6.4 Immediate Past President of the Medical Staff: This officer will serve as a consultant to the President of the Medical Staff and Vice President of the Medical Staff.

4.6.5 MEC At-Large Members (Plymouth only)**:** These members will advise and support the medical staff officers and are responsible for representing the needs/interests of the entire medical staff, not simply representing the preferences of their own clinical specialty.

4.7 Removal and Resignation from Office

4.7.1 Removal by Vote of the Medical Staff: Criteria for removal are failure to meet the responsibilities assigned within these bylaws (including due to an infirmity that renders the individual incapable of fulfilling the duties of that office), failure to comply with policies and procedures of the Medical Staff, or for conduct or statements that damage the hospital, its goals, or programs. The Medical Staff may initiate the removal of any officer if at least twenty percent (20%) of the Active members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two-thirds (2/3rds) supermajority of those Active staff members casting written ballot/electronic votes. Removal may also be effectuated by a 2/3 vote of the MEC, or by the Board.

4.7.2 At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which the action is to be considered. The individual will be afforded an opportunity to speak to the MEC, Active Staff members, or the Board prior to a vote on removal.

4.8 Automatic Removal: Automatic removal shall be for failure to meet or maintain any of the qualifications, as noted in Section 4.2.1, for being an Officer. This removal is not discretionary and is effectuated by the President of the Medical Staff. The Board would effectuate removal of President of Medical Staff.

4.9 Resignation: Any elected officer may resign at any time by giving thirty (30) days' written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

4.10 Compensation: The Medical Staff may decide to compensate its officers by a majority vote of the physicians eligible to vote.

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

5.1.1 The Medical Staff shall be organized into Departments, no Department shall have fewer than three (3) Members. The Medical Staff may create Sections within a Department in order to facilitate Medical Staff activities. A list of Departments organized by the Medical Staff and formally recognized by the MEC is listed in the Organization and Functions Manual which is Part IV.

5.1.2 The MEC, with final approval of the Board, may designate new Medical Staff Departments or Sections or dissolve current Departments or Sections as it determines will best promote the Medical Staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

5.1.3. Any MEC action in this regard must (i.) occur at a regular or special MEC meeting where at least two-thirds (2/3) of the voting members are present, and (ii.) receive a majority vote of the MEC members present and voting at the meeting.

5.1.4 Functions of Departments – The departments shall be organized for the purpose of implementing processes to (i.) monitor and evaluate the quality and appropriateness of the care of the patients served by the departments, and (ii.) to monitor the clinical practice of all those with clinical privileges in a given department. Each department shall ensure emergency call coverage for all patients.

5.1.5 Functions of Sections – Sections may perform any of the following activities: continuing education; discussion of policy; discussion of equipment needs; development of recommendations to the department chairperson or the MEC; participation in the development of criteria for clinical privileges (when requested by the department chairperson); and discussion of a specific issue at the request of a department chairperson or the MEC. Sections shall not be required to hold a specific number of regularly scheduled meetings

5.2 Qualifications, Selection, Term, and Removal of Department Chairs [and Section Chiefs]

5.2.1 Appointment or Election of Department Chairs and Section Chiefs

(a) Qualifications for Department Chairs [and Section Chiefs]: All Chairs [and Chiefs] must be members of the Active medical staff, have relevant clinical privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process. In addition, Department Chairs [and Section Chiefs] shall indicate a willingness and ability to serve; have no pending adverse recommendations concerning medical staff appointment or clinical privileges; be in compliance with the professional conduct policies of the hospital; have experience in a leadership position, or other involvement in performance improvement functions; be committed to attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of their office; and have demonstrated an ability to work well with others. Department Chairs [and Section Chiefs] may not simultaneously hold a leadership position (any position in which the Member serves on the MEC or the Board) on another hospital's medical staff. Noncompliance with this requirement will result in the Department Chair [or Section Chief] being automatically removed from office.

(b) Selection of Department Chairs [and Section Chiefs]

i. Election of Department Chairs [and Section Chiefs]: Department Chairs [and Section Chiefs] shall be nominated by the Nominating Committee, consisting of the three (3) most readily available immediate past chairpersons of that department currently on the Medical Staff and including the CMO or designee, and shall offer one (1) or more candidates for each available position except as otherwise provided by contract and subject to Board confirmation. Department Chairs [and Section Chiefs] will be elected by plurality vote of the Active members of the Department[/Section], subject to ratification by the MEC. The election process will be the same as that for Officers of the Medical Staff other than voting shall be limited to the Active Members of the affected Department [or Section] and there shall be no additional nominations made by petition. Each Department Chair [and Section Chief] shall be elected to serve a term of two (2) years commencing on January 1st and may be elected to serve successive terms, with no limit on the number of successive terms.

ii. (Plymouth only) Except as otherwise provided by contract, department chairpersons shall be appointed by the President of the Medical Staff, subject to Board confirmation.

5.2.2 Removal of Department Chairs [or Section Chiefs]

(a) Removal of Chairs [or Chiefs] by Vote: Criteria for removal are failure to meet the responsibilities assigned within these bylaws, failure to comply with policies and procedures of the Medical Staff, or for conduct or statements that damage the hospital, its goals, or programs, or an infirmity that renders the individual incapable of fulfilling that office. A request for removal by a petition signed by twenty percent (20%) of the Active Members of the Department [or Section] shall initiate the removal of any Chair [or Chief]. Removal shall become effective upon an affirmative vote by two-thirds (2/3) supermajority of those Active Department [or Section] members or the MEC casting ballot/electronic votes, or by the Board after reasonable notice and the opportunity to be heard (defined below).

(b) Any action of the Active Staff members of the department shall be by written or electronic ballot, sent to such members at least five (5) days before the voting date. Prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action will be taken at least ten (10) days prior to the date of the meeting. The individual shall be afforded the opportunity to speak to the department, the MEC, or the Board, as applicable, prior to a vote on such removal.

(c) Automatic Removal of Chairs [and Chiefs]: The Department Chair [or Section Chief] may be automatically removed from his/her position if he/she no longer meets the qualifications of the position as defined in these bylaws.

(d) If a Department Chair [or Section Chief] is removed through these processes, or a vacancy occurs for any other reason, an election shall be held within fourteen (14) days to elect a new Chair [or Chief] who will preside through the remainder of the term.

5.3 Responsibilities of Department Chair

(a) To oversee all clinically-related activities of the Department;

(b) To oversee all administratively-related activities of the Department, unless otherwise provided by the hospital;

(c) To provide ongoing surveillance of the performance of all individuals in the Medical Staff Department who have been granted clinical privileges;

(d) To recommend to the Credentials Committee the criteria for requesting clinical privileges that are relevant to the care provided in the Medical Staff Department;

(e) To recommend clinical privileges for each member of the Department and other licensed independent practitioners practicing with privileges within the scope of the Department;

(f) To assess and recommend to the MEC and hospital administration off-site sources for needed patient care services not provided by the Medical Staff Department or the hospital;

(g) To integrate the Department into the primary functions of the hospital;

(h) To coordinate and integrate interdepartmental and intradepartmental services and communication;

(i) To develop and implement Medical Staff and hospital policies and procedures that guide and support the provision of patient care services and review and update these, at least triennially, in such a manner to reflect required changes consistent with current practice, problem resolution, and standards changes;

(j) To recommend to the CMO (local or regional), sufficient numbers of qualified and competent persons to provide patient care and service;

(k) To provide input to the CMO (local or regional), regarding the qualifications and competence of Department or service personnel who are not licensed independent practitioners (LIPs) but provide patient care, treatment, and services;

(l) To continually assess and improve of the quality of care, treatment, and services;

(m) To maintain quality control programs as appropriate;To orient and continuously educate all persons in the Department;

(n) To orient and continuously educate all persons in the Department;

(o) To make recommendations to the MEC and the hospital administration for space and other resources needed by the Medical Staff Department to provide patient care services;

(p) To perform all functions authorized in the Credentials Manual including collegial intervention;

(q) To appoint section chairpersons as deemed necessary, subject to approval of the MEC.

5.4 Department Vice Chairs (Mishawaka Only)– Plymouth does not have Vice Chairs

Department Vice Chairs shall be nominated and elected in a similar manner as Department Chairs as in 5.2.1 b above. There is no automatic succession from Department Vice Chair to Department Chairs. If the position of Department Chair becomes vacant, a new election will be held as soon as possible using the process noted in Part I Section 5.2.1.b.ii. Department Vice Chairs shall act in the temporary absence of the Department Chair and shall perform such other duties as assigned by the Department Chair.

5.5 Section Chiefs

5.5.1 Section Chiefs, if present, are appointed by the Department Chair, subject to approval by the MEC. Sections Chiefs shall meet the same qualifications, and shall be subject to the same removal provisions, as department chairpersons.

5.5.2 If the position of Section Chief becomes vacant, the Department Chair shall appoint a new Section Chief. Section Chiefs shall perform such duties as assigned by the Department Chair and/or the MEC.

5.3.3 These duties may include: review and reporting on applications for initial appointment and clinical privileges, including interviewing candidates; review and reporting on applications for reappointment and renewal of clinical privileges; participation in the development of criteria for clinical privileges; and review and reporting on the professional performance of individuals practicing within the section.

5.6 Assignment to Department

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

5.6.2 An individual may request a change in department assignment to reflect a change in that individual's clinical practice.

Section 6. Medical Staff Committees and Performance Improvement Functions

6.1 Medical Staff Committees and Functions

This Section and the Medical Staff Organization and Functions Manual outline the Medical Staff committees that carry out peer review and other performance improvement functions that are

delegated to the Medical Staff by the Board.

6.2 Designation and Substitution

There shall be a Medical Executive Committee (MEC) and such other standing and ad hoc committees as established by the MEC and enumerated in the Organization and Functions Manual which is part of the Rules and Regulations. Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the Medical Staff may be discharged by Medical Staff representation on such hospital committees as are established to perform such functions. The President of the Medical Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.3.1 Appointment of Committee Chairs and Members

(a) All committee chairs and members shall be appointed for terms of two (2) years by the President of the Medical Staff, in consultation with the MEC. Committee chairs shall be selected based on the criteria set forth in Section 5.2 of these Bylaws. Appointments are renewed at the discretion of the President of the Medical Staff, in consultation with the MEC.

(b) Unless otherwise provided, all SJRMC and administrative representatives on the committees shall be appointed (and removed) by the President or designee. All such representatives shall serve on the committees without vote.

(c) The President of the Medical Staff and the President (or their respective designees) shall be members, *ex officio,* without vote, on all committees, unless vote is required for a quorum.

6.3.2 Removal of Committee Chairs and Members

(a) Any committee chair or member may be removed by a two-thirds (2/3) vote of the MEC, after reasonable notice and an opportunity to be heard.

(b) Grounds for removal shall be: failure to comply with applicable policies, Bylaws, or Rules and Regulations; failure to perform the duties of the position held; conduct detrimental to the interests of SJRMC and/or its Medical Staff; or an infirmity that renders the individual incapable of fulfilling the duties of the office.

(c) Meeting, Reports, and Recommendations
Unless otherwise indicated, each committee described in these Bylaws or in the Medical Staff Organization and Function Manual shall meet as necessary to accomplish its functions, and shall make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated.

6.4 Medical Executive Committee (MEC)

6.4.1 Committee Membership:

(a) Composition - voting: The MEC shall be a standing committee consisting of the following voting members: the Officers of the Medical Staff, the Department Chairs,

and the Chair of the Credentials Committee. The chair will be the President of the Medical Staff.

(b) [Plymouth only] The MEC shall include the President and the Vice President of the Medical Staff, and three members elected At-Large by the Medical Staff and the Chair of the Credentials Committee.

(c) Mishawaka: Composition – nonvoting: The non-voting attendees to the MEC shall consist of the CEO and Hospital President, Chief Medical Officer (CMO)/Vice President of Medical Affairs (VPMA), the Chief Clinical Officer (CCO), the Chief Nursing Officer (CNO), the Director of Medical Education, the Director of the Family Medicine Residency Program, the Chief Medical Information Officer (CMIO), a representative of the Hospital Medicine Program, the Chairs of the Peer Review Committees, (at the discretion of the President of the Medical Staff, they will participate to provide a presentation when requested and then be excused) and a representative of the Board of Directors. Other individuals may be invited to MEC meetings, without vote.

(d) Plymouth: Composition - The non-voting attendees to the MEC shall consist of the CEO and Hospital President, Chief Medical Officer (CMO)/Vice President of Medical Affairs (VPMA), the Chief Clinical Officer (CCO), the Chief Nursing Officer (CNO), the Chief Medical Information Officer (CMIO), the Chairs of the Peer Review Committees, (at the discretion of the President of the Medical Staff, they will participate to provide a presentation when requested and then be excused) and a representative of the Board of Directors Other individuals may be invited to MEC meetings, without vote.

6.4.2 **Removal from MEC**:

A Medical Staff Officer or Department Chair who is removed from his/her position in accordance with Section 4.7 and/or Section 5.2.2 above will automatically lose his/her membership on the MEC.

6.4.3 Duties:

The MEC is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with clinical privileges. The duties of the MEC, as delegated by the Medical Staff, shall be to:

(a) Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff bylaws and provide oversight for all Medical Staff functions;

(b) Coordinate the implementation of policies adopted by the Board;

(c) Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, Department assignments, clinical privileges, and corrective action;

(d) Report to the Board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and

coordinate the participation of the Medical Staff in organizational performance improvement activities;

(e) Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of practitioners with privileges including educational efforts and investigations, when warranted;

(f) Make recommendations to the Board on medical administrative and, as requested, on hospital management matters;

(g) Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the hospital;

(h) Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;

(i) Review and act on reports from Medical Staff committees, Departments, and other assigned activity groups;

(j) Formulate and recommend to the Board Medical Staff rules, policies, and procedures;

(k) Request evaluations of practitioners privileged through the Medical Staff process when there is question about an applicant or practitioner's ability to perform privileges requested or currently granted;

(l) Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

(m) Consult with administration on the quality, timeliness, and quality metrics of contracts for patient care services provided to the hospital by entities outside the hospital;

(n) Assist with that portion of the corporate compliance plan that pertains to the Medical Staff;

(o) Hold Medical Staff leaders, committees, and Departments accountable for fulfilling their duties and responsibilities;

(p) Make recommendations to the Medical Staff for changes or amendments to the Medical Staff bylaws;

(q) The MEC is empowered to act for the organized Medical Staff between meetings of the organized Medical Staff.

(r) Perform other such functions as are assigned to it by these Bylaws, the Credentials Manual, or other applicable policies.

(s) All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of Ind Code Ann. $16-21-2-8, $16-39-6-3, $34-30-15-1 et seq., $34-6-2-44, $34-6-2-64, $34-6-2-99, $34-6-2-

104, and $$34-6-2-116 through 34-6-2-118, and/or the corresponding provisions of any subsequent federal or state statute providing protection to peer review and related activities.

6.4.5 Meetings: The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

6.5 Performance Improvement Functions (As per Part IV Organization and Functions Manual)

6.6 Responsibilities and Related Documents

Medical Staff members shall fulfill all applicable responsibilities contained in these Bylaws, Part I Governance, Part II – Investigations, Corrective Action, Hearing and Appeal Plan, Part III – Credentials Procedures Manual, Part IV – Organization and Functions Manual, the Allied Health Manual, the Medical Staff Code of Conduct Policy, the Medical Staff Rules and Regulations, and other applicable policies, and abide by same when performing all responsibilities.

6.7 Creation of Standing Committees

In accordance with the amendment provisions in the Medical Staff Organization Manual, the MEC may, by resolution and approval of the Board and without amendment to these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the MEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special committee shall be performed by the MEC.

6.8 Special Committees

Special committees shall be created and their members and chairs shall be appointed by the President of the Medical Staff. Such special committees shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

7.1.1 An annual meeting of the Medical Staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all Medical Staff members.

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

7.1.3 Special Meetings of the Medical Staff

(a) The President of the Medical Staff may call a special meeting of the Medical Staff at any time. The President of the Medical Staff must call a special meeting if so directed by resolution of the MEC, the President, the Board, or by a petition signed by twenty percent (20%) of the Active Medical Staff. Such request or resolution shall state the purpose of the meeting. The President of the Medical Staff shall designate the time and place of any special meeting.

(b) Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.2 Regular Meetings of Medical Staff Committees and Departments

Committees, Departments, [and Sections] may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments, Sections, and committees shall meet at least annually, unless otherwise stipulated in these bylaws. Attendance at meetings may be by physical presence or by secure videoconferencing. Telephonic participation is permitted when confidential items are discussed only when confidentiality is assured. Otherwise, each department and committee shall meet as necessary to accomplish its functions, at times set by the presiding officer.

7.3 Special Meetings of Committees and Departments

A special meeting of any committee, Department, [or Section] may be called by the committee chair or Chair of the Department/Section thereof or by the President of the Medical Staff, the CMO, the President, or by a petition signed by not less than twenty percent (20%)of the Active Medical Staff of the department, section, or committee, but not by fewer than two (2) members.

7.4 Quorum

7.4.1 Medical Staff Meetings: Those present (in person, or via secure video/telephonically) and eligible Active Medical Staff members (but never fewer than two (2) members) voting on an issue.

7.4.2 MEC and Credentials Committee. A quorum will exist when fifty percent (50%) of the members are present. When dealing with Category 1 requests for routine appointment, reappointment, and clinical privileges the MEC quorum will consist of at least two (2) members.

7.4.3 Department [or Section] meetings or Medical Staff committees other than those listed in 7.4.2 above: Those present and eligible Active Medical Staff members voting on an issue (but never fewer than two (2) members).

7.4.4 For any amendments to these Medical Staff Bylaws Part I - Governance, at least fifty percent (50%) of the voting staff (or less if in accordance with Section 11.A.(5) and (6) shall be required to establish a quorum. [Plymouth only] For any amendments to the Medical Staff Bylaws that are presented to the Medical Staff by mail, facsimile, e-mail, hand delivery, or telephone, a response of at least 20% of the voting staff shall be required to establish a quorum.

7.4.5 For regular or special meetings of the MEC at which an amendment to the Bylaws, Part II – Investigations, Corrective Action, Hearing and Appeal Plan, Part III – Credentials Procedures Manual, Part IV – Organization and Functions Manual, the Allied Health Manual, or Medical Staff Rules and Regulations will be considered, at least two-thirds (2/3) of all voting members must be present.

7.4.6 Recommendations and actions of the Medical Staff, departments, sections, and committees shall be by consensus. In the event that it is necessary to vote on an issue, that issue will be determined by a majority vote, except for amendments to the Medical Staff Bylaws as described in Section 9. The appropriate presiding officer for the meetings of the Medical Staff, a department, a section, or a committee may determine to present the voting members of these groups with a question by mail, facsimile, e-mail, hand delivery, or telephone, and their votes returned to the presiding officer by the method designated in the notice.

7.4.7 Except for amendments to these Bylaws and the related Medical Staff documents and actions by the MEC or Credentials Committee (as described in Sections 7.4.2 through 7.4.5) renumber, a quorum for purposes of these votes shall be the number of responses returned to the presiding officer by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

7.4.8 Meetings may be conducted by telephone including video conference.

7.5 Attendance Requirements

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

(a) MEC, Credentials Committee, and Peer Excellence Committees meetings: Members of these committees are expected to attend at least two-thirds (2/3rds) of the meetings held. Failure to meet the attendance requirement will result in replacement on the committee.

(b) Special meeting attendance requirements: Whenever there is a reason to believe that a practitioner is not complying with Medical Staff or hospital policies or has deviated from standard clinical or professional practice, the President of the Medical Staff or the applicable Department Chair or Medical Staff committee chair may require the

practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) days prior to the meeting. This notice shall include the date, time, place, issue involved and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting twice, unless excused by the MEC for an adequate reason, will result in an automatic termination of the practitioner's membership and privileges. In any case, the appearance must occur within 60 days of the MEC's first request. Such termination would not give rise to a fair hearing, but would automatically be rescinded if and when the practitioner participates in the previously referenced meeting.

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

7.6 Participation by the CEO and Hospital President and the CMO

The CEO and Hospital President and the CMO, or their designees, may attend any general, committee, Department or Section meetings of the Medical Staff as an ex-officio member without vote.

7.7 Robert's Rules of Order

Medical Staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest abridged edition of Robert's Rules of Order shall determine procedure, but shall not be binding. Specific provisions of these Bylaws, and Medical Staff, department or committee custom shall prevail at all meetings, and the presiding officer shall have the authority to rule definitively on all matters of procedure.

7.8 Notice of Meetings

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

7.9 Action of Committee or Department

The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, section, or committee. Only items noted on the agenda, may be voted upon at the meeting. The recommendation of a majority of its Active members present at a meeting at which a quorum is present shall be the action of a committee or Department. Such recommendation will then be forwarded to the MEC for action. The chair of a committee or meeting shall vote only in order to break a tie.

7.10 Rights of Ex Officio Members

Except as otherwise provided in these bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members, except that they shall not vote,

be able to make motions, or be counted in determining the existence of a quorum.

7.11 Minutes

7.11.1 Minutes of each regular and special meetings of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding committee chair or Department Chair shall authenticate the minutes and copies thereof shall be submitted to the MEC or another designated committee, as may be indicated. A file of the minutes of each meeting shall be maintained in accordance with document retention procedures.

7.11.2 A summary of all recommendations and actions of the Medical Staff, departments, sections, and committees shall be transmitted to the MEC and the President, as may be indicated. The Board shall be kept apprised of the recommendations of the Medical Staff and its departments, sections, and committees.

7.11.3 Confidentiality.

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

(b) All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of Ind Code Ann. $16-21-2-8, $16-39-6-3, $34-30-15-1 et seq., $34-6-2-44, $34-6-2-64, $34-6-2-99, $34-6-2-104, and $$34-6-2-116 through 34-6-2-118, and/or the corresponding provisions of any subsequent federal or state statute providing protection to peer review and related activities.

Section 8. Conflict Resolution

8.1 Conflict Resolution

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

8.1.2 To promote timely and effective communication and to foster collaboration between the Board, management, and Medical Staff, the chair of the Board, CEO and Hospital President, or the President of the Medical Staff may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.

8.1.3 Any conflict between the Medical Staff and the Medical Executive Committee will be resolved using the mechanisms noted in Sections 2.7.1 through 2.7.5 of Part I of these bylaws.

Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

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

9.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

9.2 Methods of Adoption and Amendment to these Bylaws

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

9.2.2 All proposed amendments to these Medical Staff Bylaws shall be referred to the Bylaws Committee for its review. The Bylaws Committee will forward its recommendations concerning the amendments to the MEC

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9.2.3 The MEC will then review all proposed amendments and the Bylaws Committee's recommendations regarding them prior to a vote by the Medical Staff. The MEC may, in its discretion, provide a report on them either favorably or unfavorably, at the next regular meeting of the Medical Staff, or at a special meeting for such purpose.

9.2.4 The proposed amendments may be voted upon at any meeting of the Medical Staff if notice has been provided at least 14 days prior to the meeting. When the MEC disagrees with the Bylaws Committee's recommendations, it shall inform the Medical Staff of that disagreement and explain the differences. To be adopted, the amendment must receive a majority of the votes cast by the voting staff present at the meeting of the medical staff.

9.2.5 Each Active member of the medical staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active members of the medical staff shall receive at least fourteen 14 days advance notice of the proposed changes.

9.2.6 The MEC may also present proposed amendments to the voting staff by mail ballot, e-mail, hand-delivery, or telephone, to be returned to the Medical Staff Office by the date indicated by the MEC. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably.

9.2.7 Regardless of the method of presentation, the amendment shall be considered approved by the medical staff unless more than thirty-three percent (33%) of Active members returns a ballot marked "no." **Plymouth** only To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by at least 20% of the staff eligible to vote.

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

determined not to accept a recommendation submitted to it by the MEC or Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for the recommendation. Such a conference will be scheduled by the President within two weeks after receipt of a request for same submitted by the President of the Medical Staff.

9.3 Methods of Adoption and Amendment to Other Medical Staff Documents

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

9.3.2 When a new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized Medical Staff) will communicate the proposal to the other party prior to vote.

9.3.3 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, rules and regulations may be adopted, amended, or repealed, in whole or in part and such changes shall be effective when approved by the Board. Policies and procedures will become effective upon approval of the MEC.

9.3.4 In addition to the process described in 9.3.3 above, the organized Medical Staff itself may recommend to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by twenty percent (20%) of the members of the Active category using the Conflict Resolution Mechanism noted in Part I Section 9,4. Upon presentation of such petition, the adoption process outlined in Part I Section 9.2.1 renumber above will be followed.

9.3.5 Any such proposed amendments will be reviewed by the MEC, which may comment on the amendments before they are forwarded to the Board for final action.
All policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior notice is required

9.3.6 Notice of all proposed amendments to the Medical Staff Rules and Regulations shall be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the MEC.

9.3.7 Adoption of and changes to the Medical Staff Rules and Regulations, will become effective only when approved by the Board.

9.3.8 In addition, as delineated below, specific documents exist to address unique policies, rules and regulations for specific Medical Staff functions and may have unique processes for creation of amendments. All Medical Staff policies, procedures, and rules and regulations shall be considered an integral part of the Medical Staff Bylaws but amended in accordance with this section.

(a) Part II – Investigations, Corrective Action, Hearing and Appeal Plan and Part III – Credentials Procedures Manual, will address the following matters: qualifications for appointment, the process for granting initial appointment, clinical privileges, reappointment, collegial intervention, the investigation process, automatic relinquishments, precautionary suspensions, and the process for hearings and appeals.

(b) Part IV - The Medical Staff Organization and Functions Manual will list the departments of the Medical Staff. The Organization and Functions Manual will also contain a description of the committees of the Medical Staff.

(c) The Policy for Allied Health Professionals will address the following matters as they relate to allied health professionals: process for determining the need for new allied health professionals, qualifications for appointment, the process for granting clinical privileges or a scope of practice initially and on an ongoing basis, collegial intervention, investigations and suspensions, and procedural rights.

(d) An amendment to the Part II – Investigations, Corrective Action, Hearing and Appeal Plan, Part III – Credentials Procedures Manual, and Part IV The Medical Staff Organization and Functions Manual or the Policy on Allied Health Professionals must be approved jointly by the MECs for each of the SJRMC facilities (Saint Joseph Health System – South Bend and Saint Joseph Health System – Plymouth Campus, Inc.), for an amendment to be adopted:

i. Notice of all proposed amendments shall be provided to all voting Medical Staff members in each facility at least 14 days prior to the MEC meeting at which the amendment will be considered, and any member of the Medical Staff may submit written comments to the MEC; and

ii. The quorum for the regular or special MEC meeting at which the amendment will be considered must be at least two-thirds (2/3) of all voting members: and

iii. The amendment must receive a majority vote of the MEC members present and voting at the meeting.

9.4 Conflict Management Process

9.4.1 When there is a conflict between the Medical Staff and the MEC with respect to:

(a) Proposed amendments to the Medical Staff Rules and Regulations,

(b) A new policy proposed by the MEC, or

(c) Proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting to discuss the conflict may be called by a petition signed by at least 20% of the voting members of the Medical Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

9.4.2 If the differences cannot be resolved at the meeting, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting members of the Medical Staff, to the Board for final action. This conflict management section is limited to the matters above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

9.4.3 In cases of a documented need for an urgent amendment to rules and regulations

necessary to comply with local, state, or federal law or regulation, the MEC may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the MEC immediately informs the Medical Staff. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized Medical Staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized Medical Staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the Board for action.

9.4.4 The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or non-substantive legal modifications, or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression and shall be effective when approved by the Board. Neither the organized Medical Staff nor the Board may unilaterally amend the Medical Staff bylaws or rules and regulations.

9.4.5 The present Medical Staff Rules and Regulations of SJRMC are hereby adopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

Section 10. Conflicts of Interest

10.1 When performing a function outlined in these Bylaws or any related Medical Staff document, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any matter involving another individual, the individual with the conflict shall not participate in the discussion or voting on the matter and shall be excused from any meeting during that time. However, the individual may be asked, and may answer, any questions regarding the matter before leaving.

10.2 The existence of a potential conflict of interest or bias on the part of any member may be called to the attention of the President of the Medical Staff or applicable committee chair or department chairperson by any other member with knowledge of it.

10.3 The fact that a department chairperson or other staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel a determination that a conflict exists.

10.4 The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

10..5 Medical Staff members shall be bound by corporate conflict of interest and compliance policies adopted by the Board to the extent that those policies apply to the Medical Staff member in question.

Section 11. Basic Steps and Details

The details associated with the following Basic Steps are contained in the Part III - Credentials Manual and the Policy on Allied Health Professionals in a more expansive form.

11.1 Qualifications for Appointment

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, and ability to safely and competently perform the clinical privileges requested, as set forth in the Part III -Credentials Manual and the Policy on Allied Health Professionals.

11.2 Process for Privileging and Credentialing (Appointment and Reappointment)

Complete applications are transmitted to the applicable department chairperson, who prepares a written report to the Credentials Committee. The Credentials Committee then prepares a recommendation and forwards it, along with the department chairperson's report, to the MEC for review and recommendation, and to the Board for final action.

11.3 Indication and Process for Automatic Relinquishment of Appointment and/or Privileges (further details in Part II)

11.3.1 Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;
(ii) satisfy threshold eligibility criteria;
(iii) provide requested information; or
(iv) attend a special conference to discuss issues or concerns;

(b) is involved or alleged to be involved in defined criminal activity; or

(c) makes a misstatement or omission on an application form.

11.3.2 Automatic relinquishment will take effect immediately and will continue until the matter is resolved, if applicable.

11.4 Indications and Process for Precautionary Suspension (further details in Part II)

11.4.1 Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, any two of the following individuals are authorized to suspend or restrict all or any portion of an individual's clinical privileges pending an investigation: the President of the Medical Staff, the chairperson of a clinical department, the Chair of the Credentials Committee, the CMO, or the President.

11.4.2 A precautionary suspension is effective immediately and will remain in effect unless it is modified by the President or the MEC.

11.4.3 The President of the Medical Staff shall meet with the member to explain the grounds for

and nature of the action taken at the time of suspension. The individual shall also be provided a brief written description of the reason(s) for the precautionary suspension.

11.4.4 The MEC shall review the reasons for the suspension within a reasonable time.

11.4.5 Prior to, or as part of this review, the individual may be given an opportunity to meet with the MEC.

11.5 Indications and Process for Recommending Termination or Suspension of Appointment and Privileges or Reduction of Privileges (further details in Part II)

11.5.1 Following an investigation, the MEC may recommend suspension of appointment or clinical privileges based on concerns about (a) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment, or management of a patient or group of patients; (b) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of SJHS or the Medical Staff; and/or © conduct by any member of the Medical Staff that is considered lower than the standards of the Medical Staff or disruptive to the orderly operation of SJHS or its Medical Staff, including the inability of the member to work harmoniously with others.

11.6 Hearing and Appeal Process, Including Process for Scheduling and Conducting Hearings and the Composition of the Hearing Panel (further details in Part II)

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

11.6.2 The Hearing Panel will consist of at least three members or there will be a hearing officer.

11.6.3 The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

11.6.4 A stenographer reporter will be present to make a record of the hearing.

11.6.5 Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent that they are available and willing to testify; (b) to introduce exhibits: (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit a written statement at the close of the hearing.

11.6.6 The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

11.6.7 The Hearing Panel (or Hearing Officer) may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

11.6.8 The affected individual and the MEC may request an appeal of the recommendation of the Hearing Panel (or Hearing Officer) to the Board.

Section 12. Adoption

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

Recommended by the Medical Executive Committee:

(Mishawaka)	February 6, 2023
(Plymouth)	February 14, 2023

Adopted by the Medical Staff:

(Mishawaka)	February 6, 2023
(Plymouth)	February 6, 2023

Approved by the Board:

March 14, 2023

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

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Secction 1. Educational and/or Informal Proceedings – Collegial Intervention

1.1 Criteria for Initiation

1.1.1 These bylaws encourage Medical Staff leaders and hospital management to use progressive steps, beginning with education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that have been raised. All educational intervention efforts by Medical Staff leaders and hospital management shall be considered confidential and part of the hospital's performance improvement and professional and peer review activities. Educational intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and hospital management. When any observations arise suggesting opportunities for a practitioner to improve his/her clinical skills or professional behavior, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the Medical Staff and hospital. Educational intervention efforts may include but are not limited to the following:

(a) Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

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

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

1.1.2 The relevant Medical Staff leader(s) shall determine whether it is appropriate to include documentation of collegial intervention effort in an individual's confidential file. If the document of collegial efforts is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

1.1.3 The President of the Medical Staff, in conjunction with the CMO and the President, shall determine whether to direct that a matter be handled in accordance with another policy, such as the Policy on Practitioner Health or the Code of Conduct Policy, or to direct it to the MEC for further determination.

1.1.4 Following educational intervention efforts, if it appears that the practitioner's performance places patients in danger or compromises the quality of care, or in cases where it appears that patients may be placed in harm's way while educational interventions are undertaken, the MEC will consider whether it should be recommended to the Board to restrict or revoke the practitioner's membership and/or privileges. Before issuing such a recommendation the MEC may authorize an investigation for the purpose of gathering and evaluating any evidence and its sufficiency

Secction 2. Investigations

2.1 Initiation

2.1.1 A request for an investigation must be submitted in writing by a Medical Staff officer, committee chair, Department Chair, CEO and Hospital President, CMO, or hospital Board chair to the MEC. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC itself initiates an investigation, it shall appropriately document its reasons and notify the practitioner.

(a) An Initial Review shall be initiated whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding;

(b) The clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients:

(c) The known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of SJHS or the Medical Staff; and/or

(d) Conduct by any member of the Medical Staff that is considered lower than the standards of SJHS or its Medical Staff, including the inability of the member to work harmoniously with others,

2.1.2 The matter may be referred to the President of the Medical Staff, the chairperson of the department, the chair of a standing committee, the CMO, or the President.

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

2.1.4 No action taken pursuant to this Initial Review shall constitute an investigation.

2.2 Investigation

2.2.1 When a question involving clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (such as the Policy on Practitioner Health or the Code of Conduct Policy), or to proceed in another manner. In making this determination, the MEC may discuss the matter with the individual. An investigation shall begin only after a formal determination by the MEC to do so.

2.2.2 If the MEC decides that an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution.

2.2.3 The MEC shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation. Any ad hoc committee shall not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., another physician, dentist, or podiatrist).

2.2.4 In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

2.2.5 The MEC shall inform the individual that an investigation has begun. Notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

2.2.6 The Board may also determine to commence an investigation and may delegate the investigation to the MEC, a subcommittee of the Board, or an ad hoc committee.

2.2.7 The President of the Medical Staff shall keep the President fully informed of all action taken in connection with an investigation.

2.2.8 The committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and the CMO (local or regional). The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams.

2.2.9 The individual being investigated shall execute a release allowing (i) the investigating committee (or its representative) to discuss the healthcare professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the result of such examination directly to the investigating committee. The individual being investigated shall be responsible for the cost of the examination.

2.2.10 The investigating body shall notify the practitioner in question of the allegations that are the basis for the investigation and provide to the practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate.

2.2.11 A summary of the interview shall be made by the investigating committee and included with its report.

2.2.12 The meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as that term is used in the hearing and appeals sections of these bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the Medical Staff to engage external consultation. However, both parties shall have the right to seek guidance and counsel from an attorney prior to this meeting. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process; or other action.

2.2.13 An external peer review consultant may be considered when:

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

(b) There is no one on the Medical Staff with expertise in the subject under review, or when the only physicians on the Medical Staff with appropriate expertise are direct competitors, partners, or associates of the practitioner under review

(c) The individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff.

(d) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary.

(e) When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review.

2.2.14 These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

2.2.15 At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions, and recommendations.

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

(a) Relevant literature and clinical practice guidelines, as appropriate;

(b) All of the opinions and views that were expressed throughout the review, including report(s) form any outside review(s);

(c) Any information or explanations provided by the individual under review.

2.3 MEC Action

The MEC may accept, modify, or reject any recommendation it receives from an investigating committee.

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

(a) Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the practitioner's file;

(b) Deferring action for a reasonable time when circumstances warrant;

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

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

(e) Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;

(f) Recommending reductions of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care;

(g) Recommending suspension, revocation, or probation of Medical Staff membership; or

(h) Taking other actions deemed appropriate under the circumstances.

2.4 Subsequent Action

2.4.1 If the MEC recommends any termination or restriction of the practitioner's membership or privileges, the practitioner shall be entitled to the procedural rights afforded in this hearing and appeal plan. The Board shall act on the MEC's recommendation unless the member requests a hearing, in which case the final decision shall be determined as set forth in this Hearing and Appeal plan.

2.4.2 A recommendation by the MEC that would entitle the individual to request a hearing shall be forwarded to the President, who shall promptly inform the individual by special notice. The President shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

2.4.3 If the MEC makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.

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

2.4.5 When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by the Medical Staff leaders on an ongoing basis

through the SJHS's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

Secction 3. Corrective Action

3.1 Automatic Suspension and/or Relinquishment

In the following triggering circumstances, the practitioner's privileges and/or membership will be considered suspended or relinquished, or limited as described, and the action shall be final without a right to hearing. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. The President of the Medical Staff, with the approval of the CMO, may reinstate the practitioner's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within **sixty (60) days**, the practitioner will have to reapply for membership and/or privileges. Any action taken by any licensing board, professional liability insurance company, court, or government agency regarding any of the matters set forth below must be promptly reported to the President or the CMO. In addition, further corrective action may be recommended in accordance with these bylaws whenever any of the following actions occur:

3.1.1 Licensure

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

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

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

3.1.2 Medicare, Medicaid, Tricare or other federal programs: Whenever a practitioner is excluded, precluded, or barred from participation in Medicare, Medicaid, Tricare, or other federal programs, Medical Staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

3.1.3 Controlled Substances

(a) **DEA Certificate or Indiana CSR:** Whenever a practitioner's United States Drug Enforcement Agency (DEA) certificate or Indiana Controlled Substance Registration (CSR) is involuntarily revoked, limited, or suspended, the practitioner will

automatically undergo relinquishment of appointment and clinical privileges. This shall remain in force until such a time as certification is fully restored.

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

3.1.4 Medical Record Completion Requirements: A practitioner will be considered to have their privileges to admit new patients or schedule new procedures voluntarily suspended whenever s/he fails to complete medical records within time frames established as per policy approved by the MEC. The suspended privileges will be automatically restored upon completion of the medical records and compliance with medical records policies or Medical Staff Rules and Regulations. Refer to Medical Records Completion policy for details.

3.1.5 Professional Liability Insurance: Failure of a practitioner to maintain professional liability insurance in the amount required by state regulations and Medical Staff and Board policies [and sufficient to cover the clinical privileges granted] shall result in automatic suspension of a practitioner's clinical privileges. If within sixty (60) calendar days of the suspension the practitioner does not provide evidence of required professional liability insurance (including prior acts or "nose" coverage for any period during which insurance was not maintained), the practitioner shall be considered to have voluntarily resigned from the Medical Staff. The practitioner must notify the Medical Staff office immediately, within twenty-four (24) hours, of any change in professional liability insurance carrier or coverage. Refer to the Malpractice Guideline for Credentialing Practitioners policy and Malpractice Insurance – Acceptable Coverage policy for details.

3.1.6 Medical Staff Dues/Special Assessments: Failure to promptly pay Medical Staff dues or any special assessment shall be considered an automatic suspension of a practitioner's appointment and privileges. If within sixty (60) calendar days after written warning of the delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership and privileges on the Medical Staff.

3.1.7 Misdemeanor and Felony Convictions:

3.1.7.1 A practitioner who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to any misdemeanor involving (i) controlled substances, (ii) illegal drugs, (iii) Medicare, Medicaid, or insurance or health care fraud or abuse, (iv) sexual misconduct, or (v) criminal violence against another in any jurisdiction shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed.

3.1.7.2 A practitioner who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a felony relating to any of the following: death or injury of another person, insurance or healthcare fraud or abuse, violence, abuse (physical, sexual, child, or elder) in any jurisdiction shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed.

3.1.7.3 A practitioner who has been convicted of or entered a plea of "guilty" or "no

contest" or its equivalent to a felony relating to alcohol, controlled substances or illegal drugs, unless such conviction results in the death or injury of another person, in any jurisdiction shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary. This does not preclude the MEC from taking action on charges or indictments of the above offenses.

3.1.7.4 Automatic relinquishment shall take effect immediately and continue until the matter is resolved, if applicable. Requests for reinstatement will be reviewed by the relevant department chairperson, the Chair of the Credentials Committee, the President of the Medical Staff, the CMO, and the President. If all of these make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at SJRMC. This determination shall then be forwarded to the Credentials Committee, MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

3.1.8 Failure to Satisfy the Special Appearance Requirement: Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the department chairperson, or the President of the Medical Staff may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff. The notice to the individual regarding this conference shall be given by a special notice at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory. A practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these bylaws shall be considered to have all clinical privileges automatically suspended with the exception of emergencies and imminent deliveries. These privileges will be restored when the practitioner complies with the special appearance requirement. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.9 Failure to Provide Requested Information: Failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the MEC, the CMO, the President, or any other committee authorized to request such information, shall result in the automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party. Failure to comply within forty-five (45) calendar days will be considered a voluntary withdrawal or resignation from the Medical Staff.

3.1.10 Failure to Participate in an Evaluation: A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills) and authorizes release of this information to the MEC, shall be considered to have all privileges automatically suspended. These privileges will be restored when the practitioner complies with the requirement for an evaluation. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.11 Failure to Fulfill Mandatory Health Requirements: A practitioner who fails to be compliant with the Trinity Hospital policy on required testing (i.e., Tb testing) or required

vaccinations/immunizations shall be automatically suspended until compliance is noted. Failure to comply within sixty (60) calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.12 Failure to Become Board Certified: A practitioner who fails to become board certified in compliance with these bylaws or Medical Staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her Medical Staff appointment and clinical privileges, unless an exception is granted via the FPPE process, or other acceptable process, according to the Medical Staff Board Certification Assessment policy.

3.1.13 Failure to Maintain Board Certification: A practitioner who fails to maintain their board certification will be deemed to have immediately and voluntarily relinquished his or her medical staff appointment and clinical privileges, unless an exception is granted via the FPPE process, or other acceptable process, according to the Medical Staff Board Certification Assessment policy.

3.1.14 Failure to Execute Release and/or Provide Documents: A practitioner who fails to execute a general or specific release of information and/or provide documents when requested by the President of the Medical Staff or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall be considered to have all privileges automatically suspended. If the release is executed and/or documents provided within thirty calendar days of notice of the automatic suspension, the practitioner may be reinstated. After sixty (60) calendar days, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

3.1.15 Suspension at a Trinity Hospital Within the Region: A practitioner who is suspended at another Trinity Hospital within the Region, with the exception of suspensions due to medical records violations or the payment of dues, shall be considered to have all privileges at this Hospital automatically suspended. If the suspension is terminated at the other Trinity Hospital in the Region, the suspension will be automatically rescinded at this Hospital.

3.1.16 Involuntary Termination at a Trinity Hospital: A practitioner who is involuntarily terminated at another Trinity Hospital shall result in automatic termination at this Hospital.

3.1.17 Loss of supervising/collaborating physician for Advanced Practice Professionals: If an APP loses their relationship with a supervising/collaborating physician on staff at this Hospital, then the APP is automatically suspended until the APP develops a new supervision/collaboration relationship with another Member of the Medical Staff. If another supervising/collaborating relationship is not developed within sixty (60) days, then the APP automatically relinquishes their privileges.

3.1.18 MEC Deliberation: As soon as feasible after action is taken or warranted as described above, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in these bylaws.

3.2 Summary Restriction or Suspension

3.2.1 Criteria for Initiation: A summary restriction or suspension may be imposed when a good faith belief exists that immediate action must be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life,

health, and safety of any person or when Medical Staff leaders and/or the CMO (local or regional) determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to adversely affect patient or employee safety or the effective operation of the institution. Under such circumstances any two individuals from the following (Medical Staff Officer, Department Chair, Chair of the Credentials Committee, CEO and Hospital President, CMO, or administrator on call) may restrict or suspend the Medical Staff membership or clinical privileges of such practitioner. If there is a dispute over whether the practitioner should be summarily suspended, a third individual from the above-named group shall make the decision. A suspension of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a summary suspension of all or any of the practitioner's clinical privileges at this hospital.

3.2.2 The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation.

3.2.3 If a member is summarily (precautionarily) suspended, the President of the Medical Staff shall meet with the member (and with another appropriate Medical Staff colleague if the member is unable to comprehend the grounds or action) to explain the grounds and action at the time of the suspension. A written notice with explanation will also be sent to the affected individual by certified mail.

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

3.2.5 Unless otherwise indicated by the terms of the summary restriction or suspension, the practitioner's patients shall be promptly assigned to another Medical Staff member by the President of the Medical Staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner. The assignment of the patient(s) shall remain in effect until discharge of the patient(s).

3.2.6 MEC Action: As soon as feasible and within fourteen (14) calendar days after such summary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary, begin the investigation process as noted in Section 12.2 above. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply.

(a) The individual may propose ways other than summary (precautionary) suspension or restriction to protect patients, employees, and/or the smooth operation of the Health System, depending on the circumstances.

(b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the MEC shall determine whether there is sufficient

information to warrant a final recommendation, or whether it is necessary to commence an investigation.

(c) The MEC may modify, continue, or terminate the summary restriction or suspension, pending the completion of the investigation (and hearing, if applicable), but in any event, it shall furnish the practitioner with notice of its decision.

(d) There is no right to a hearing based on the imposition or continuation of a precautionary (summary) suspension or restriction.

3.2.7 Rights: Unless the MEC promptly terminates the summary restriction or suspension prior to or immediately after reviewing the results of any investigation described above, the member or other physician or dentist with privileges without membership (or applicant for the above) shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days.

3.2.8 Care of Patients: As delineated in 13.2.2, above, all members of the Medical Staff have a duty to cooperate with the President of the Medical Staff, the department chairpersons, the MEC, and the President in enforcing precautionary (summary) suspensions or restrictions.

Secction 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any practitioner eligible for Medical Staff appointment or physicians eligible for privileges without membership shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following "adverse actions" when the basis for such action is related to clinical competence or professional conduct:

(a) Denial of Medical Staff appointment or reappointment;

(b) Revocation of Medical Staff appointment;

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

(d) Involuntary reduction or revocation of clinical privileges;

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

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

(g) If the Board makes any of these recommendations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Section refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Section to the "MEC" shall be interpreted as a reference to "the Board".

4.2 Hearings Will Not Be Triggered by the Following Actions

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

a) Issuance of a letter of guidance, warning, or reprimand;

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

c) Imposition of a requirement for additional training or continuing education;

d) Imposition of conditions, monitoring, or a general consultation requirement (i.e. the individual must obtain a consult but need not get prior approval of the treatment);

e) Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;

f) Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;

g) Requirement to appear for a special meeting under the provisions of these bylaws;

h) Imposition of a summary suspension that does not exceed fourteen (14) calendar days;

i) Denial of a request for leave of absence, or for an extension of a leave;

j) Determination that an application is incomplete or untimely;

k) Determination that an application will not be processed due to misstatement or omission;

l) Decision not to expedite an application;

m) Denial, termination, or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

n) Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership;

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

p) Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;

q) Termination of any contract with or employment by hospital;

r) Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any accreditation standards on focused professional practice evaluation;

s) Any recommendation voluntarily accepted by the practitioner;Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

t) Change in assigned staff category;

u) Refusal of the Credentials Committee or MEC to consider a request for appointment, reappointment, or privileges after a final adverse decision at any hospital within the Trinity Health System regarding such request;

v) Removal or limitations of emergency department call obligations;

w) Any requirement to complete an educational assessment;

x) Retrospective chart review;

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

z) Grant of conditional appointment or appointment for a limited duration; or

aa) Appointment or reappointment for duration of less than 24 months.

4.3 Notice of Recommendation of Adverse Action\

When a summary suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which, according to this plan entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall promptly (but no longer than five (5) calendar days) be given written notice by the CMO/Medical Staff Office delivered either 1) in person, 2) by certified mail, return receipt requested, or 3) by overnight delivery with delivery confirmation. This notice shall contain:

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

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

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

(d) The individual shall receive a copy of Part II of these bylaws outlining procedural rights with regard to the hearing.

4.4 Request for Hearing

A practitioner shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the CMO/Medical Staff Office, or designee. The letter shall include the name, address, and telephone number of the individual's counsel, if any. In the event the affected individual does not request a hearing within the time and in the manner required by this policy, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final Board action.

4.5 Notice of Hearing and Statement of Reasons

Upon receipt of the practitioner's timely request for a hearing, the CMO, in conjunction with the President of the Medical Staff, shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

(a) The time, place, and date of the hearing;

(b) A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony and a brief summary of the anticipated testimony or evidence on behalf of the MEC, (or the Board), at the hearing;

(c) The names of the Hearing Committee members and Presiding Officer or Hearing Officer, if known; and

(d) A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and the individual's counsel have sufficient time, up to 30 days, to study this additional information and rebut it.

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

4.6 Witness List

At least fifteen (15) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses intended to be called. The witness list shall include a brief summary of the anticipated testimony. Either party may request that the other party provide either a list of, or copies of, all documents that will be offered as pertinent information or relied upon by witnesses at the Hearing Committee and which are pertinent to the basis for which the disciplinary action was proposed. The witness list of either party may, in the discretion of the Presiding Officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The Presiding Officer shall have the authority to limit the number of witnesses.

Secction 5. Hearing Committee and Presiding Officer or Hearing Officer

5.1 Hearing Committee

5.1.1 When a hearing is requested, a Hearing Committee of not fewer than three (3) individuals will be appointed. This panel will be appointed by the President of the Medical Staff, in conjunction with the CMO, one of whom will be designated as chair. No individual appointed to the Hearing Committee shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Committee. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the Hearing Committee. Hearing Committee members need not be members of the hospital Medical Staff but should be a Member of a Trinity Health System hospital. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.

5.1.2 The Hearing Committee shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is in professional practice with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or the Presiding Officer.

5.1.3 The CMO/Medical Staff Office, or designee shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the Hearing Committee or to the Hearing Officer or Presiding Officer shall be made in writing to the CMO/Medical Staff Office. The President of the Medical Staff, in conjunction with the CMO, shall determine whether a replacement panel member should be identified. Although the practitioner who is the subject of the hearing may object to a panel member, s/he is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the CMO.

5.2 Hearing Committee Chairperson or Presiding Officer

5.2.1 In lieu of a Hearing Committee chair, the CMO, acting for the Board and after considering the recommendations of the President of the Medical Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may appoint an attorney at law or other individual experienced in legal proceedings as Presiding Officer. The Presiding Officer should have no previous relationship with either the hospital (other than in the capacity of a Presiding Officer), organized Medical Staff, or the practitioner. Such Presiding Officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Committee and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.

5.2.2 If no Presiding Officer has been appointed, a chair of the Hearing Committee shall be appointed by the CMO to serve as the Presiding Officer and shall be entitled to one vote.

5.2.3 The Presiding Officer (or Hearing Committee chair) shall do the following:

a) Act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to

both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

b) Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay;

c) Maintain decorum throughout the hearing;

d) Determine the order of procedure throughout the hearing;

e) Have the authority and discretion, in accordance with these bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;

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

g) Conduct argument by counsel on procedural points and may do so outside the presence of the Hearing Committee, unless the Committee wishes to be present; and

h) Seek legal counsel when s/he feels it is appropriate. Legal counsel to the hospital may advise the Presiding Officer or panel chair.

i) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

5.3 Hearing Officer

5.3.1 As an alternative to the Hearing Committee described above, the CMO, acting for the Board and in conjunction with the President of the Medical Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer may be an attorney in non-clinical matters.

5.3.2 The appointment of a Hearing Committee of peers will always be preferred to the appointment of a Hearing Officer other than under severe circumstances of inability to appoint a Hearing Committee in a reasonable period of time.

5.3.3 The Hearing Officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references to the "Hearing Committee" or "Presiding Officer" shall be deemed to refer instead to the Hearing Officer, unless the context would clearly require otherwise.

5.4 Objections

Any objection to any member of the Hearing Committee, or to the Hearing Officer or Presiding Officer, shall be made in writing, within 10 days of receipt of notice, to the President. A copy of

such written objections must be provided to the President of the Medical Staff and must include the basis for the objection and may include proposed questions to be asked of the Committee member(s) regarding any potential bias. The Presiding Officer shall give the President of the Medical Staff a reasonable opportunity to comment. The Presiding Officer may pose some or all of the questions to the Committee member(s). The Presiding Officer shall then make a recommendation to the President regarding the objections, and the President shall determine whether to replace any Panel member(s).

5.5 Counsel

The Presiding Officer, Hearing Officer, and counsel for either party may be attorneys at law who are licensed to practice, in good standing, in any state.

Secction 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

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

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

(b) Reports of experts relied upon by the MEC;

(c) Copies of redacted relevant committee minutes;

(d) Copies of any other documents relied upon by the MEC or the Board;

(e) No information regarding other practitioners shall be requested, provided, or considered; and

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

(g) The provision of this information is not intended to waive any privilege under the state peer review protection statute.

(h) The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any Protected Health Information contained in any documents provided.

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

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

6.2 Pre-Hearing Conference

6.2.1 The Presiding Officer may require a representative for the individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be allotted to each witness's testimony and cross-examination.

6.2.2 It is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

6.2.3 The appropriate role of attorneys will be decided at the pre-hearing conference.

6.3 Stipulations

The parties and their counsel shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

6.4 Provision of Information to the Committee

At least two weeks in advance of the hearing, the Presiding Officer shall transmit to the Hearing Panel the Statement of Reasons, any pre-hearing statement that the individual requesting the hearing may choose to submit, and an exhibit book agreed upon by the parties, without the need for authentication.

6.5 Failure to Appear

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

6.6 Record of Hearing

The Hearing Committee shall maintain a record of the hearing by a court reporter present to make a record of the hearing or a recording of the proceedings. The cost of such court reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The Hearing Committee shall be required to order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Indiana.

6.7 Rights of the Practitioner and the Hospital

6.7.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

(a) To call and examine witnesses to the extent available;

(b) To introduce exhibits;

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

(d) To have representation by counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may not argue the case for his/her client. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;

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

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

6.7.3 The Hearing Committee may question the witnesses, call additional witnesses or request additional documentary evidence.

6.8 Admissibility of Evidence

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

6.8.2 The guiding principle shall be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and/or clinical privileges.

6.9 Burden of Proof

It is the burden of the MEC (or Board of Directors) to demonstrate that the action recommended is valid and appropriate. It is the burden of the practitioner under review to demonstrate that s/he satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all Medical Staff and hospital policies.

6.10 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum, and the Hearing Committee may request such a memorandum to be filed within ten (10) business days, following the close of the hearing.

6.11 Official Notice

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

6.12 Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the Presiding Officer or the CEO and Hospital President on a showing of good cause. The hearing shall not proceed unless all hearing panel members are present, unless an excused absence has been requested, and granted, for extenuating circumstances. In all proceedings, a majority of the Hearing Committee shall be present throughout the hearing. In the unusual circumstances when a Hearing Committee member must be absent for any part of the hearing, he or she shall be read the entire transcript of the portion of the hearing from which he or she was absent.

6.13 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceedings. Administrative personnel may be present as requested by the of the Medical Staff or CMO. All members of the Hearing Committee shall be present, absent good cause, for all stages of the hearing and deliberations.

6.14 Order of Presentation

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

6.15 Adjournment and Conclusion

The Presiding Officer may recess the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and questions by the Hearing Committee, the hearing shall be closed.

6.16 Deliberations and Recommendation of the Hearing Committee

Within twenty (20) calendar days after final adjournment of the hearing which may be designated as the time the Hearing Committee receives the hearing transcript or any post-hearing statements, whichever is later, the Hearing Committee shall conduct its deliberations outside the presence of any other person (except the Presiding Officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation.

6.17 Basis of Recommendation

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges, the Hearing Committee shall recommend in favor of the MEC (or the Board) unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

6.18 Disposition of Hearing Committee Report

The Hearing Committee shall deliver its report and recommendation to the CMO who shall forward it, along with all supporting documentation, to the Board for further action. The CMO shall also send a copy of the report and recommendation, certified mail, return receipt requested or by overnight delivery with delivery confirmation, to the individual who requested the hearing, and to the MEC for information and comment. If the Hearing Committee report confirms the original adverse recommendation, the practitioner shall have the right to appellate review as outlined below. If the Hearing Committee report differs from the original MEC or Board recommendation, the MEC or Board may uphold its original recommendation or modify or adjust its recommendation and submit its new recommendation in writing to the affected practitioner, including a statement of the basis for its recommendation.

Secction 7. Appeal to the Hospital Board

7.1 Time for Appeal

Within ten (10) calendar days after the Hearing Committee makes a recommendation, or after the MEC or Board makes its final recommendation, either the practitioner subject to the hearing or the MEC may appeal an adverse recommendation. The request for appellate review shall be in writing, and shall be delivered to the CMO/Medical Staff Office or designee either in person or by certified mail, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days, both parties shall be deemed to have accepted the recommendation involved, and the Hearing Committee's report and recommendation shall be forwarded to the Board.

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

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

(b) The recommendation of the Hearing Committee was made arbitrarily, capriciously, or with prejudice; or

(c) The recommendation of the Hearing Committee was not supported by substantial evidence based upon the hearing record.

7.3 Time, Place, and Notice

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

7.4 Nature of Appellate Review

(a) The Chair of the Board shall appoint a review panel composed of at least three (3) members of the Board or others, including but not limited to, reputable persons outside SJHS, to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration. Alternatively, the Board may consider the appeal as a whole body.

(b) The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the Hearing Committee or Hearing Officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied, and then only at the discretion of the Review Panel (or Board). If additional oral evidence or oral argument is conducted, the review panel shall maintain a

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

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

(d) The Board may affirm, modify, or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges.

7.5 Final Decision of the Hospital Board

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

7.5.2 The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and/or clinical privileges. A copy also shall be provided to the MEC for its information.

7.5.3 Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.6 Right to One Appeal Only

No applicant or Medical Staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current member or a physician or dentist with privileges without membership, that individual may not apply for Medical Staff appointment or for those clinical privileges at another Trinity Health hospital unless the Board advises otherwise. An application for the Medical Staff to the SJHS Hospitals may be re-submitted following a 5-year period.

7.7 Fair hearing and appeal for those with privileges without medical staff membership and who are not physicians or dentists

7.7.1 Psychologists, physician assistants (PAs), Advanced Practice Registered Nurses (APRNs), and Allied Health Professionals are not entitled to the hearing and appeals procedures set forth in the medical staff Bylaws. In the event one of these practitioners receives notice of a recommendation by the Medical Executive Committee that will adversely affect his/her exercise of clinical privileges, the practitioner and his/her supervising physician, if applicable, shall have the right to meet personally with two physicians and a peer assigned by the President of the Medical Staff to discuss the recommendation. The practitioner and the supervising physician, if applicable, must request such a meeting in writing to the Hospital President within ten (10) business days from the date of receipt of such notice. At the meeting, the practitioner and the supervising physician, if applicable, must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in the medical staff Bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected practitioner, the MEC and the Board.

7.7.2 The practitioner and the supervising physician, if applicable, may request an appeal in writing to the Hospital President within ten (10) days of receipt of the findings of the review body. Two members of the Board assigned by the chair of the Board shall hear the appeal from the practitioner and the supervising physician. A representative from the medical staff leadership may be present. The decision of the appeal body will be forwarded to the Board for final decision. The practitioner and the supervising physician will be notified within ten (10) days of the final decision of the Board. If the decision is adverse to the practitioner, they will not be allowed to reapply for privileges.

7.8 Reporting Requirements

The CMO or his/her designee shall be responsible for assuring that the hospital satisfies its obligations under State law and the Health Care Quality Improvement Act of 1986 and its successor statutes. Whenever a practitioner's privileges are limited, revoked, or in any way constrained, the hospital must, in accordance with State and Federal laws or regulations, report those constraints to the appropriate State and Federal authorities, registries, and/or data bases, such as the NPDB. Actions that must be reported include, but are not limited to, any negative professional review action against a physician or dentist related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 8 Amendments

8.1 All amendments to this Investigations, Corrective Action, Hearting and Appeal Plan Manual Section of the Bylaws must be approved by the MECs for each of the SJHS facilities (Saint Joseph Regional Medical Center, and Saint Joseph Regional Medical Center-Plymouth Campus, Inc.)

8.2 For an amendment to be adopted:

(a) Notice of all proposed amendments shall be provided to all voting Medical Staff members in each facility at least 14 days prior to the MEC meeting at which the amendment will be considered, and any member of the Medical Staff may submit written comments to the MEC; and

(b) The quorum for a regular or special MEC meeting at which the amendment will be considered must be at least two-thirds (2/3) of all voting members; and

(c) The amendment must receive a majority vote of all the MEC members present and voting at the meeting.

8.3 If there is any disagreement among or between the MECs for the two facilities concerning a proposed amendment, a joint meeting shall be called for the purpose of discussing and resolving the disagreement.

8.4 No amendment shall be effective unless and until it has been approved by the Board.

Section 9. Adoption

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

Recommended by the Medical Executive Committee:

(Mishawaka)	February 6, 2023
(Plymouth)	February 14, 2023

Adopted by the Medical Staff:

(Mishawaka)	February 6, 2023
(Plymouth)	February 6, 2023

Approved by the Board:

March 14, 2023

Part III: Credentials Procedures Manual

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Section 1. Medical Staff Credentials Committee

1.1. Composition

1.1..1 Membership of the Medical Staff Credentials Committee shall consist of no less than 3members of the Active Medical Staff who are experienced leaders that are not Department Chairs with a broad representation from the Medical Staff and the officers of the Medical Staff. The President of the Medical Staff will appoint the Chair, who must have previous Credentials Committee experience, and the other members of the committee. Particular consideration is to be given to Past Presidents of the Medical Staff and to other physicians knowledgeable in the credentialing and quality improvement processes.

1.1.2 Members will be appointed for staggered three (3) year terms. The chair will be appointed for a three (3) year term. The chair and members may be reappointed for additional terms without limit. The CMO shall be an ex-officio, non-voting member of the committee. The committee may also invite members such as representatives from hospital administration and the Board.

1.2 Meetings

The Medical Staff Credentials Committee shall meet at least ten (10) times per year and on call of the chair or President of the Medical Staff.

1.3 Responsibilities

1.3.1 In accordance with the Credentials Manual:

(a) To review and recommend action on all applications and reapplications for membership on the Medical Staff including assignments of Medical Staff category;

(b) To review and recommend action on all requests regarding privileges from eligible practitioners;

(c) To recommend eligibility criteria for the granting of Medical Staff membership and privileges;

(d) To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;

(e) To review, and where appropriate take action on, reports that are referred to it from other Medical Staff committees, Medical Staff or hospital leaders;

(f) Make a written report of its findings and recommendations, on 18.3.1 through 18.3.5 above.

1.3.2 In accordance with the Policy on Allied Health Professionals,

(a) review the credentials of all applicants seeking to practice a Licensed Independent Practitioners, Licensed Advanced Practitioners or Dependent Practitioners, conduct a thorough review of the applications, interview such applicants as may be necessary, and make a written report of its findings and recommendations;

(b) Review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Allied Health Professional and, as a result of such review, make a written report of its findings and recommendations;

(c) Review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges with SJHS, including specifically as set forth in Medical Staff Policy "Developing Criteria for Privileges"; as well as, "Clinical Privileges for New Procedures" and "Clinical Procedures That Cross Specialty Lines" of the Credentials Manual (Section 5.12).

(d) To perform such other functions as requested by the MEC.

1.4 Confidentiality and Peer Review Protection

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

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

1.4.2 Individuals participating in credentialing and peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committees, except: (1) when disclosures are to another authorized member of the Medical Staff or authorized SJHS employee and are for the purpose of conducting legitimate credentialing and peer review activities; or (2) when the disclosures are authorized in writing, by the President or by legal counsel to SJHS.

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

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

(a) Only upon written request approved by the President of the Medical Staff, CEO and Hospital President, credentials chair or Chief Medical Officer (CMO). Review of such files will be conducted in the presence of the Medical Staff service professional, Medical Staff leader, or a designee of administration. Confidential letters of reference and other verifications responses may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. Nothing may be removed from the file by the practitioner. Only items supplied by the practitioner or directly addressed to the practitioner may be copied and given to the practitioner; no photographs may be taken. The

practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

1.5 Peer Review Protection

1.5.1 All credentialing and peer review activities pursuant to this Manual and related Medical Staff documents shall be performed by "Peer Review Committees" in accordance with Indiana law. "Peer Review Committees" include, but are not limited to: (a) all standing and ad hoc Medical Staff and SJHS committees; (b) Hearing Panels; c. the board and its committees: (d) any individual acting for or on behalf of SJHS, including but not limited to department chairpersons, committee chairs and members, officers of the Medical Staff, and experts or consultants retained to assist in peer review activities, (e) Peer Excellence Committees; and (f) all departments.

1.5.2 All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of Ind. Code Ann. Sect. 16-21-2-8, Sect. 16-39-6-3, Sect. 34-30-15-1 et seq., Sect. 34-6-2-44, Sect. 34-6-2-64, Sect. 34-6-2-99, Sect. 34-6-2-104, and Sect. 34-6-2-116 through 34-6-2-118, and/or the subsequent federal or state statue providing protection to peer review or related activities.

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

Section 2. Qualifications for Membership and/or Privilege

2.1 No practitioner shall be entitled to membership on the Medical Staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization, reside in the geographic service area of SJHS, is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

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

2.2.1 Demonstrate that s/he has successfully graduated from an approved ACGME or AOA (spelled) school of medicine, osteopathy, dentistry, podiatry, clinical psychology, advanced practice nursing, physician assistant program, or applicable recognized course of training in a clinical profession eligible to hold privileges;

2.2.2 Have a current state or federal license, that is not suspended, as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Indiana. The license must be unrestricted for initial appointment;

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

2.2.4 Have a record that shows the applicant has never been convicted of, or entered a plea of guilty or no contest to, any felony, relating to the death or injury of another person, insurance or health care fraud or abuse (nor have been required to pay civil monetary penalties as defined in the federal or state statutes and regulations), violence, or abuse (physical, sexual, child or elder) in any jurisdiction; and

2.2.5 Have a record that shows the applicant has not been convicted of or entered a plea of guilty or not contest to any felony, relating to alcohol, controlled substances, illegal drugs in the past ten (10) years.

2.2.6 Have a record that is free from involuntary termination at another hospital within the Trinity Health System or voluntary resignation in lieu of termination;

2.2.7 Have never had Medical Staff appointment, clinical privileges, employment, or other contractual arrangement denied, revoked, resigned, relinquished, or terminated by any health care facility, health plan, or group practice for reasons related to clinical competence or professional conduct;

2.2.8 Have appropriate written and verbal communication skills;

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

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

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

2.2.10 A physician applicant, MD, or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) and be currently board certified or become board certified within five (5) years of completing formal training or longer as defined by the appropriate specialty board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association or foreign boards which are deemed to be of equivalent status. Recertification may be through the ABMS, AOA, or is deemed to meet the training/qualifications of the American board;

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

2.2.12 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within five (5) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery, or any foreign board accepted by the American board or is deemed to meet the training/qualifications of the American board;

2.2.13 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within five (5) years of completing formal training as determined by the American Board of Foot and Ankle Surgery, the American Board of Podiatric Medicine, or any foreign board accepted by the American board or is deemed to meet the training/qualifications of the American board;

2.2.14 For Practitioners referenced in 2.1.9 through 2.1.12 certification must be maintained and to the extent of the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed on an ongoing basis and at the time of applicable specialty/subspecialty board certification expiration.

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

2.2.16 A certified registered nurse anesthetist (CRNA) must have graduated from an approved program of anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or a predecessor or successor agency. Certification by the National Board on Certification and Recertification for Nurse Anesthetists (NBCRNA), or by a predecessor or successor agency to either is required for initial applicants or be actively seeking initial certification and obtain the same on the first examination for which eligible. Certification is also required for reapplicants.

2.2.17 A certified nurse midwife (CNM) must have successfully completed an Accreditation Commission for Midwifery Education (ACME) (formerly the American College of Nurse Midwives – ACNM) accredited nurse midwifery program. Current active certification by the

American Midwifery Certification Board (AMCB), or be actively seeking initial certification and obtain the same on the first examination for which eligible is required for initial applicants. Certification is also required for reapplicants.

2.2.18 A nurse practitioner (NP) must have completed a masters, post-masters, or doctorate degree in a nurse practitioner program accredited by the Commission on Collegiate of Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN). Current certification by the American Nurses Credentialing Center (ANCC), the American Association of Critical Care Nurses (AACN), or other applicable accepted certifying body. Certification is also required for reapplicants.

2.2.19 A physician assistant (PA) must have completed an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) approved program (prior to January 2001 – Commission on Accreditation of Allied Health Education Programs). Current certification by the National Commission on Certification of Physician Assistants (NCCPA) as a PA-C is required for initial applicants and reapplicants.

2.3 In Addition to Privilege-Specific Criteria, the Following Qualifications Must Also be Met and Maintained by All Applicants Requesting Clinical Privileges:

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

2.3.2 Possess a current and valid drug enforcement administration (DEA) number if applicable. The DEA or Indiana Controlled Substance Registration (CSR) must be unrestricted for initial appointment, when applicable per area of practice (i.e., Pathology, etc.);

2.3.3 Possess a valid NPI number, as applicable;

2.2.4 Upon request provide evidence of both physical and mental health that does not impair the fulfillment of his/her responsibilities of Medical Staff membership and/or the specific privileges requested by and granted to the applicant. This certification of physical and mental health must be from a practitioner acceptable to the Credentials Committee;

2.2.5 Any practitioner granted privileges who may have occasion to admit an inpatient must be located (office and residence) close enough to SJHS to fulfill their Medical Staff responsibilities and demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Board; (Emergency Medicine physicians are exempt from this requirement);

2.2.6 Demonstrate recent clinical performance within the last twenty-four (24) months with an active clinical practice in the area in which independent clinical privileges are sought adequate to meet current clinical competence criteria;

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

2.2.8 Provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board.

2.2.9 Agree to fulfill all responsibilities regarding emergency call;

2.2.10 Have or agree to make acceptable coverage arrangements with other members of the Medical Staff for those times when the individual will be unavailable.

2.4 Exceptions/Waivers

2.4.1 All practitioners who are current Medical Staff members and/or hold privileges as of January 1, 2007 and who have met prior qualifications for membership and/or privileges shall be exempt from these board certification requirements.

2.4.2 Only the Board may create additional exceptions in extenuating circumstances, but only after consultation with the MEC, and if there is documented evidence that a practitioner demonstrates an equivalent competence in the areas of the requested privileges.

2.4.3 The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, MEC, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of SJHS and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

2.4.4 No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.

2.4.5 A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that an individual is ineligible to request appointment or privileges. A determination of ineligibility is not a matter that is reportable to either the State of Indiana or the National Practitioner Data Bank.

2.5 Factors for Evaluation

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

(a) Relevant training, experience, demonstrated current clinical competence, and judgment;

(b) Adherence to the ethics of their profession;

(c) Good reputation and character;

(d) Ability to perform, safely and competently, the clinical privileges requested;

(e) Ability to utilize medical resources efficiently; and

(f) Ability to work harmoniously with others sufficiently to convince SJHS that all patients treated by them will receive quality care and that SJHS and its Medical staff will be able to operate in an orderly manner.

2.6 General Conditions of Appointment and Reappointment

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

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

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

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

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

(e) To immediately submit to a blood and/or urine test, or to a complete physical and/or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and one member of the Administrative Team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leaders;

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

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

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

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

(j) To seek consultation whenever necessary;

(k) To participate in monitoring and evaluation activities;

(l) To complete in a timely manner all medical and other required records, containing all information required by SJHS;

(m) To participate in an Organized Health Care Arrangement with SJHS, to abide by the terms of SJHS's Notice of Privacy Practices with respect to health care organized at SJHS, and to provide patients with a Notice of Organized Health Care Arrangement as a supplement to their own Notice of Privacy Practices;

(n) To perform all services and conduct himself/herself at all times in a cooperative and professional manner;

(o) To promptly pay any applicable dues, assessments, and/or fines;

(p) To satisfy continuing medical educational requirements; and

(q) That if there is any misstatement in, or omission from, the application, SJHS may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal.

Section 3. Initial Appointment Procedure

3.1 Completion of Application

3.1.1 All requests for applications for appointment to the Medical Staff and requests for clinical privileges will be forwarded to the Medical Staff office. Upon receipt of the request, the Medical Staff office will provide the applicant an application package on forms approved by the Board, upon recommendation by the MEC and Credentials Committee, which will include a complete set or overview of the Medical Staff bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for Medical Staff membership and/or privileges and a list of expectations of performance for individuals granted Medical Staff membership or privileges (if such expectations have been adopted by the Medical Staff).

3.1.2 Applications may be provided to Residents and Fellows who are in the final 6 months of their training and processed in accordance with this Manual. The Board may determine to appoint and grant privileges to qualified applicants, which shall become effective when SJHS receives confirmation of the successful completion of training.

3.1.3 A completed application includes, at a minimum:

(a) A completed, signed, dated application form;

(b) A completed privilege delineation form if requesting privileges including the individual's professional qualifications to justify the privileges;

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

(d) All applicable fees;

(e) Receipt of all references; references shall be selected by the Credentials Committee and come from peers knowledgeable about the applicant's experience, ability, and current competence to perform the privileges being requested. At least one reference must be from someone in the same professional discipline;

(f) Relevant practitioner-specific data as compared to aggregate data, when available; and

(g) Morbidity and mortality data, when available.

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

3.1.4 The burden is on the applicant to provide all required information. It is the applicant's

responsibility to ensure that the Medical Staff office receives all required supporting documents verifying information from primary sources on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for Medical Staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, notification requesting such information will be sent to the applicant. If the requested information is not returned to the Medical Staff office within forty-five (45) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

3.1.5 Upon receipt of a completed application the CMO or credentials chair, in collaboration with the Medical Staff office, will determine if the requirements of sections 2.2 and 2.3 are met. In the event the requirements of sections 2.2 and 2.3 are not met, the potential applicant will be notified that s/he is ineligible to apply for membership or privileges on the Medical Staff, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of sections 2.2 and 2.3 are met, the application will be accepted for further processing.

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

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

(a) Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments, (if any), the substance of the allegations as well as the findings and the ultimate disposition, and any additional information concerning such proceedings or actions as the Credentials Committee, the MEC, or the Board may request during the past ten (10) years;

(b) Verification of the applicant's past clinical work experience for at least the past ten (10) years with the exception that ten (10) affiliations over the past five (5) years will be checked for telemedicine and locum tenens practitioners;

(c) Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the Medical Staff office will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;

(d) Whether DEA registration, or any state's controlled substance license and has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(e) Information from the AMA or AOA Physician Profile, OIG list of Excluded Individuals/Entities or SAM (System for Award Management), and FSMB (Federation of State Medical Boards) for applicants with out-of-state experience;

(f) Information from professional training programs including residency and fellowship programs;

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

(h) Other information about adverse credentialing and privileging decisions;

(i) Three (3) peer recommendations, as selected by the organization, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges;

(j) Information from a ten (10) year criminal background check for initial application only;

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

(l) Morbidity and mortality data and relevant practitioner-specific data (OPPE data) as compared to aggregate data, when available;

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

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

(o) Individuals who apply to exercise clinical privileges after the age of 72 must obtain appropriate health assessments. Individuals will be required to have a physical and mental health assessment performed by a physician who is acceptable both to the Credentials Committee and the applicant. The cost of the health assessment shall be borne by the applicant. The examining physician shall provide a written report addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff membership, or work cooperatively in a hospital setting. The examining physician shall provide this report directly to the Committee and shall be available to discuss any questions or concerns that the Committee may have.

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

3.2 Applicant's Attestation, Authorization, and Acknowledgement

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

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

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

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

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

(a) Professional qualifications and competence to carry out the clinical privileges requested;

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

(c) Professional and ethical qualifications;

(d) Professional liability actions including currently pending claims involving the applicant; and

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

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

3.2.7 Authorizes the hospital Medical Staff and administrative representatives to release any and all credentialing and peer review information to other hospitals, licensing boards, appropriate government bodies and other health care entities or to engage in any valid discussion relating to the past and present evaluation of the applicant's training, experience, character, conduct,

judgment, or other matters relevant to the determination of the applicant's overall qualifications upon appropriately signed release of information document(s). Acknowledges and consents to agree to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits, or challenges against any Medical Staff or hospital representative regarding the release of any requested information and further, that all such representatives shall have the full benefit of this release and absolute waiver as well as any legal protections afforded under the law.

3.2.8 The individual specifically authorizes the SJHS facilities (SJHS – Mishawaka and SJHS – Plymouth) to share credentialing and peer review information pertaining to the individual's clinical competence and/or professional conduct. This information may be shared at initial appointment or reappointment and at any other time during the individual's appointment.

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

3.2.10 Agrees to provide accurate answers to the questions on the application, and agrees to immediately, within twenty-four (24) hours, notify the hospital in writing should any of the information regarding these items change during processing of this application or the period of the applicant's Medical Staff membership or privileges. If the applicant answers any of the following questions affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

3.2.11 The individual agrees that the hearing and appeals procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by SJHS. If, notwithstanding the provisions in this Article, an individual institutes legal action and does not prevail, he or she shall reimburse SJHS and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

3.3 Initial/Preliminary Review of Application:

3.3.1 A completed application form with copies of all required documents must be returned to the Medical Staff Office within 30 days after receipt. The application must be accompanied by the registration fee.

3.3.2 As a preliminary step, the application will be reviewed by the Medical Staff Office and the CMO (if necessary) to determine that all questions have been answered and that the individual satisfies all threshold criteria. Incomplete applications will not be processed. Individuals who fail to return completed applications or fail to meet the threshold criteria will be notified by the CMO that their application will not be processed.

3.3.3 The Medical Staff Office shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received.

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

others.

3.4 Application Evaluation

3.4.1 Credentialing Process:

All applications must be reviewed and acted on by the Department Chair, Credentials Committee, MEC, and the Board. The Credentials Committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that s/he meets the criteria for membership on the Medical Staff and for the granting of requested privileges. Criteria to be reviewed for all applications include, but are not necessarily limited to the following:

(a) The completeness of the application;

(b) The final recommendation of the MEC is adverse or with limitation;

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

(d) Applicant is, or has been, under investigation by a state medical board, state-controlled substance registration authority, DEA or has prior disciplinary actions or legal sanctions;

(e) Applicant has had two (2) or more or an unusual pattern of malpractice cases filed within the past five (5) years or one final adverse judgment or settlement in a professional liability action in excess of $250,000 within the past five (5) years;

(f) Applicant changed medical schools or residency programs or has unexplained gaps in training or practice twenty-eight (28) days or greater;

(g) Applicant has changed practice affiliations three or more times in the past ten (10) years, excluding telemedicine and locum tenens practitioners and those serving in the military;

(h) Applicant has one or more reference responses that raise concerns or questions;

(i) Substantive discrepancy is found between information received from the applicant and references or verified information;

(j) Applicant has an adverse National Practitioner Data Bank report unrelated to professional liability actions;

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

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

(m) Applicant has potentially relevant physical, mental, and/or emotional health problems;

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

3.4.2 Applicant Interview

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

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

3.4.3 Department Chair Action

(a) All completed applications are presented to the Department Chair for review and recommendation. The Department Chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Department Chair may obtain input if necessary, from an appropriate subject matter expert. If a Department Chair believes a conflict of interest exists that might preclude his/her ability to make an unbiased recommendation s/he will notify the credentials chair and forward the application without comment.

(b) The Department Chair forwards to the Medical Staff Credentials Committee the following:

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

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

iii. Comments to support these recommendations.

3.4.4 Medical Staff Credentials Committee Action

The Medical Staff Credentials Committee reviews the application and forwards the following to the MEC:

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

(b) A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges. These circumstances may relate to behavior (e.g. code of conduct) or to clinical issues (e.g. general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

(c) Comments to support these recommendations.

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

(e) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee shall review the applicant's "Confirmation of Ability to Perform Privileges Requested" form to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to both the Credentials Committee and the applicant. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered voluntary withdrawal of the application and all processing of the application shall cease.

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

3.4.5 MEC Action

The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

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

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

(c) Coments to support these recommendations.

(d) If in disagreement with the recommendation of the Credentials Committee, the MEC shall refer the matter back to the Credentials Committee (and/or its chair) for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

(e) State its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's (and/or its chair's) recommendation.

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

(a) The President shall then hold the application until after the applicant has completed or waived a hearing and appeal.

(b) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board through the President of the Medical Staff.

3.4.6 Board Action:

The Board reviews the application and votes for one of the following actions:

(a) The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the Credentials Committee or the MEC or to another source inside or outside of SJHS for additional research or information, for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made.

(b) If the Board concurs with the applicant's request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months;

(c) If the Board's action is adverse to the applicant, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, a special notice, stating the reason, will be sent to the applicant by the President, who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan); or

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

3.4.7 Notice of Final Decision: Notice of the Board's final decision to grant, deny, revise, or revoke appointment and/or clinical privileges shall be given, through the CEO and Hospital President to the MEC and to the Chair of each Department concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the Department to which s/he is assigned, the clinical privileges s/he may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

3.4.8 **Time Periods for Processing:** All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days. A recommendation shall be made to the MEC within sixty (60) days of a complete application.

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

Section 4. Reappointment

4.1 Criteria for Reappointment

4.1.1 It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in Section 19. The MEC must also determine that the practitioner provides effective care that is consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program. The practitioner must provide the information enumerated in Section (21.2) below. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing Medical Staff members or other practitioners with privileges will follow the steps described in Section 22 below concerning the initial granting of new clinical privileges and Section 23.1 below concerning focused professional practice evaluation. A suitable peer shall substitute for the Department Chair in the evaluation of current competency of the Department Chair, and recommend appropriate action to the Credentials Committee.

4.1.2 To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term: completed all medical records and be current at the time of reappointment; completed all continuing medical education requirements; satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments; continued to meet all qualifications and criteria for appointment and the clinical privileges requested; had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at SJHS must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization) before the application will be considered complete and processed further; and paid the reappointment processing fee.

4.2 Information Collection and Verification

4.2.1 From appointee: On or before four (4) months prior to the date of expiration of a Medical Staff appointment or grant of privileges, a representative from the Medical Staff office notifies the practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least forty-five (45) calendar days after release of the reapplication, the practitioner must return the following to the Medical Staff office:

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

(b) Information concerning continuing training and education internal and external to the hospital during the preceding period; and

(c) By signing the reapplication form the appointee agrees to the same terms as identified in Section 3.1 The Active and Voting Category

4.2.2 From internal and/or external sources: The Medical Staff office collects and verifies information regarding each practitioner's professional and collegial activities.

4.2.3 The following information is also collected and verified:

(a) A summary of clinical activity at this hospital for each practitioner due for reappointment;

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

(c) Attestation of any required hours of continuing medical education activity;

(d) Service on Medical Staff, Department, and hospital committees and participation in emergency call responsibilities (where applicable);

(e) Timely and accurate completion of medical records;

(f) Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and Medical Staff;

(g) Any significant gaps in employment or practice since the previous appointment or reappointment twenty-eight (28) days or greater;

(h) Verification of current licensure;

(i) Verification of identity may be requested by comparing a current picture ID card issued by a state or federal agency (e.g. driver's license or passport) or current picture hospital ID card and comparing it to the applicant;

(j) National Practitioner Data Bank query, information from the OIG List of Excluded Individuals/Entities or SAM (System for Award Management) and FSMB (Federation of State Medical Boards);

(k) When sufficient peer review data is not available to evaluate competency, one or more peer recommendations, as selected by the Credentials Committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges;

(l) Malpractice history for the past three (3) years, which is primary source verified by the Medical Staff office with the practitioner's malpractice carrier(s). This information shall include: current professional liability coverage, information regarding past and pending claims, final judgments, or settlements, the substance of the allegations as well as the findings of the ultimate disposition and any additional information concerning such proceedings or actions as the Credentials Committee, the MEC, or the Board may request; and

(m) Whether the applicant's Medical Staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended,

subjected to probationary or other conditions, or otherwise limited at any other hospital or health care facility, or are currently being investigated or challenged;

(n) Whether the applicant's license to practice in any state, DEA registration, or any state controlled substances registration has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished, or is currently being investigated or challenged;

(o) Appropriate resolution, or acceptable plan for currently unresolved complaints in place, of any verified complaints received from patients and/or staff;

(p) Use of SJHS's facilities for patients, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (other practitioners shall not be identified); and

(q) Other reasonable indicators of continuing qualifications.

4.2.4 Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment may result in automatic expiration of appointment when the appointment period is concluded if the application cannot be processed within the shortened timeframe. Once the information is received, the Medical Staff office verifies this additional information and notifies the practitioner of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

4.2.5 Failure to return a completed application within this time frame may result in the assessment of a reappointment processing fee.

4.2.6 The application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment and for the clinical privileges requested.

4.2.7 The Medical Staff Office shall oversee the process of gathering and verifying relevant information. The Medical Staff Office shall also be responsible for confirming that all relevant information has been received.

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

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

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

4.3.2 If it becomes apparent to the Credentials Committee or the MEC that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the chair of the committee may notify the individual of the general tenor of the

possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain, or refute it. This meeting is not a hearing, and none of the procedures for hearings shall apply. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

4.4. Time Periods for Processing

Once an application is deemed complete and verified, it is expected to be processed within 180 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

Section 5. Clinical Privileges

5.1 Exercise of Privileges

A practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board or temporary, emergency or disaster privileges as described herein. Appointment or reappointment shall not confer any clinical privileges or right to practice at SJHS. `Privileges may be granted by the Board, upon recommendation of the MEC to practitioners who are not members of the Medical Staff. Such individuals may be clinical psychologists, APPs, AHPs, physicians serving short locum tenens positions, telemedicine physicians, house staff such as residents and fellows moonlighting in the hospital, or others deemed appropriate by the MEC and Board.

5.2 Requests

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

5.3 Basis for Privileges Determination

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

5.3.2 The granting of clinical privileges includes responsibility for emergency service call established to fulfill SJHS's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.

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

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

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

5.3.6 Additional considerations will include: provision of documentation of adequate professional liability insurance coverage for the clinical privileges requested; the presence of any

previously successful or currently pending challenges to any licensure or registration, or voluntary or involuntary relinquishment of such licensure or registration; any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical appointment at another hospital; and practitioner-specific quality and resource utilization data compared to aggregate data, when available. The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.

5.3.7 Th report of the chairperson of the clinical department in which privileges are sought shall be forwarded to the Chair of the Credentials Committee and processed as part of the initial application for staff appointment.

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

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

5.4 Special Conditions for Dental Privileges

5.4.1 Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests.

5.4.2 Surgical procedures performed by hospital-trained dentists and maxillofacial surgeons shall be under the overall supervision of the Chairperson of Surgery or of Dentistry (as applicable).

5.4.3 Privileges for surgical procedures performed by dentists and/or oral and maxillofacial surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff with privileges to perform such an evaluation prior to surgery, which will be recorded in the medical record.

5.4.4 A designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

5.4.5 Oral and maxillofacial surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral and maxillofacial surgery and demonstrated current competence, as deemed qualified to do so by the Credentials Committee and MEC.

5.4.6 The hospital-trained dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Hospital-trained dentists and oral and maxillofacial surgeons may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with SJHS and Medical Staff Bylaws and this Manual.

5.5 Special Conditions for Podiatric Privileges

5.5.1 Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests.

5.5.2 Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson of Orthopedic Surgery (Mishawaka) or the Chairperson of Surgery (Plymouth).

5.5.3 All podiatric patients will receive a basic medical evaluation (history and physical) prior to surgery, by a physician member of the Medical Staff that will be recorded in the medical record.

5.5.4 A designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

5.5.5 Podiatrists may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in podiatric surgery and demonstrated current competence.

5.5.6 The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with SJHS and Medical Staff Bylaws and this Policy.

5.6 Special Conditions for Residents or Fellows in Training

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

5.6.2 The CMO or designee, (e.g. Program Director) must communicate periodically with the MEC and the Board about the performance of residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

5.7 Telemedicine Privileges

Telemedicine privileges are limited to those services the MEC, acting for the medical staff, has approved for telemedicine delivery. The Board has the ultimate determination of the clinical services that may be provided by telemedicine in consultation with the department chairpersons, the Credentials Committee, and the MEC.

Requests for telemedicine privileges at the Hospital that includes patient care, treatment, and

services will be reviewed by the MEC and will be processed through one of the following mechanisms:

(a) The Hospital fully privileges and credentials the practitioner if the telemedicine Hospital/entity is not Joint Commission accredited; **OR**

(b) The Hospital privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission-accredited Hospital or telemedicine entity and the information is then processed through the routine medical staff credentialing and privileging process. The distant-site practitioner must have a license that is issued or recognized by the State of Indiana; **OR**

(c) The hospital uses the credentialing and privileging decision from the distant site if all of the following requirements are met:

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

ii. The practitioner is privileged at the distant site for those services to be provided at this hospital and the practitioner has a license that is issued or recognized by the State of Indiana; and

iii. The hospital has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by the The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the hospital; **OR**

iv. The hospital may credential and grant privileges to the practitioner in accordance with the provisions of this Manual in the same manner as any other applicant.

v. The contractual arrangement that authorizes them to provide services at SJHS shall address quality review and assessment mechanisms that are designed to promote the provision of safe and competent services.

5.8 Temporary Privileges

5.8.1 The CEO and Hospital President, or designee (CMO/VPMA), acting on behalf of the Board and based on the recommendation of the President of the Medical Staff or designee, Chair of Credentials and Department Chair, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment, or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

5.8.2 Prior to temporary privileges being granted in this situation, the credentialing process must be complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested; compliance with privileges

criteria; and consideration of information from the Data Bank. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration, and that the individual has not been subject to involuntary termination of Medical Staff membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health facility.

5.8.3 Important Patient Care, Treatment, or Service Need: Temporary privileges may be granted on a case by case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days.

(a) Specifically, temporary privileges may be granted for situations such as the following: (I) the care of a specific patient; (ii) an individual serving as a locum tenens for a member of the Medical Staff; or (iii) when necessary to prevent a lack or lapse of services in a needed specialty area. When granting such privileges, the organized Medical Staff verifies current licensure and current competence.

(b) Temporary privileges shall expire at the end of the time period for which they are granted.

5.8.4 Clean Application Awaiting Approval.

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

5.8.6 Prior to granting of temporary privileges, the Credentials Chair or the CMO shall review the applicant's "Confirmation of Ability to Perform Privileges Requested" (Health Statement) form and if no concerns are raised, 120 days temporary privileges are granted.

5.8.7 Termination of temporary privileges: The granting of temporary privileges is a courtesy and may be terminated for any reason. The CEO and Hospital President, acting on behalf of the Board and after consultation with the President of the Medical Staff, the Chair of the Credentials Committee, or the department chairperson may terminate temporary admitting privileges. Clinical privileges shall be terminated when the individual's inpatients are discharged. A termination notice with explanation will be sent to the individual by certified mail.

5.8.8 The CEO and Hospital President, acting on behalf of the Board and after consultation with the President of the Medical Staff, the Chair of the Credentials Committee, or the department chairperson, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose a summary suspension under the Medical Staff bylaws may effect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the President of the Medical Staff or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner. A termination notice with explanation will be sent to the individual by certified mail.

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

5.9 Emergency Privileges:

5.9.1 In the case of a medical emergency, any practitioner on the Medical Staff is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, regardless of Department affiliation, staff category, or level of privileges.

5.9.2 Similarly, in an emergency situation, any practitioner who is not currently appointed to the Medical Staff may administer treatment to the extent permitted by his or her license. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

5.9.3 When the emergency no longer exists, the patient shall be assigned by the department chairperson or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

5.10 Disaster Privileges:

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

(a) A current picture hospital ID card that clearly identifies professional designation;

(b) A current license to practice;

(c) Primary source verification of the license;

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

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

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

(g) Further information regarding the volunteering professionals will be gathered by the Medical Staff as soon as is reasonably possible.

5.10.2 The Medical Staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.

5.10.3 The Medical Staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

5.10.4 Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.

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

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

5.11 Clinical Privileges for Procedures New to SJHS

5.11.1 Requests for clinical privileges to perform either a significant procedure not currently performed at SJHS or a significant new technique to perform an existing procedure will not be processed until (1) a determination has been made that the procedure will be offered at SJHS, and (2) criteria to be eligible to request those clinical privileges have been established.

5.11.2 The Credentials Committee shall make a preliminary recommendation as to whether the new procedure should be offered, considering whether SJHS has the capabilities, including support services, to perform the new procedure.

5.11.3 If it is recommended that the new procedure be offered, the Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff and those outside SJHS (such as recognized source including the American Medical Association, ACGME and AOA training programs, and specialty societies and academies). The Credentials Committee shall then develop recommendations regarding (1) the minimum education, training, and experience to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendation to the Board for final action.

5.12 Clinical Privileges That Cross Specialty Lines

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

5.12.2 The Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff (e.g. department chairpersons, individuals with special interest and/or expertise) and those outside SJHS (e.g. other hospitals, residency training programs, specialty societies).

5.12.3 The Credentials Committee shall develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the clinical privilege in question, and (2) the extent of monitoring and supervision that should occur. These recommendations may or may not permit individuals from different specialties to request the privileges at issue. The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action

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5.13 Clinical Privileges After Age 72

5.13.1. Individuals who desire to exercise privileges after the age of 72 must obtain appropriate health assessments within three (3) months of turning 72 and annually thereafter.

5.13.2 These individuals will be required to have a physical and mental health assessment performed by a physician who is acceptable to both the Credentials Committee and the applicant. The cost of the health assessment shall be borne by the applicant. The examining physician shall provide a written report, addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff membership, and work cooperatively in a hospital setting. The examining physician shall provide the report directly to the Committee and shall be available to discuss any questions or concerns that the Committee may have.

Section 6. Clinical Competency Evaluation

6.1 Focused Professional Practice Evaluation (FPPE)

All initially requested privileges shall undergo a period of FPPE. The Credentials Committee, after receiving a recommendation from the Department Chair and with the approval of the MEC, will define the circumstances which require monitoring and evaluation of the clinical performance of each practitioner following his or her initial grant of clinical privileges at the hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The Credentials Committee will also establish the duration for such FPPE and triggers that indicate the need for performance monitoring.

6.2 Ongoing Professional Practice Evaluation (OPPE)

The Medical Staff will also engage in OPPE to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of practitioner's current clinical competency. In addition, each practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

6.3 Physician Re-Entry

A practitioner who has not provided acute inpatient care within the past two (2) years who requests clinical privileges at the hospital must arrange for a preceptorship, that is acceptable to the Credentials Committee and MEC, either with a current member in good standing of the Medical Staff who practices in the same specialty or with a training program or other equivalently competent physician practicing outside of the hospital. If a practitioner has not provided any clinical care within the past five (5) years as determined by the Indiana Board of Registration in Medicine or the MEC, s/he may be required to go through a formal re-entry process through an ACGME or AOA accredited residency program or other approved formal process to assess and confirm clinical competence. The practitioner must assume responsibility for any financial costs required to fulfill these requirements. A description of the preceptorship or training program, including details of monitoring and consultation must be written and submitted for approval to the Department Chair and/or Credentials Committee and MEC. At a minimum, the preceptorship or training program description must include the following:

(a) The scope and intensity of the required activities;

(b) The requirement for submission of a written report from the preceptor or training program prior to termination of the preceptorship period assessing, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records

documentation, ability to perform the privileges requested, and professional ethics and conduct.

Section 7. Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies

7.1 Reapplication After Adverse Credentials Decision

Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the Medical Staff or for clinical privileges.

7.2 Request for Modification of Appointment Status or Privileges

A practitioner, either in connection with reappointment or at any other time, may request modification of staff category, Department assignment, or clinical privileges by submitting a written request to the Medical Staff office. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment, which is outlined in Section 21 of this manual. A practitioner who determines that s/he no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that s/he has been granted shall send written notice, through the Medical Staff office, to the Credentials Committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file.

7.3 Resignation of Staff Appointment or Privileges

7.3.1 A practitioner who wishes to resign his/her staff appointment and/or clinical privileges must provide thirty (30) days' written notice to the appropriate Department Chair or President of the Medical Staff. The resignation shall specify the reason for the resignation and the effective date. Credentials Committee shall make a recommendation to the MEC concerning the request. The MEC may request a meeting with the member involved. The MEC shall make a recommendation to the Board. The Board shall make a final decision on the request.

7.3.2 The Board's decision shall be reported in writing by the to the member. If the Board permits the relinquishment of privileges, it shall specify the effective date of relinquishment. Failure of a member to request relinquishment of clinical privileges as set forth above shall result in the member being maintained on the call schedule without any change to his or her call responsibilities. Members who have voluntarily limited their practice to include less than core privileges typically associated with their specialty may be required to participate in a general on-call schedule and to maintain sufficient competence to fulfill this responsibility or arrange for appropriate coverage.

7.3.3 A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which s/he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

7.4 Exhaustion of Administrative Remedies

Every practitioner agrees that s/he will exhaust all the administrative remedies afforded in the

various sections of this manual, the Governance and the Investigation, Corrective Action, Hearing and Appeal Plan before initiating legal action against the hospital or its agents.

Section 8. Leave of Absence

8.1 Leave Request

A leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities longer than sixty (60) days and whether such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently.

8.1.1 In circumstances where a practitioner requires an urgent leave of absence due to physical or mental health reasons, the CMO (local or regional), or CEO and Hospital President if no CMO, in consultation with the President of the Medical Staff, may trigger an immediate medical leave of absence.

8.1.2 A practitioner who wishes to obtain a voluntary leave of absence must provide written notice preferably thirty (30) calendar days prior to the requested absence to the President of the Medical Staff stating the reasons for the leave and approximate period of time of the leave, which may not exceed one year except for military service or express permission by the Board.

8.1.3 Requests for leaves are approved by the President in SJHS following consultation with the CMO, the President of the Medical Staff, and the relevant department chairperson.

8.1.4 While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities. Leaves of absence are matters of courtesy, not of right. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

8.1.5 Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the President. Extensions will only be granted in extraordinary cases where the extension of a leave is in the best interest of the Medical Center.

8.1.6 The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

8.2 Termination of Leave

8.2.1 At least ten (10) calendar days prior to the termination of the leave for non-medical reasons, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the President of the Medical Staff. The practitioner must submit a written summary of relevant activities during the leave.

8.2.2 Requests for reinstatement shall then be reviewed by the relevant department chairperson, the Chair of the Credentials Committee, the President of the Medical staff, the CMO, and the President. If all of these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume practice at the Medical Center. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of these individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, the MEC, and the Board for review and recommendation.

8.2.3 At least thirty (30) calendar days prior to the termination of a leave for medical reasons, the practitioner must provide a report from his/her physician who has no conflict of interest, that answers any questions that the MEC may have as part of considering the request for reinstatement. The MEC can reinstate the practitioner's membership and/or privileges.

8.2.4 If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the practitioner must:

(a) apply for reappointment, or his/her appointment and/or clinical privileges shall lapse at the end of the appointment period, or

(b) the appointment and/or clinical privileges shall lapse at the end of the appointment period and the practitioner must reapply upon return.

(c) Failure to Request Reinstatement

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

Section 9. Practitioners Providing Contracted Service

9.1 Exclusivity policy

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

9.1.2 If any such exclusive contract would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member shall be given notice of the exclusive contract and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the effective date of the contract in question. At the meeting, the affected member shall be entitled to present any information relevant to the decision to enter into exclusive contract. That individual shall not be entitled to any other procedural rights with respect to the decision or the effect of the contract on his/her clinical privileges, notwithstanding any other provision of this Policy. The inability of a physician to exercise clinical privileges because of an exclusive contract is not a matter that requires a report to the state licensure board or the National Practitioner Data Bank.

9.2 Qualifications

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

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

9.4 Effect of Contract or Employment Expiration or Termination

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

9.5 In the event of any conflict between this Manual or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall override and take precedence.

Section 10. Medical Administrative Officers

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

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

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

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

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

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

Section 11. Amendments

11.1 All amendments to this Credentials Procedure Manual Section of the Bylaws must be approved by the MECs for each of the SJHS facilities (Saint Joseph Regional Medical Center, and Saint Joseph Regional Medical Center-Plymouth Campus, Inc.)

11.2 For an amendment to be adopted:

(d) Notice of all proposed amendments shall be provided to all voting Medical Staff members in each facility at least 14 days prior to the MEC meeting at which the amendment will be considered, and any member of the Medical Staff may submit written comments to the MEC; and

(e) The quorum for a regular or special MEC meeting at which the amendment will be considered must be at least two-thirds (2/3) of all voting members; and

(f) The amendment must receive a majority vote of all the MEC members present and voting at the meeting.

11.3 If there is any disagreement among or between the MECs for the two facilities concerning a proposed amendment, a joint meeting shall be called for the purpose of discussing and resolving the disagreement.

11.4 No amendment shall be effective unless and until it has been approved by the Board.

Section 12. Adoption

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

Recommended by the Medical Executive Committee:

(Mishawaka)	February 6, 2023
(Plymouth)	February 14, 2023

Adopted by the Medical Staff:

(Mishawaka)	February 6, 2023
(Plymouth)	February 6, 2023

Approved by the Board:

March 14, 2023

Part IV: Organization and Functions Manual

Table of Contents

Section 1. Organization and Functions of the Staff

1.1. Organization of the Medical Staff

The Medical Staff shall be organized as a departmentalized staff including the following departments:

1.1.1 Mishawaka Medical Center

(a) Anesthesiology
(b) Cardiovascular Services
(c) Dental
(d) Emergency
(e) Family Medicine
(f) Medical
(g) Obstetrics & Gynecology
(h) Ophthalmology
(i) Orthopedics
(j) Pathology
(k) Pediatrics
(l) Radiology
(m) Surgery

1.1.2 Plymouth Medical Center

(a) Anesthesiology
(b) Emergency Medicine
(c) Family Medicine
(d) Internal Medicine
(e) Obstetrics/Gynecology
(f) Pathology
(g) Pediatrics
(h) Radiation Oncology
(i) Radiology
(j) Surgery

1.1.3 A Department Chair shall head each Department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

1.2 Responsibilities for Medical Staff Functions

The organized Medical Staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The Medical Staff officers, Department Chair, hospital and Medical Staff committee chairs, are responsible for working collaboratively to accomplish required Medical Staff functions. This process may include periodic reports as appropriate to the appropriate Department or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory and accreditation

compliance and appropriate standards of medical care.

1.3 Description of Medical Staff Functions

1.3.1 The performance improvement functions are the way the Medical Staff works to improve the clinical and non-clinical processes that require the Medical Staff leadership or participation. These functions shall be performed by such committees, departments, Physician Advisors, and other individuals as may be designated by the MEC, in consultation with the President. When the performance of a process is dependent primarily on the activities of individuals with clinical privileges, the Medical Staff shall provide leadership for and participate in process management, assessment, and improvement.

1.3.2 The Medical Staff, acting as a whole or through committee, participates in or has oversight over the following activities:

1.3.3 Governance, direction, coordination, and action

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

(b) Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care at the hospital;

(c) Take reasonable steps to maintain professional and ethical conduct and initiate investigations, and pursue corrective action of practitioners with privileges when warranted;

(d) Make recommendations on medical, administrative, and hospital clinical and operational matters;

(e) Inform the Medical Staff of the accreditation and state licensure status of the hospital;

(f) Act on all matters of Medical Staff business, and fulfill any state and federal reporting requirements;

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

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

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

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

1.3.4 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

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

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

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

i. Medical assessment and treatment of patients
ii. Use of medications
iii. Use of blood and blood components
iv. Operative and other procedures
v. Education of patients and families
vi. Accurate, timely, and legible completion of patients' medical records to include the quality of medical histories and physical examinations
vii. Appropriateness of clinical practice patterns
viii. Significant departures from established pattern of clinical performance
ix. Use of developed criteria for autopsies
x. Sentinel event data
xi. Patient safety data
xii. Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient
xiii. Findings of the assessment process relevant to individual performance; and

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

1.3.5 Hospital Performance Improvement and Patient Safety Programs

(a) Understand the Medical Staff's and administration's approach to and methods of performance improvement;

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

(c) Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and

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

1.3.6 Credentials review (see Part III: Credentials Procedures Manual)

1.3.7 Information Management

(a) Review and evaluate medical records to determine that they:

i. Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and

ii. Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.

(b) Develop, review, enforce, and maintain surveillance over enforcement of Medical Staff and hospital policies and rules relating to medical records including completion, preparation, forms, and format and recommend methods of enforcement thereof and changes therein; and

(c) Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

1.3.8 Emergency Preparedness

Assist the hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the hospital.

1.3.9 Strategic Planning

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

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

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

1.3.10 Bylaws review

(a) Conduct periodic review of the Medical Staff bylaw, rules, regulations, and policies; and

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

1.3.11 Nominating

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

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

1.3.12 Infection Prevention and Control Oversight

(a) The Medical Staff oversees the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection;

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

i. Review of cumulative microbiology recurrence and sensitivity reports;
ii. Review of prevalence and incidence studies, as appropriate; and
iii. Collection of additional data as needed.

(c) Approve infection prevention and control actions based on evaluation of surveillance reports and other information;

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

(e) Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;

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

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

(h) Review all policies and procedures on infection prevention, surveillance, and control at least biennially.

1.3.13 Pharmacy and Therapeutics Functions

(a) Maintain a formulary of drugs approved for use by the hospital;

(b) Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;
(c) Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);

(d) Perform drug usage evaluation studies on selected topics;

(e) Perform medication usage evaluation studies as required by accreditation agencies;

(f) Perform practitioner analysis related to medication use;

(g) Approve policies and procedures related to accreditation standards: to include the review of nutrition policies and practices; including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the hospital;

(h) Develop and measure indicators for the following elements of the patient treatment functions:

i. Prescribing/ordering of medications;
ii. Preparing and dispensing of medications;
iii. Administrating medications; and
iv. Monitoring of the effects of medication.

(i) Analyze and profile data regarding the measurement of patient treatment functions by service and practitioner, where appropriate;

(j) Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;

(k) Serve as an advisory group to the hospital and Medical Staff pertaining to the choice of available medications; and

(l) Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

1.3.14 Practitioner Health

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

(b) Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment;

(c) Notify the Chief Medical Officer or the Medical Staff Office for presentation to the President of the Hospital or the Medical Staff President (or the Well-Being Committee) and the MEC whenever the impaired practitioner's actions could endanger patients per the Medical Staff Impaired or Dysfunctional Provider policy. The existence of the Centralized Well Being Committee does not alter the primary responsibility of the Department Chair for clinical performance within that chair's Department;

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

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

1.3.15 Utilization Management

(a) Study recommendations from Medical Staff members, quality assessment coordinators and others to identify problems in utilization and the review program;

(b) Monitor the effectiveness of the review program and perform retrospective review in cases identified through the utilization management process;

(c) Forward all unjustified cases in any review category to the appropriate Department or committee for review and action;

(d) Review case-mix financial data and any other internal/external statistical data;

(e) Upon review of any data, conduct further studies, perform education or refer the data to the Medical Staff Quality Committee for their review and action;

(f) Develop, with the aid of legal counsel, policies to guide the director of utilization management, Medical Staff, and administration in matters of privileged communication and legal release of information.

Section 2. Medical Staff Committees

2.1 General Language Governing Committees

2.1.1 The following shall be the standing committees of the Medical Staff: Medical Executive, Credentials, Bylaws, Peer Excellence Committees, Blood Transfusion Committee, Infection Prevention Committee, Medical Staff Professional Practice Council, and Centralized Well Being Committee. A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The President of the Medical Staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease to meet when they have accomplished their appointed purpose or on a date set by the President of the Medical Staff when establishing the committee. The President of the Medical Staff and the CEO and Hospital President, or their designees, are ex officio members of all standing and ad hoc committees.

2.1.2 Committee members may be removed from the committee by the President of the Medical Staff or by action of the MEC for failure to remain a member of the Medical Staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

2.1.3 Medical Staff members may be appointed to hospital committees. Actions taken by hospital committees that affect the practice of practitioners with privileges must have those actions approved by the MEC prior to going into effect.

2.2 MEC

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

2.3 Credentials Committee

Description of the Credentials Committee is in Part III: Credentials Procedures Manual; Section 1.

2.4 Peer Excellence Committees

2.4.1 CARDIOVASCULAR SERVICES PEER REVIEW COMMITTEE (Joint Committee)

2.4.1.1 Composition:

(a) The Cardiovascular Services Peer Review Committee shall consist of one member nominated from each group practice and up to two at-large members from the solo practitioners assigned to the Cardiovascular Services Department. The Vice President of Clinical Services, Director of Surgical Services, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(b) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(c) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

2.4.1.2 Duties:

(a) The Cardiovascular Peer Review Committee is a peer review committee of the medical staff and shall:

i. review professional performance including the assessment and improvement of the quality of care, treatment, and services provided.

ii. review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing procedures and, as a result of such review, make a report of its findings and recommendations to the appropriate Department Chair.

2.4.2 MEDICAL REVIEW COMMITTEE (Joint Committee)

2.4.2.1 Composition:

(a) The Medical Review Committee shall consist of at least four physicians appointed by the President of the Medical Staff, in consultation with the MEC. The Chief Medical Officer, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(b) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(c) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

2.4.2.2 Duties:

(a) The Medical Review Committee is a peer review committee of the medical staff and shall:

i. review professional performance including the assessment and improvement of the quality of care, treatment, and services provided.

ii. review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing

procedures and, as a result of such review, make a report of its findings and recommendations to the appropriate Department Chair.

2.4.3 MEDICAL STAFF PROFESSIONAL PRACTICE COUNCL (Joint Committee)

2.4.3.1 Composition:

(a) The Medical Staff Professional Practice Council shall consist of 8 members of the medical staff including the President of the Medical Staff. Consideration is to be given to physicians who are knowledgeable in the credentialing and quality improvement processes.

(b) The President of the Medical Staff, in consultation with the MEC, shall appoint the members and the chair of the Medical Staff Professional Practice Council. If the chair is not a member of the MEC, he/she may be requested to attend MEC meetings in order to report on activities.

(c) The President of the Medical Center, the Chief Nursing Officer and the Chief Medical Officer and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(d) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(e) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

2.4.3.2 Duties:

The Medical Staff Professional Practice Council shall:

(a) Be the identified committee that assures the Medical Executive Committee that all required peer review steps are effectively implemented, including multidisciplinary peer review.

(b) Ensure consistency across departments by providing oversight of the peer review program carried out by medical staff departments and committees

(c) Reward physicians who provide exemplary care

(d) Monitor initial and ongoing compliance with standards outlined in Medical Staff Bylaws, Rules and Regulations, policies and procedures and guidelines

(e) Ensure adherence to external and internal guidelines to practice management which would include utilization pattern and variances

(f) Implement interventions, as needed, to improve operations and in situations that pose a threat to health/welfare of our patients

(g) All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of Ind. Code Ann. '16-21-2-8, '16-39-6-3, ''34-30-15-1 et seq., '34-6-2-44, '34-6-2-64, '34-6-2-99, '34-6-2-104, and ''34-6-2-116 through 34-6-2-118, and/or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

2.4.4 OBSTETRICAL REVIEW COMMITTEE (Joint Committee)

2.4.4.1 Composition:

(a) The Obstetrical Review Committee shall consist of at least four physicians appointed by the President of the Medical Staff, in consultation with the MEC. The Chief Medical Officer, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(b) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(c) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

2.4.4.2 Duties:

(a) The Obstetrical Review Committee is a peer review committee of the medical staff and shall:

i. review professional performance including the assessment and improvement of the quality of care, treatment, and services provided.

ii. review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing procedures and, as a result of such review, make a report of its findings and recommendations to the appropriate Department Chair.

2.4.5 PEDIATRICS REVIEW COMMITTEE (Joint Committee)

2.4.5.1. Composition:

(a) The Pediatrics Review Committee shall consist of at least four physicians appointed by the President of the Medical Staff, in consultation with the MEC. The Chief Medical Officer, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(b) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(c) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

2.4.5.2 Duties:

(a) The Pediatrics Review Committee is a peer review committee of the medical staff and shall:

(b) review professional performance including the assessment and improvement of the quality of care, treatment, and services provided.

(c) review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing procedures and, as a result of such review, make a report of its findings and recommendations to the appropriate Department Chair.

2.4.6 SURGICAL REVIEW COMMITTEE (Joint Committee)

2.4.6.1 Composition:

(a) The Surgical Review Committee shall consist of at least four physicians appointed by the President of the Medical Staff, in consultation with the MEC. The Chief Medical Officer, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(b) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(c) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

2.4.6.2 Duties:

(a) The Surgical Review Committee is a peer review committee of the medical staff and shall:

i. review professional performance including the assessment and improvement of the quality of care, treatment, and services provided.

ii. review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing procedures and, as a result of such review, make a report of its findings and recommendations to the appropriate Department Chair.

2.4.7 Blood Transfusion Committee (Joint Committee)

2.4.7.1 Composition:

(a) The Blood Transfusion Committee shall consist of at least four physicians appointed by the President of the Medical Staff, in consultation with the MEC. The Chief Medical Officer, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, ex officio, without vote.

(b) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(c) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

2.4.7.2 Duties:

The Blood Transfusion Committee is a peer review committee of the medical staff and shall:

(a) review professional performance including the assessment and improvement of the quality of care, treatment, and services provided.

(b) review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing procedures and, as a result of such review, make a report of its findings and recommendations to the appropriate Department Chair.

(c) All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of Ind. Code Ann. '16 21-2-8, '16-39-6-3, "34-30-15-1 et seq., '34-6-2-44, '34-6-2-64, '34-6-2-99, '34-6-2-104, and "34-6-2-116 through 34-6-2-118, and/or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

2.5 INFECTION PREVENTION COMMITTEE (Joint Committee)

2.5.1 Composition:

(a) The Infection Prevention Committee shall consist of at least four physicians

(b) appointed by the President of the Medical Staff, in consultation with the MEC. The Chief Medical Officer, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(c) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(d) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

2.5.2 Duties:

The Infection Prevention Committee is a peer review committee of the medical staff and shall:

(a) review professional performance including the assessment and improvement of the quality of care, treatment, and services provided.

(b) review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing procedures and, as a result of such review, make a report of its findings and recommendations to the appropriate Department Chair.

2.6. Bylaws Committee (Propose Joint Committee)

2.6.1 Composition: The bylaws committee shall consist of at least 3 Members of the Active staff allowing for representation of both campuses, and one (1) representative from Administration, who shall be an ex-officio member.

2.6.2 Responsibilities**:** The committee shall be responsible for those functions described in section 1.3.8 above.

2.7. Centralized Well Being (Joint Committee)

2.7.1 Composition:

The Centralized Well Being Committee shall serve as the provider well being committee of this medical staff. The composition of the Centralized Well Being Committee is set forth in the Centralized Well Being Medical Staff Policy.

2.7.2 Duties:

The Well Being Committee shall:

(a) be the identified point within the Medical Center where early informal reports concerning suspected provider impairment can be delivered for consideration;

(b) seek, evaluate, and substantiate additional information to determine if significant impairment exists to determine if a provider is able to perform all of the essential functions of the job with or without a reasonable accommodation, or to determine if a provider poses a direct threat to the health or safety of himself/herself or others;

(c) select two or more individuals to be an adjunct to the Committee and act as an

intervention team for each impaired provider; the intervention team is to review the Committee's findings with the provider and provide assistance to enter into a treatment program;

(d) serve as the recovering provider's advocate and facilitate rehabilitation and re-entry into practice without humiliation or rejection; the Committee will select a person who is responsible to the Committee to monitor the recovering provider's progress after re-entry into practice whenever necessary;

(e) educate Medical Staff, Medical Center personnel, and families of provider's concerning provider impairment; and

(f) perform any and all other functions as may be set forth in the Impaired Provider Policy.

(g) All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of Ind. Code Ann. '16-21-2-8, '16-39-6-3, ''34-30-15-1 et seq., '34-6-2-44, '34-6-2-64, '34-6-2-99, '34-6-2-104, and ''34-6-2-116 through 34-6-2-118, and/or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

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

3.1 Confidentiality of Information

3.1.1 To the fullest extent permitted by law, the following shall be kept confidential:

(a) Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or Medical Staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;

(b) Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; and

(c) Contributions to teaching or clinical research; or

(d) Determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

3.1.2 This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

3.2 Immunity from Liability

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of the hospital or Medical Staff. No representative of this healthcare organization acting in good faith and without malice shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

3.3 Covered Activities

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

(a) Applications for appointment/affiliation, clinical privileges, or specified services;

(b) Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;

(c) Corrective or disciplinary actions;

(d) Hearings and appellate reviews;

(e) Quality assessment and performance improvement/peer review activities;

(f) Utilization review and improvement activities;

(g) Claims reviews;

(h) Risk management and liability prevention activities; and

(i) Other hospital, committee, Department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

3.4 Releases

When requested by the President of the Medical Staff or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

3.5 Conflict of Interest

A member of the Medical Staff requested to perform a Board designated Medical Staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the practitioner under review, his/her spouse, or his/her first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the practitioner involved as a direct competitor, partner, or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case by case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.

Section 4. Amendments

4.1 All amendments to this Organization and Functions Manual Section of the Bylaws must be approved by the MECs for each of the SJHS facilities (Saint Joseph Regional Medical Center, and Saint Joseph Regional Medical Center-Plymouth Campus, Inc.)

4.2 For an amendment to be adopted:

(j) Notice of all proposed amendments shall be provided to all voting Medical Staff members in each facility at least 14 days prior to the MEC meeting at which the amendment will be considered, and any member of the Medical Staff may submit written comments to the MEC; and

(k) The quorum for a regular or special MEC meeting at which the amendment will be considered must be at least two-thirds (2/3) of all voting members; and

(l) The amendment must receive a majority vote of all the MEC members present and voting at the meeting.

4.3 If there is any disagreement among or between the MECs for the two facilities concerning a proposed amendment, a joint meeting shall be called for the purpose of discussing and resolving the disagreement.

4.4 No amendment shall be effective unless and until it has been approved by the Board.

Section 5. Adoption

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

Recommended by the Medical Executive Committee:

(Mishawaka)	February 6, 2023
(Plymouth)	February 14, 2023

Adopted by the Medical Staff:

(Mishawaka)	February 6, 2023
(Plymouth)	February 6, 2023

Approved by the Board:

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