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

TIPTON HOSPITAL

MEDICAL STAFF BYLAWS

Approved -

MEDICAL STAFF
BYLAWS

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ARTICLE 1
GENERAL

1.A. DEFINITIONS

a. HOSPITAL means Indiana University Health Tipton Hospital.

b. BOARD OF DIRECTORS means the Board of Directors of Indiana University Health Tipton Hospital. The Board of Directors is the governing body of the Hospital.

c. PRESIDENT means the President of Indiana University Health Tipton Hospital, appointed by the Board of Directors to serve as the Chief Executive Officer of the Hospital.

d. MEDICAL STAFF or STAFF means those physicians both medical and osteopathic and dentists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

e. EXECUTIVE COMMITTEE (MEC) means the governing body of the Medical Staff.

f. MEMBER means, unless otherwise expressly limited, any physician or dentist holding a current, valid and unsuspended unlimited Indiana license to practice medicine or dentistry within the scope of the license who is a member of the Medical Staff.

g. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Medical Staff member to render specific services to patients.

h. MEDICAL STAFF YEAR means the calendar year.

i. MEDICAL STAFF PRESIDENT means the President of the Medical Staff elected by the Medical Staff.

j. In referring to the men and women members of the Medical Staff, the masculine gender is used and implies the feminine gender as well.

1.B. TIME LIMITS

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.C. DELEGATION OF FUNCTIONS

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

1.D. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be as recommended by the MEC and may vary by category.

(2) Dues shall be payable annually upon request in accordance with Hospital Policy.

ARTICLE 2
CATEGORIES OF THE MEDICAL STAFF

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of members who are involved in the minimum number of patient contacts (24) per appointment term.

2.A.2. Prerogatives:

Active Staff members:

(a) may vote in all general and special meetings of the Medical Staff, and committee meetings;

(b) may hold office, serve as Credentials Advisors, and serve on committees.

2.A.3. Responsibilities:

Active Staff members must:

(a) assume all the responsibilities of membership on the Active Medical Staff, including committee service, emergency call, care for unassigned patients and

evaluation of members during the provisional period.

(b) actively participate in the peer review and performance improvement process;

(c) accept consultations when requested;

(d) attend applicable meetings;

(e) pay application fees, dues and assessments; and

(f) perform assigned duties.

2.B. AFFILIATE STAFF

2.B.1. Qualifications:

(a) The Affiliate Staff shall consist of those members who desire to be associated with, but who do not intend to establish a practice at, this Hospital. 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 Hospital services for their patients by referral of patients to Active Staff members for admission and care.

(b) Individuals requesting appointment to the Affiliate Staff must submit an application as prescribed in the Credentials Policy.

2.B.2. Prerogatives and Responsibilities:

Affiliate Staff members:

(a) may visit their hospitalized patients and review their Hospital medical records but may not admit patients, attend patients, or exercise any clinical privileges. They may write orders or progress notes, and make notations in the medical record, in conjunction with the attending or consulting physician who has primary management of care of the patient in the Hospital;

(b) may attend educational activities of the Medical Staff and the Hospital;

(c) may not vote,serve as Credentials Advisor, hold office, or serve on Medical Staff committees;

(d) may use the Hospital's diagnostic facilities; and

(e) must pay application fees, dues and assessments.

2.C. ASSOCIATE STAFF

2.C.1. Qualifications:

The Associate Staff shall consist of practitioners of demonstrated competence qualified for staff appointment, who have an Active Staff appointment at another hospital, who:

(a) may be members of a group, which provides periodic coverage for a practitioner who is an Active Staff member in good standing at the Hospital; or

(b) are office/ambulatory-based practitioners who may have fewer than 24 patient contacts in a reappointment term.

Associate Staff members must provide evidence of clinical performance at their primary hospital, in such form as may be requested, at each reappointment time.

2.C.2. Prerogatives and Responsibilities:

(a) may attend educational activities of the Medical Staff and the Hospital; (b) may not vote, hold office, serve as a Credentials Advisor r serve on Medical Staff committees;

(c) may use the Hospital's diagnostic facilities; and

(d) must pay application fees, dues and assessments.

2.D. HONORARY STAFF

2.D.1. Qualifications:

The Honorary Staff shall consist of practitioners who are recognized for outstanding or noteworthy contributions to the medical sciences, or have a record of previous long- standing service to the Hospital, and have retired from the active practice of medicine.

2.D.2. Prerogatives and Responsibilities: Honorary Staff members may:

(a) not consult, admit or attend to patients;

(b) attend staff meetings when invited to do so (without vote); (c) be appointed to committees (with vote);

(d) not vote, hold office, be appointed to committees, serve as Credentials Advisor; and

(e) not pay application fees, dues or assessments.

2.E. ALLIED HEALTH STAFF

2.E.1. Qualifications:

The Allied Health Staff consists of allied health practitioners who satisfy the qualifications and conditions for appointment to the Allied Health Staff contained in the Credentials Policy. The Allied Health Staff also includes those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the Hospital (e.g., moonlighting residents). The Allied Health Staff is not a category of the Medical Staff, but is included in this Article for convenient reference. For ease of use, any reference in these Bylaws or associated policies to "members" shall include allied health practitioners unless specifically limited to members of the Medical Staff.

2.E.2. Prerogatives and Responsibilities: Allied Health Staff members:

(a) may attend applicable meetings (without vote);

(b) may not hold office or serve as a Credentials Advisoror as committee Chairmen;

(c) may serve on a committee, if requested (with vote);

(d) must cooperate in the peer review and performance improvement process; and

(e) must pay applicable fees, dues, and assessments.

2.F RESIDENT/FELLOW MOONLIGHTERS

A Resident/Fellow Moonlighter undertakes professional activities outside the scope of graduate medical education programs, either within the institution or at other health care institutions. Appointment as a Moonlighter is contingent upon the resident/fellow being a house staff member in an approved graduate medical education program and being a duly licensed physician in the State of Indiana. Moonlighters may be appointed to the Medical Staff if they meet the

requirements for Medical Staff membership, but may not be privileged in areas which are in the scope of their Residency or Fellowship.

ARTICLE 3 OFFICERS

3.A. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

(1) be appointed in good standing to the Active Staff;

(2) have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

(3) not be presently be serving as Medical Staff officers, Board members or department chairmen at any other hospital and shall not so serve during their terms of office;

(4) be willing to faithfully discharge the duties and responsibilities of the position;

(5) have experience in a leadership position, or other involvement in performance improvement functions;

(7) have demonstrated an ability to work well with others; and

(8) not have any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

3.B. DUTIES

3.B.1. President of the Medical Staff:

The President of Staff shall:

a) act in coordination and cooperation with Hospital management in matters of mutual concern involving the care of patients in the Hospital;

b) represent and communicate the views, policies and needs, and report on the activities of the Medical Staff to the CEO, Chief Medical Officer and the Board;

c) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MEC;

d) appoint all Medical Staff committee chairmen and committee members, in consultation with the MEC, and, except where otherwise indicated, designating the chairman of these committees;

e) chair the MEC (with vote, as necessary) and be a member of all other Medical Staff committees, *ex officio,* without vote;

f) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the Policies and Procedures of the Hospital;

g) recommend Medical Staff representatives to Hospital committees; and

h) perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy;

i) serve as spokesman for the Medical Staff in external professional and public relations;

j) perform such other functions as may be assigned by these Bylaws, the Medical Staff, or the Executive Committee;

k) serve on liaison committees with the Board of Directors and Hospital administration, as well as outside licensing or accreditation agencies; and

l) provide for the review of the clinical work performed in the Hospital and the functioning of the Medical Staff .

3.B.2. Vice President:

The Vice President shall:

(a) assume all duties of the President of the Medical Staff and act with full authority as President of the Medical Staff in his or her absence;

(b) serve on the MEC;

(c) assume all such additional duties as are assigned to him or her by the President of the Medical Staff or the MEC.

3.B.3. Immediate Past President of the Medical Staff:

The Immediate Past President of the Medical Staff shall:

(a) serve on the MEC;

(b) serve as an advisor to other Medical Staff leaders; and

(c) assume all duties assigned by the President of the Medical Staff or the MEC.

3.C. NOMINATIONS

The Medical Executive Committee shall appoint a Nominating Committee consisting of members of the Active Staff for all general and special elections. The Committee shall convene at least 45 days prior to the election and shall submit to the President of the Medical Staff the names of one or more qualified nominees for each office. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3A, in the judgment of the Nominating Committee, and be willing to serve.

The Executive Committee shall select its nominees from the list presented by the Nominating Committee and from any additional nominations that may be made from the floor. The names of the nominees selected by the Executive Committee shall be announced to the Medical Staff at least ten (10) days before the annual meeting.

At the Medical Staff annual meeting, additional nominations may be made from the floor for any office by any voting member of the Medical Staff, provided that the candidate has consented, in writing, in advance.

3.D. ELECTION

The President, and Vice President shall be elected at the annual meeting of the Medical Staff. Voting shall be by ballot. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly

between the two candidates receiving the highest number of votes. Only Active members in good standing and who are in attendance may vote.

3.E. TERM OF OFFICE

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following his election. Each officer shall serve in each office until the end of his term, or until a successor is elected and assumes office, unless he shall sooner resign, vacate the office or be removed. Medical Staff officers shall be eligible to succeed themselves.

3.F. REMOVAL

(1) Removal of an elected officer or a member of the MEC may be effectuated by a two-thirds vote of the MEC, or by the Board, or by a petition signed by at least one-third of the Active members of the Medical Staff for:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to perform the duties of the position held;

(c) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(d) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least ten days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC or the Board prior to a vote on removal.

3.G. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the Vice President, who shall serve until the end of the President's unexpired term. In the event there is a vacancy in another office, the MEC shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, in the discretion of the MEC.

ARTICLE 4

PHYSICIAN ADVISORS, PHYSICIAN DIRECTORS, AND CREDENTIALS ADVISORS

4A: Characteristics of Physician Adivsors:

A. Physician advisers shall be Active Medical Staff members and shall be appointed annually by the chief of staff.

B. They shall be knowledgeable and skilled by training and/or experience in the provision of services in the respective Hospital services to which they have been appointed.

4B: Functions

The physician advisers shall each:

A. Be responsible for assuring that a planned and systematic process for monitoring and evaluating the quality, safety, and appropriateness of Hospital services provided is implemented and shall participate in the problem-solving activities related to such evaluations;

B. Act as technical consultant and adviser to the Hospital administrative director of the Hospital services provided;

C. Be available for patient consultations; and

D. Serve as chairmen of the committees related to the Hospital services (if applicable).

4C: Characteristics of Physician Directors of Hospital Services

A. Physician directors shall be Active Staff members and shall have contractual arrangements with Hospital administration.

B. They shall be knowledgeable and skilled by training and experience in the provision of services in the respective Hospital services to which they have contracted.

4D: Functions

The physician directors shall each:

A. Be responsible for assuring that a planned and systematic process for monitoring and evaluating the quality, safety, and appropriateness of Hospital services provided is implemented and shall participate in the problem-solving activities related to such evaluations;

B. Act as a technical consultant and adviser to the Hospital administrative director of the Hospital services provided;

C. Be available for patient consultations;

D. Serve as chairmen of the committees related to the Hospital services (if applicable);

E. Establish, together with the Medical Staff and administration, the type and scope of services required to meet the need of patients and the Hospital;

F. Develop and implement policies and procedures that guide and support the provision of services in the department;

G. Recommend to the Medical Staff the criteria for clinical privileges in the department; and

H. Provide continuous surveillance of the professional performance of all individuals with clinical privileges in the department.

4E : CHARACTERISTICS: The characteristics of the Credentialing Advisors shall be:

A. Active members of the Medical Staff and be appointed by the Chief of Staff.

4F: FUNCTIONS: The functions of the Credentialing Advisors shall be:

A. To act as advisors to the Credentials Committee;

B. Responsible to review all initial applications and reappointments and clinical privileges; and

C. To make recommendations regarding appointments and reappointments and granting of clinical privileges to the Credentials Committee.

ARTICLE 5
MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. STANDING COMMITTEES

The Standing Committees of the Medical Staff shall consist of the following:

(a) The Executive Committee (MEC);

(b) The Patient Care Review Committee; (c) The Credentials Committee;

(d) The Pharmacy and Therapeutics Committee;

(e) Infection Control Committee.

(f) Cancer Committee

(g) The Radiation Safety Committee

5.B. MEC

5.B.1. Composition:

The MEC shall consist of the following:

(a) the President of the Medical Staff;

(b) the Vice President of the Medical Staff;

(c) the Chair of the Credentials Committee;

(d) the Chair of the Patient Care Review Committee;

(e) the immediate past President of the Medical Staff;

(f) the President of the Hospital, and CMO ex officio without vote;

5.B.2. Duties:

(a) The MEC is delegated the primary authority over activities related to the functions of the Medical Staff. The MEC is responsible for reviewing and making any necessary recommendations to the Board with regard to the following:

(1) the structure of the Medical Staff;

(2) the process used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical Staff appointment;

(4) a delineation of clinical privileges for each eligible individual;

(5) the participation of the Medical Staff in Hospital performance improvement activities;

(6) the process by which Medical Staff appointment may be terminated; (7) hearing procedures;

(8) the sources of clinical patient care services to be provided through contracts; (9) reports and recommendations from Medical Staff committees, and other groups as appropriate;

(10) quality indicators to promote uniformity regarding patient care services; (11) activities related to patient safety;

(12) the process of analyzing and improving patient satisfaction; (13) continuing medical education activities;

(14) performing any other functions as are assigned to it by these Bylaws, the Credentials Policy or other applicable policies.

(b) The MEC is empowered to act on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between MEC meetings).

5.B.3. Meetings

The MEC shall meet as often as necessary to fulfill its responsibilities and maintain a permanent record of its proceedings and actions. The presence of fifty percent (50%) of the members in good standing of the Executive Committee shall constitute a quorum at any regular or special meeting.

5.B.4. Performance Improvement Functions

(1) The MEC is actively involved in the measurement, assessment and improvement of the following:

(a) medical assessment and treatment of patients;

(b) use of information about adverse privileging decisions for any practitioner privileged through the Medical Staff process;

(c) medication usage;

(d) the use of blood and blood components;

(e) operative and other procedures;

(f) appropriateness of clinical practice patterns;

(g) significant departures from established patterns of clinical practice; (h) the use of developed criteria for autopsies;

(i) sentinel event data; (j) patient safety data;

(k) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures; and

(l) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in the Medical Staff Rules and Regulations.

(2) The Medical Staff participates in the following activities:

(a) education of patients and families;

(b) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(c) accurate, timely, and legible completion of patient's medical records;

(d) review of findings of the assessment process that are relevant to an individual's performance. The Medical Staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner's competence; and

(e) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.

5.B.5. Responsibilities as a Professional Standards Committee.

Acting as a Professional Standards Committee, the MEC shall:

(a) Receive and investigate complaints and allegations referred to it regarding unethical, unprofessional or incompetent medical practice involving Medical Staff Members; and

(b) Act as a liaison between impaired physicians and the Indiana State Medical Association-Physician Assistance Committee.

(c) The MEC's responsibilities as a Professional Standards Committee may be delegated to an ad hoc committee or to the Performance Assessment and Improvement Committee.

5.B.6. Responsibilities as a Bylaws Committee

Acting as a Bylaws Committee, the Executive Committee shall conduct a review at least every three (3) years of the Bylaws, Rules and Regulations, Credentials Manual, and Organization Manual of the Medical Staff and recommend changes as appropriate.

5.C. CREATION OF STANDING COMMITTEES

In accordance with the provisions in the Organization Manual, the MEC may, by resolution and upon approval of the Board and without amendment of 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 task force shall be performed by the MEC.

5.D. SPECIAL TASK FORCES

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

5.E. APPOINTMENT OF COMMITTEE CHAIRMEN AND MEMBERS

(1) All committee chairmen and members shall be appointed by the President of the Medical Staff, in consultation with the MEC.

(2) Committee chairmen and members shall be appointed for initial terms of one year, but may be reappointed for additional terms.

(3) The President of the Medical Staff and the CEO (or their respective designees) shall be members, *ex officio*, without vote, on all committees, unless otherwise stated.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

Regular meetings of the Medical Staff shall be held every other month at time and place to be provided for in the rules and regulations for the government of the Medical Staff. The annual meeting of the Medical Staff shall be at the November meeting.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MEC, the Board, or by a petition signed by not less than 25% of the Active Staff.

6.C. COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Organization Manual, each committee shall meet as often as necessary to fulfill its responsibilities, at times set by the presiding officer.

6.C.2. Special Meetings:

Special meetings of a committee, may be called at any time by the committee chairman, Medical Staff President the Executive Committee,or shall be called upon the written request of one-third (1/3) of the membership but no less than 2 members. The person(s) calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Committee within thirty (30) days of receipt of such request. No later than ten (10) days prior to the special meeting, notice stating the business for which the meeting is called shall be mailed or delivered to the members. No business shall be transacted at any special meeting other than that stated in the notice calling the meeting.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings committees in a reasonable time frame in advance of the meetings. All notices shall state the date, time, and place of the meetings.

(b) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meetings of committees, a quorum shall consist of the following number of Active members in good standing: fifty percent (50%) or not less than two members, unless the Medical Executive Committee adopts a policy requiring a different number with respect to specific or committees.

(b) The presence of a minimum of fifty percent (50%) of the members in good standing of the Active Staff at any regular or special meeting of the Medical Staff shall constitute a quorum.

(c) Recommendations and actions of the Medical Staff, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present.

(d) The voting members of the Medical Staff, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Chairman by the method designated in the notice.

(e) The Executive Committee shall have the authority to allow for voting by proxy at meetings of the Medical Staff, if voting by proxy is requested in writing by any Active Member of the Medical Staff not less than fifteen (15) days prior to the meeting. In such event, the Executive Committee shall notify the Medical Staff, not less than seven (7) days prior to the meeting, of the procedures for proxy voting, and provide an acceptable form of proxy for such purpose.

(f) The voting members of the Medical Staff, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Chairman by the method designated in the notice. A quorum for purposes of these votes shall be the number of responses returned to the Chairman by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

6.D.3. Agenda:

The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, or committee.

6.D.4. Rules of Order:

"Robert's Rules of Order" shall not be binding at Medical Staff meetings or elections, but may be used for reference in the discretion of the presiding officer for the meeting. Rather, specific provisions of these Bylaws, or committee

custom shall prevail at all meetings, and the Committee Chairman shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.

(b) A summary of all recommendations and actions of the Medical Staff, and committees shall be transmitted to the MEC, CEO, and Chief Medical Officer. The Board shall be kept apprised of the recommendations of the Medical Staff and its Sections and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

Members of the Medical Staff who have access to or are the subjects of 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, except as authorized by the Medical Staff Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

Each Active Staff member is expected to attend and participate in all Medical Staff meetings and applicable committee meetings each year.

ARTICLE 7
BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy.

7.A. QUALIFICATIONS FOR APPOINTMENT

Initial appointment and reappointment to the Medical Staff shall be made by the Board of Directors. All appointments shall be for a maximum of two years. Re-appointments shall occur at the end of biennial appointments. To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical 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 Credentials Policy.

7.B. PROCESS FOR APPOINTMENT, REAPPOINTMENT AND PRIVILEGING (CREDENTIALING)

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

7.C. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges will 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;

(iv) attend a special conference to discuss issues or concerns;

(b) is arrested, indicted, convicted, or pleads guilty or no contest pertaining to any felony, or is indicted, convicted or pleads guilty or no contest

pertaining to any misdemeanor involving

(i) controlled substances; (ii) illegal drugs;

(iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or

(iv) violence;

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

(d) in the case of an Advanced Dependent Practitioner, fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in the Credentials Policy or if the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated.

(2) Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

7.D. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the CEO, the President of the MedicalStaff, the CMO, the MEC, or the Board chairman is authorized to suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the CEO or MEC.

(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MEC will review the reasons for the suspension within a reasonable time.

(5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the MEC or an ad hoc committee of the MEC as designated by the President of the MedicalStaff.

7.E. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an investigation, the MEC may recommend suspension or revocation of appointment or clinical privileges based on concerns about

(a) clinical competence or practice;

(b) violation of ethical standards or the bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; or

(c) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

7.F. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members.

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

(4) A stenographic reporter will be present to make a record of the hearing.

(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 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 proposed findings, conclusions, and recommendations to the Hearing Panel.

(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.

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

(8) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel to the Board.

7.G. PROCESS AND INDICATIONS FOR DISASTER PRIVILEGES

In the case of some natural catastrophe, local or national emergency, or other emergency, any physician who is presently treating an emergency patient or has initiated therapy may continue such therapy upon arrival at the Hospital and continue to do so and be assisted to do everything possible to save the life of the patient using every facility of the Hospital necessary including the calling of any consultation necessary. Allowing such an applicant to render care to a patient shall not extend beyond the immediate need for such emergency care and shall give rise to no rights under these bylaws. When a disaster plan and the Hospital is not able to meet immediate patient needs, disaster clinical privileges may be granted to volunteers eligible to be licensed independent health care providers by the Chief of Staff and the Chief Executive Officer, acting as an agent of the Board. A modified credentialing and privileging process for eligible volunteer health care providers will be implemented.

Such volunteer health care providers shall provide evidence of a valid current professional license with the health care provider's license number and a valid government issued identification. Disaster clinical privileges will be granted to volunteer health care providers on a case-by-case basis in accordance with the needs of the Hospital and the patients, and on the qualifications of the volunteer health care providers. When the volunteer health care provider is not a member of Tipton Hospital's Medical Staff, the volunteer health care provider shall be assigned to a current Medical Staff member if the Tipton Hospital Medical Staff who is in the same specialty and act under the supervision of the Medical Staff member. Such clinical privileges shall immediately terminate once the disaster is over and may be terminated at any time without any reason or cause. A volunteer health care provider is not entitled to the procedural rights afforded by Article IX because a request for disaster clinical privileges is denied or terminated or otherwise limited.

ARTICLE 8
AMENDMENTS

8.A. MEDICAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by the Chief of Staff , or by the MEC.

(2) All proposed amendments must be reviewed by the MEC prior to a vote by the Medical Staff. The MEC shall provide notice of all proposed amendments, including amendments proposed by the voting members of the Medical Staff as set forth above, to the voting staff. The MEC may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose.

(3) The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(4) The MEC may also present any proposed amendments to the voting staff by written or electronic ballot, 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. To be adopted, an amendment must receive a majority of the votes cast

(5) The MEC shall have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

(6) All amendments shall be effective only after approval by the Board.

(7) If the Board has determined not to accept a recommendation submitted to it by the MEC or the 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 its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.

8.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations that are applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. 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.

(2) An amendment to the Credentials Policy may be made by a majority vote of the members of the Medical Staff, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the MEC. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the vote by the Medical Staff. Any voting member may submit written comments on the amendments to the MEC.

(3) An amendment to the Medical Staff Organization Manual or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Staff. Notice of all proposed amendments to these two documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the vote by the Medical Staff. Any voting member may submit written comments on the amendments to the MEC.

(4) The MEC and the Board shall have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally

adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have 14 days to review and provide comments on the provisional amendments to the MEC. If there is no conflict between the Medical Staff and the MEC, the provisional amendments shall stand. If there is conflict over the provisional amendments, then the process for resolving conflicts set forth below shall be implemented.

(5) All other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Staff. No prior notice is required.

(6) Amendments to Medical Staff policies and Rules and Regulations may also be proposed any member of the Medical Staff or by majority vote of a Committee. Such proposal shall be submitted in writing to the Executive Committee. If the proposal in its original form, or as modified by the MEC, is approved by the majority vote of the members of the Medical Staff present at a regular meeting, a quorum being present, the amendment shall become effective upon review and approval by the Board of Directors. Notice of any such proposed amendment to these documents shall be provided to each voting member of the Medical Staff 14 days in advance of forwarding the proposed recommendation to the Medical Staff.

(7) Adoption of and changes to the Credentials Policy, Medical Staff Organization Manual, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

8.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard 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 of the Medical Staff will be called. The agenda for that meeting will be limited to the

amendment(s) or policy at issue. The purpose of the meeting is to resolve the differences that exist with respect to Medical Staff Rules and Regulations or policies.

(2) If the differences cannot be resolved at the meeting, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the Board for final action.

(3) This conflict management section is limited to the matters noted 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.

ARTICLE 9
INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, credentials advisors, committee chairmen, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by law, in accordance with the Hospital's bylaws.

ARTICLE 10
ADOPTION

The organized medical staff adopts and amends medical staff Bylaws. Adoption or amendment cannot be delegated. The Medical Staff by action of the Executive Committee shall adopt such Bylaws as are necessary as set forth below for the conduct of its affairs. 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 Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff on: September 14, 2015

Dianna L. Andrews, MD
President of the Medical Staff Indiana University Health Tipton Hospital

Approved by the Board on: September 24, 2015

Michael Harlowe, MHA MS, FACHE
President and CEO Indiana University Health Tipton Hospital

Steven Wertz
Chairman, Board of Directors Indiana University Health Tipton Hospital

Appendix A

History and Physical

A complete history and physical examination must be completed within twenty-four (24) hours after admission or prior to a surgery or procedure by the attending physician or physician designee with oversight (physician assistant, nurse practitioner). A legible original or copy of a medical history and physical obtained in the physician/dentist's office completed within thirty (30) days prior to date of admission is acceptable if the patient's clinical status information is updated within twenty-four (24) hours after admission or prior to a surgery or procedure if occurring within the first twenty-four (24) hours.
In an emergency situation, the responsible physician/dentist must make a comprehensive entry regarding the condition of the patient prior to the start of the procedure. A complete history and physical examination is then to be recorded immediately following the emergency procedure.
A comprehensive history and physical examination report is to include the chief complaint, details of the present illness, all relevant past medical, social and family histories, inventory of body systems, current physical examination, allergies / medications / dosage / reactions, conclusions, and plan of action.

For further details, please reference IU Health Tipton Hospital Medical Staff Policy on Completion of Medical Records and IU Health Information Management Policy on Content of Medical Records.

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF INDIANA UNIVERSITY HEALTH TIPTON HOSPITAL

CREDENTIALS MANUAL

Approved – September 22, 2016

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ARTICLE 1
GENERAL

1.A. PREAMBLE

All Medical Staff members commit to working cooperatively and professionally with each other and Hospital employees and management to promote safe, appropriate patient care. Medical Staff leaders shall strive to address professional practice issues fairly, reasonably, and collegially in a manner that is consistent with quality care and patient safety.

1.B. ALLIED HEALTH PRACTITIONERS

(1) Any Allied Health Practitioner seeking permission to practice at the Hospital as a Licensed Independent Practitioner or an Advanced Dependent Practitioner shall be subject to the terms and conditions outlined in this Policy. (See Appendix C for approved categories of Allied Health Practitioners.)

(2) This Policy will not apply to Allied Health Practitioners who function as Dependent Practitioners. Whenever a question or concern is raised about the care or conduct of a Dependent Practitioner, MEC will have the discretion to determine the action, if any, needed to address and resolve such question or concern. If the question or concern about a Dependent Practitioner originates from the Medical Staff, a report shall be provided to the MEC upon resolution of the issue.

1.C. TIME LIMITS

Time limits referred to in this Policy and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated. Medical Staff leaders shall strive to be fair under the circumstances and to comply with the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C. Section 11101 et seq. ("HCQIA").

1.D. DELEGATION OF FUNCTIONS

Functions assigned to an identified individual or committee may be delegated to one or more designees.

1.E. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.E.1. Confidentiality:

All professional review activity and recommendations shall be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the Peer Review Committees, except:

(a) to another authorized individual and for the purpose of conducting professional review activity;

(b) as authorized by a policy; or

(c) as authorized, in writing, by the CEO or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions.

1.E.2. Peer Review Protection:

All professional review activity shall be performed by the peer review committees. Peer Review Committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(b) all sections;

(c) hearing and appellate review panels;

(d) the Board and its committees; and

(e) any individual acting for or on behalf of any such entity, Medical Staff leaders, and experts or consultants retained to assist in professional review activities.

All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law.

1.F. INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff leaders, peer review committees, members, and authorized representatives when engaged

in professional review activity, to the fullest extent permitted by law, in accordance with the Hospital's Bylaws.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment or clinical privileges, the applicant must, as applicable:

(a) have a current, unrestricted license to practice in this state and have never had a license to practice revoked, restricted or suspended by any state licensing agency;

(b) have a current, unrestricted DEA registration and state controlled substance license;

(c) be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital;

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital and the state of Indiana;

(e) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

(f) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(g) have never had Medical Staff appointment, permission to practice, or clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, or termination of employment with "do not rehire" status from IU Health;

(h) have never resigned Medical Staff appointment or permission to practice or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;

(i) have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

(j) demonstrate recent clinical activity in their primary area of practice during at least two of the last four years;

(k) if seeking to practice as an Advanced Dependent Practitioner, have a written agreement with a Supervising Physician, which agreement must meet all applicable requirements of state law and Hospital policy;

(l) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;

(m) be board certified in their primary area of practice at the Hospital. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training; and

(n) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification shall be assessed at reappointment.

The requirements in (l), (m) and (n) shall be applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy. Existing

members shall be governed by the residency training and board certification requirements in effect at the time of their initial appointment.

2.A.2. Waiver of Threshold Eligibility Criteria:

(a) Waivers of threshold eligibility criteria shall not be granted routinely. No one is entitled to a waiver. An application from an applicant who does not meet the threshold criteria for appointment, reappointment, or clinical privileges shall not be processed unless the Board has granted the requested waiver.

(b) A request for a waiver shall only be considered if the applicant provides information sufficient to demonstrate that his or her qualifications are equivalent to, or exceed, the criterion in question and that there are exceptional circumstances that warrant a waiver.

(c) The Credentials Committee may consider supporting documentation submitted by the applicant, any relevant information from third parties, input from the relevant Credentials Advisor, and the best interests of the Hospital and the communities it serves. The Credentials Committee shall forward its recommendation, including the basis for such, to the MEC.

(d) The MEC shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.

(e) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment shall be granted; only that processing of the application can begin.

2.A.3. Factors for Evaluation:

The following factors shall be evaluated as part of the appointment and reappointment processes:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;

(c) good reputation and character;

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

(e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

No one is entitled to receive an application or to be appointed or reappointed to the Medical Staff or Allied Health Staff or to be granted particular clinical privileges merely because he or she:

(a) is licensed to practice a profession in this or any other state;

(b) is a member of any particular professional organization;

(c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;

(d) resides in the geographic service area of the Hospital; or

(e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

Any decision not to tender an application to a physician or Allied Health practitioner will be made by the Credentials Committee.

2.A.5. Nondiscrimination:

No one shall be denied appointment on the basis of gender, race, creed, or national origin.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

(a) As a condition of Medical Staff or Allied Health Staff membership, every applicant and member specifically agree to the following, as applicable:

(1) to provide continuous and timely care;

(2) to abide by the bylaws, policies, and rules and regulations of the Hospital and Medical Staff and any revisions or amendments thereto;

(3) to participate in Medical Staff affairs through committee service and participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;

(4) to provide emergency call coverage, consultations, and care for unassigned patients;

(5) to comply with applicable clinical practice protocols and guidelines or document the clinical reasons for variance;

(6) to immediately submit to a blood, hair or urine test, or to a complete physical or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and the CEO or CMO) are concerned about his or her ability to safely and competently care for patients. The health care professional(s) to perform the testing or evaluations shall be determined by the Medical Staff leaders;

(7) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

(8) to use the Hospital sufficiently to allow continuing assessment of current competence;

(9) to seek consultation whenever necessary;

(10) to complete in a timely manner all medical and other required records;

(11) to perform all services and to act in a cooperative and professional manner;

(12) to promptly pay any applicable dues, assessments, or fines; and

(13) to satisfy continuing medical education requirements.

(14) Results of annual TB surveillance must be submitted with completed application for reappointment as condition to practice in the Hospital. TB tests are required for providers in Emergency Medicine and surgical specialites while TB questionnaires can be completed for all other providers.

(b) In addition to the above, every individual seeking to practice as an Advanced Dependent Practitioner and his or her respective Supervising Physician specifically agree that:

(1) any privileges granted by the Board to any Allied Health Practitioner who is an Advanced Dependent Practitioner will be performed in the Hospital only under the supervision of a Supervising Physician;

(2) the number of Advanced Dependent Practitioners employed by or under the supervision of a Member of the Medical Staff will be consistent with state law and the rules and regulations of the Medical Staff; and

(3) an Advanced Dependent Practitioner will give notice, within three business days, to the Medical Staff Office of any revisions or modifications that are made to the supervision agreement.

(c) Additional supervision requirements are set forth in Appendix A.

2.B.2. Burden of Providing Information:

(a) All applicants and members have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

(b) Applicants have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information. Any

application that continues to be incomplete 30 days after the applicant has been notified of the additional information required shall be deemed to be withdrawn.

(d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

(e) Notification of any change in status or any change in the information provided on the application form shall be given to the President of the Medical Staff or the CEO or their designee. This information shall be provided with or without request, at the time the change occurs. Failure to provide this information shall deem the applicant ineligible for staff membership or clinical privileges. Failure to provide this information as a member shall result in automatic relinquishment.

2.B.3. Provisional Period:

(a) Initial appointment to the Medical Staff (regardless of the staff category), Allied Health Staff, and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, shall be provisional.

(b) During the provisional period, the exercise of clinical privileges shall be evaluated by the Credentials Advisor or by a physician(s) designated by the Credentials Committee. This evaluation may include chart review, monitoring, proctoring, external review, and other information. The numbers and types of cases to be reviewed shall be determined by the Credentials Committee.

(c) The duration of the provisional period for initial appointment and privileges shall be recommended by the Credentials Committee. The duration of the provisional period for all other initial grants of privileges shall be as recommended by the Credentials Committee.

(d) During the provisional period, a member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed by the Credentials Advisor or by other designated physicians.

(e) A newly appointed member shall automatically relinquish his or her appointment and privileges at the end of the provisional period if he or she fails, during the provisional period, to:

(1) participate in the required number of cases or provide documentation of competence;

(2) cooperate with the monitoring and review conditions; or

(3) fulfill all requirements of appointment, including but not limited to those relating to completion of medical records or emergency call responsibilities.

In such case, the individual may not reapply for initial appointment or privileges for two years.

(f) If a member who has been granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases, or provide documentation of competence, or cooperate with the monitoring and review conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period. The member may not reapply for the privileges in question for two years.

(g) When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence or professional conduct, the member shall be entitled to a hearing and appeal.

2.C. APPLICATION

2.C.1. Information:

Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the applicant's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy. The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Misstatements and Omissions:

(a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant shall be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The President of the Medical Staff and CEO or their designee shall review the response and determine whether the application should be processed further.

(b) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished pursuant to Section 6.D.3.

(c) No action taken pursuant to this section shall entitle the applicant or member to a hearing or appeal.

2.C.3. Grant of Immunity and Authorization to Obtain/Release Information:

By applying for appointment, reappointment, or clinical privileges, the applicant accepts the following conditions throughout the term of appointment and thereafter as to any inquiries received about the applicant:

(a) Immunity:

To the fullest extent permitted by law, the applicant releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the applicant's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Medical Staff, the Hospital, its representatives, or third parties in the course of credentialing and peer review activities. The participant agrees not to sue any individuals for acts that are covered under the immunities set forth above.

(b) Authorization to Obtain Information from Third Parties:

The applicant authorizes the Hospital, Medical Staff leaders, and their representatives (1) to consult with any third party who may have information

bearing on the applicant's qualifications, and (2) to obtain any and all information from third parties that may be relevant. The applicant authorizes third parties to release this information to the Hospital and its representatives upon request. The applicant also agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The applicant also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives when information is requested in order to evaluate his or her qualifications.

(d) Hearing and Appeal Procedures:

The applicant agrees that the hearing and appeal procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) Legal Actions:

If an applicant institutes legal action challenging any professional review action and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

(f) Authorization to Share Information within the System:

The applicant specifically authorizes the Hospital and its affiliates to share information pertaining to the applicant's clinical competence or professional conduct.

(g) Scope of Section:

All of the provisions in this Section 2.C.3 are applicable in the following situations:

(1) whether or not appointment or clinical privileges are granted;

(2) throughout the term of any appointment or reappointment period and thereafter;

(3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

(4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff or Allied Health Staff about his/her tenure at the Hospital.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1. Application:

(a) Applications for appointment and clinical privileges shall be in writing and shall be on forms approved by the Board, upon recommendation by the MEC.

(b) Prospective applicants shall be sent a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form.

(c) Applications may be provided to residents who are in the final six months of their training. Final action shall not be taken until all applicable threshold eligibility criteria are satisfied.

(d) An Allied Health Practitioner who is in a category of practitioners that has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Practitioner to the procedural rights set forth in this Policy. Guidelines for determining the need for new categories of Allied Health Practitioners appear in Appendix B.

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 30 days after receipt.

(b) As a preliminary step, the application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.

(c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information deemed pertinent have been received.

(d) 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 chair 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.

(e) An interview(s) with the applicant may be conducted by one of or a combination of any of the following: the Credentials Advisor, the Credentials Committee, a Credentials Committee representative, the MEC, the President of the Medical Staff, CMO, or the CEO.

3.A.3. Credentials Advisors Procedure:

The Credentials Advisors for the area in which the applicant has requested clinical privileges (Surgery or Medicine) shall review the application and all supporting materials and prepare a report.

3.A.4. Credentials Committee Procedure:

(a) The Credentials Committee shall consider the report prepared by the Credentials Advisor and shall make a recommendation.

(b) The Credentials Committee may use the expertise of the Credentials Advisor, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee shall review the health status information 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 a physical or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee. Failure to undergo an examination within a reasonable time after a written request from the Credentials Committee shall be considered a voluntary withdrawal of the application.

(d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. 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 the applicant's compliance with any conditions.

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

3.A.5. MEC Recommendation:

(a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, the MEC shall:

(1) adopt the report and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration of specific questions; or

(3) state its reasons for disagreement with the report and recommendation of the Credentials Committee.

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

(c) If the recommendation of the MEC would entitle the applicant to request a hearing, the MEC shall forward its recommendation to the CEO, who shall promptly send special notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

(d) The Credentials Committee will recommend applicants and reapplicants to the MEC as "expedited" if the conditions specified in the Expedited Credentials policy are all applicable.

3.A.6. Board Action:

(a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the MEC

Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

(b) When there has been no delegation to the Board Committee, upon receipt of a recommendation for appointment and clinical privileges, the Board may:

(1) grant appointment and clinical privileges as recommended; or

(2) refer the matter back to the Credentials Committee or MEC or to another source inside or outside the Hospital for additional research or information; or

(3) disagree with or modify the recommendation.

(c) If the Board disagrees with a favorable recommendation, it should first discuss the matter with the chairman of the Credentials Committee and the chairman of the MEC. If the Board's determination remains unfavorable, the CEO shall promptly send special notice that the applicant is entitled to request a hearing.

(d) Any final decision by the Board to grant, deny, revise, or revoke appointment or clinical privileges is disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.7. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 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.

ARTICLE 4
CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment shall not confer any clinical privileges or right to practice at the Hospital. Only those clinical privileges granted by the Board may be exercised.

(b) A request for privileges shall be processed only when an applicant satisfies threshold eligibility criteria.

(c) Requests for clinical privileges that are subject to an exclusive contract shall not be processed except as consistent with the applicable contract.

(d) Recommendations for clinical privileges shall be based on consideration of the following:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;

(5) availability of coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Hospital's available resources and personnel;

(8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(10) practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions. The Credentials Committee will be made aware of any malpractice claims that a new applicant has had regardless of number, the only exceptions being claims for incidents which occurred while the applicant was a resident or claims that were dismissed with no payment.

(e) Requests for increased privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the application is complete, it shall be processed in the same manner as an application for initial clinical privileges.

4.A.2. Resignation of Privileges:

A request to resign all clinical privileges must (a) specify the desired date of resignation, at least 30 days from the date of the request, and (b) provide evidence that the individual has completed all medical records and shall be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the President

of the Medical Staff, the CEO or their designee shall act on the request. Resignations of Privileges shall be reviewed by the Credentials Committee as an informational item.

4.A.3. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform either a procedure not currently being performed or a new technique to perform an existing procedure ("new procedure") shall not be processed until a determination has been made that the procedure shall be offered by the Hospital and criteria for the privilege have been adopted.

(b) The individual seeking to perform the new procedure shall submit a report to the Credentials Committee addressing the following:

(1) minimum education, training, and experience necessary to perform the new procedure safely and competently;

(2) clinical indications for when the new procedure is appropriate;

(3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

(4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;

(5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and

(6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The Credentials Committee shall review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered to the community.

(c) If the preliminary recommendation is favorable, the Credentials Committee shall then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations.

(d) 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.

4.A.4. Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges that previously have been exercised only by members in another specialty shall not be processed until the steps outlined in this section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.

(b) The individual seeking the privilege shall submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals. The Credentials Committee shall then conduct additional research and consult with experts, as necessary.

(c) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations.

(d) 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.

4.A.5. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

(a) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

(b) A medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before dental surgery shall be performed, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(d) The 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. 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 the Hospital and Medical Staff Bylaws and this Policy.

4.A.6. Physicians in Training:

Physicians in training shall not be granted appointment to the Medical Staff or clinical privileges. The program director, clinical faculty, or attending staff member shall be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols approved by the MEC or its designee. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

4.A.7. Telemedicine Privileges:

(a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services. The Board shall determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Section chief or co-chiefs, the Credentials Committee and the MEC.

(b) Individuals applying for telemedicine privileges must meet the qualifications for Medical Staff appointment outlined in this Policy, except for those requirements relating to geographic residency, coverage arrangements, and emergency call responsibilities.

(c) Qualified applicants may be granted telemedicine privileges but not be appointed to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

(d) Applications for telemedicine privileges shall be processed in accordance with the provisions of this Policy in the same manner as for any other applicant, except

that the Hospital may use the credentialing information provided by the applicant's primary hospital if that hospital is a Medicare-participating hospital and provides: (1) a list of all privileges granted to the practitioner; (2) information indicating that the applicant has exercised such privileges in a competent manner; and (3) a signed attestation that the information is complete, accurate, and up-to-date.

(e) Telemedicine privileges, if granted, shall be for a period of not more than two years. Individuals seeking to renew telemedicine privileges shall be required to complete an application and, upon request, provide the Hospital with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant's primary practice affiliation and an evaluation form(s) from a qualified supervisor(s). If all requested information is not received by dates established by the Hospital, the individual's telemedicine privileges shall expire at the end of the current term. Once all information is received and verified, an application to renew telemedicine privileges shall be processed as set forth above.

(f) Individuals granted telemedicine privileges shall be subject to the Hospital's performance improvement, ongoing and focused professional practice evaluations and peer review activities.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Temporary Clinical Privileges:

(a) Temporary privileges may be granted by the CEO or their designee, upon recommendation of the President of the Medical Staff, to:

(1) applicants for initial appointment whose complete application is pending review by the Credentials Committee, MEC and Board, or following a favorable recommendation of the Credentials Committee or MEC. In order to be eligible for temporary privileges, an applicant must have demonstrated ability to perform the privileges requested and have had no (i) current or previously successful challenges to licensure or registration or (ii) involuntary restriction, reduction, denial or termination of Medical

Staff membership or clinical privileges at another health care facility, (iii) meet the requirements for expedited credentialing.

(2) non-applicants, when there is an important patient care, treatment, or service need, including the following:

(i) the care of a specific patient;

(ii) when necessary to prevent a lack of services in a needed specialty area;

(iii) proctoring; or

(iv) locum tenens for a member of the Medical Staff.

(b) The following verified information shall be considered prior to the granting of any temporary privileges: current licensure, relevant training, experience, current competence, current professional liability coverage acceptable to the Hospital and results of a query to the National Practitioner Data Bank.

(c) The grant of temporary clinical privileges shall be for 60 days and can be extended. However, they may not exceed 120 days. For non-applicants the days need not be consecutive and may be renewed.

(d) Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

4.B.2. Termination of Temporary Clinical Privileges:

(a) The granting of temporary privileges is a courtesy and may be terminated for any reason by the CEO at any time, after consulting with the President of the Medical Staff, the chairman of the Credentials Committee. The individual may be afforded an opportunity to refrain from exercising privileges.

(b) The President of the Medical Staff shall assign to another member of the Medical Staff responsibility for the care of patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

(c) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal.

4.C. EMERGENCY SITUATIONS

(1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a member may administer treatment to the extent permitted by his or her license, regardless of service status or specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient shall be assigned by the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

(1) Upon activation of IU Health Tipton Hospital's Emergency Operations Plan, any licensed independent practitioner not on the medical staff of IU Health Tipton Hospital and presenting themselves as volunteers to render their services during an emergency or disaster shall be eligible for disaster privileges.

(2) The eligible practitioners shall be directed to the Medical Staff office (or designated representatives) where they will need to present the following:

1. Valid government issued photo ID;
2. Current and valid Indiana state license/certificate to practice, or other state license/certificate to practice (if authorized by declaration of Indiana state emergency medical services system);
3. Identity of their current primary hospital affiliation;
4. Information with regard to their current malpractice carrier;
5. Social security number, date of birth, specialty training information, and all other necessary information required to conduct a National Practitioner Data Bank (NPDB) query and complete the Application for Emergency Credentialing form; and

6. Signed Emergency Privileges Form indicating their willingness to volunteer medical services and attesting to current clinical competence and unrestricted license to practice.
7. Information obtained from each of the practitioners shall be documented on an Application for Emergency Credentialing form.
8. If time and logistics permit, attempts will be made to verify immediately their licensure status and query the NPDB. Recognizing the credentials verification process as a high priority, all verifications shall be initiated as soon as possible (once the immediate situation is under control). Primary source verification of licensure will be completed within 72 hours from the time the volunteer practitioner presents to the organization. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible. Any adverse information will be brought to the immediate attention of the Chief of Staff and CEO.
9. Emergency Privileges Form shall be completed and include the signatures of the practitioner and the Chief of Staff or the CEO (or their designees).
10. The practitioner will be issued an identification badge and access card that denotes Emergency Privileges Provider. This badge and an access card must be worn at all times.
11. A folder shall be prepared for each individual practitioner to maintain credentials and other relevant information.
12. The Credentials Committee Chairman will review the credentials file for each practitioner within 72 hours of approval. He or she will call a full Credentials Committee meeting if necessary. A recommendation regarding the practitioner's Emergency Privileges will be presented to the Chief of Staff or the CEO (or their designees).

13. If at all possible, the volunteer shall be assigned to a current member of the IU Health Tipton Hospital Medical Staff who is in the same specialty. The volunteer is to act under the supervision of the Medical Staff member.

14. All disaster privileges shall immediately terminate once the emergency is over and may be terminated at any time without any reason or cause. Termination of these privileges will not give rise to a hearing or review.

15. A list of patients treated by the volunteer shall be maintained in the practitioner's file.4.E. CONTRACTS FOR SERVICES

(1) From time to time, the Hospital may enter into contracts with practitioners or groups of practitioners for the performance of clinical and administrative services. All individuals functioning pursuant to such contracts shall obtain and maintain clinical privileges, in accordance with the terms of this Policy. In addition, if any such individual is the subject of an adverse credentialing or peer review recommendation by the MEC based upon the individual's clinical competence or professional conduct, the individual shall be entitled to the procedural rights set forth in this Policy before the Board takes final action on the matter.

(2) To the extent that:

(a) any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, OR

(b) the Board adopts a resolution that limits the practitioners who may exercise privileges in any clinical specialty to employees of Indiana University Health or its affiliates,

no other practitioner except those authorized by the exclusive contract or Board resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only practitioners authorized by the exclusive contract or Board resolution are eligible to apply for the clinical privileges in question at the time of initial appointment, during the term of an appointment, or at reappointment. No other applications shall be processed.

(3) If any such exclusive contract or Board resolution would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the following notice and review procedures apply:

(a) The affected Medical Staff member shall be given at least 90 days advance notice of the exclusive contract or Board resolution and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the contract in question being signed by the Hospital or the Board resolution becoming effective.

(b) At the meeting, the affected Medical Staff member shall be entitled to present any information relevant to the Hospital's decision to enter into the exclusive contract or enact the Board resolution. If, following this meeting, the Board decides to enter into the exclusive contract or enact the Board resolution, the affected Medical Staff member shall be ineligible to continue to exercise the clinical privileges covered by the exclusive contract or resolution unless a waiver has been granted. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or resolution is in effect.

(c) The affected Medical Staff member shall not be entitled to any other procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 7 or any other provision of this Credentialing Policy or the Medical Staff Bylaws.

(d) The inability of a physician to exercise clinical privileges because of an exclusive contract or Board resolution is not a matter that requires a report to the Indiana licensure board or to the National Practitioner Data Bank.

(4) In the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. ELIGIBILITY FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment. In addition, to be eligible to apply for reappointment and renewal of clinical privileges, a member must have, as applicable:

(1) completed all medical records;

(2) completed all continuing medical education requirements;

(3) satisfied all Medical Staff or Allied Health Staff responsibilities, including payment of any dues, fines, and assessments;

(4) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;and

(6) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer), before the application shall be considered complete and processed further.

5.B. FACTORS FOR EVALUATION

In considering an application for reappointment, the factors listed in Section 2.A.3 of this Policy shall be considered, as shall the following additional factors relevant to the member's previous term:

(1) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;

(2) participation in Medical Staff duties, including committee assignments and emergency call;

(3) the results of the Hospital's performance improvement activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);

(4) any focused professional practice evaluations;

(5) verified complaints received from patients or staff; and

(6) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT APPLICATION

(1) Reappointment shall be for a period of not more than two years.

(2) An application for reappointment shall be furnished to members at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within ninety (90) days.

(3) Failure to submit a complete application at least four months prior to the expiration of the member's current term may result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.

(4) If an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the Member's appointment and clinical privileges shall expire at the end of the then current term of appointment. However, if the inaction is due to circumstances beyond the applicant's control, and no issues have been raised about the application, the CEO and Board chairman may grant conditional reappointment for a period not to exceed 120 days to allow for Board action at its next meeting.

(5) The application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(6) 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.

(7) If the Credentials Committee or the MEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chairman shall notify the member of the general tenor of the possible recommendation and may invite the member to meet prior to any final recommendation being made. Prior to this meeting, the member shall be notified of the general nature of the information supporting the recommendation contemplated. At the meeting, the member shall be invited to discuss, explain, or refute this information. A summary of the interview shall be made and included with the committee's recommendation. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The member shall not have the right to be represented by legal counsel at this meeting.

5.D. CONDITIONAL REAPPOINTMENTS

(1) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., performance improvement steps such as general consultation requirements, proctoring, completion of CME requirements). Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of a member's compliance with any conditions that may be imposed.

(2) A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.

(3) In the event the applicant for reappointment is the subject of an investigation or a 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.

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION

(1) This Policy encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by the individual to resolve an issue that has been raised. Collegial intervention may be carried out, within the discretion of Medical Staff leaders and Hospital management, but is not mandatory.

(2) Collegial intervention is a part of the Hospital's professional review activities and may include counseling, education, and related steps, such as the following:

(a) advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(b) proctoring, monitoring, consultation, and letters of guidance; and

(c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

(3) The relevant Medical Staff leader(s), in conjunction with the CEO or CMO, may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the MEC for further action.

(4) The relevant Medical Staff leader(s) shall determine whether to document a collegial intervention effort. Any documentation that is prepared shall be placed in an individual's confidential file. The individual shall have an opportunity to review the documentation and respond to it. The response shall be maintained in the individual's file along with the original documentation.

(5) All ongoing and focused professional practice evaluations shall be conducted in accordance with the peer review policy. Matters that cannot be appropriately resolved through collegial intervention or through the peer review policy shall be referred to the MEC.

6.B. INVESTIGATIONS

6.B.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the question may be referred to the President of the Medical Staff, the chairman of a standing committee, the CMO, the CEO, or the chairman of the Board:

(1) clinical competence or clinical practice, including patient care, treatment or management;

(2) the known or suspected violation of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; or

(3) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others.

(b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any member, the matter shall be referred to the President of the Medical Staff, the CMO, or the CEO.

(c) The person to whom the question is referred shall make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the MEC.

(d) No action taken pursuant to this section shall constitute an investigation.

6.B.2. Initiation of Investigation:

(a) The MEC shall review the question, discuss the matter with the individual, if invited, and determine whether to conduct an investigation or direct that the question be handled pursuant to another policy. An investigation shall commence only after a determination by the MEC.

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

(c) 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.

6.B.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the MEC shall investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. The Investigating Committee shall not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff.

(b) The Investigating Committee may:

(1) review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;

(2) conduct interviews;

(3) use outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or

(4) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated shall execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.

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

(d) As part of the investigation, the individual shall have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual shall be informed of the questions being investigated and shall be invited to discuss, explain, or refute the questions. A summary of the interview shall be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. Lawyers shall not be present at this meeting.

(e) At the conclusion of the investigation, the Investigating Committee shall prepare a report to the MEC with its findings, conclusions, and recommendations.

6.B.4. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the MEC may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) require monitoring, proctoring or consultation;

(5) require additional training or education;

(6) recommend reduction of clinical privileges;

(7) recommend suspension of clinical privileges for a term;

(8) recommend revocation of appointment or clinical privileges; or

(9) make any other recommendation that it deems necessary or appropriate.

(b) 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.

(c) A recommendation by the MEC that would entitle the individual to request a hearing shall be forwarded to the CEO. The Medical Staff President or the CEO shall promptly inform the individual by special notice. The recommendation shall

not be forwarded to the Board until after the individual has completed or waived a hearing and appeal.

(d) If the Board makes a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the Medical Staff President or the CEO shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.C.1. Grounds for Precautionary Suspension or Restriction:

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the CEO, the President of the Medical Staff, the CMO, the MEC, or the Board chairman is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

(b) A precautionary suspension can be imposed at any time including after a specific event, a pattern of events, or a recommendation by the MEC that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension shall meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.

(c) Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.

(d) A precautionary suspension is effective immediately and shall be promptly reported to the CEO and the President of the Medical Staff. A precautionary suspension shall remain in effect unless it is modified by the CEO or MEC.

(e) Within three days of the imposition of a suspension, a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any), shall be provided to the individual.

6.C.2. MEC Procedure:

(a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension, the MEC shall review the reasons for the suspension.

(b) As part of this review, the individual shall be invited to meet with the MEC or with an ad hoc committee of the MEC designated by the President of the Medical Staff. In advance of the meeting, the individual may submit a written statement and other information to the MEC or the designated ad hoc committee of the Medical Staff.

(c) At the meeting, the individual may provide information to the MEC or the designated ad hoc committee of the MEC and should respond to questions that may be raised by committee members. The individual may also propose ways, other than precautionary suspension, to protect patients, employees or others while an investigation is conducted.

(d) The individual may be accompanied by counsel at this meeting. The meeting is not an appeal hearing and the role of counsel will be limited to providing advice to the individual subject to the suspension. Counsel may not make a presentation to or question members of the MEC or anyone else attending the meeting. The MEC may also have counsel present subject to the same conditions that counsel may not question the individual. A record of this meeting will be maintained by a stenographic reporter and reported to the MEC.

(e) After considering the reasons for the suspension and the individual's response, if any, the MEC shall determine whether the precautionary suspension should be continued, modified, or lifted. The MEC shall also determine whether to begin or continue an investigation.

(f) If the MEC decides to continue the suspension, it shall send the individual written notice of its decision, including the basis for it and that suspensions lasting longer than 30 days must be reported to the National Practitioner Data Bank, if applicable.

(g) There is no right to a hearing based on the imposition or continuation of a precautionary suspension for a period of less than 30 days. The procedures outlined above are deemed to be fair under the circumstances. Unless the MEC terminates the suspension within 30 days after the imposition of the suspension, the individual shall be entitled to request a hearing in accordance with Article 7.

(h) Upon the imposition of a precautionary suspension, the President of the Medical Staff shall assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a covering physician.

6.D. AUTOMATIC RELINQUISHMENT

6.D.1. Failure to Complete Medical Records:

Failure to complete medical records shall result in automatic relinquishment of all clinical privileges, after notification by the medical records service of delinquency. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable Rules and Regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable Rules and Regulations shall result in automatic resignation from the Medical Staff or Allied Health Staff.

6.D.2. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or failure to satisfy any of the threshold eligibility criteria, must be promptly reported to the CMO or President of the Medical Staff.

(b) An individual's appointment and clinical privileges shall be automatically relinquished, without right to hearing or appeal, if any of the following occur:

(1) Licensure: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's license.

(2) Controlled Substance Authorization: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization.

(3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Hospital.

(4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Arrest, indictment, conviction, or a plea of guilty or no contest pertaining to any felony; is conviction or a plea of guilty or no contest pertaining or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence.

(c) An individual's appointment and clinical privileges shall be automatically relinquished, without entitlement to a hearing and appeal, if the individual fails to satisfy any of the threshold eligibility criteria or his or her responsibilities during the provisional period.

(d) Automatic relinquishment shall take effect immediately upon notice to the Hospital and continue until the matter is resolved and the individual is reinstated.

(e) If the underlying matter leading to automatic relinquishment is resolved within 60 days, the individual may request reinstatement. Failure to resolve the matter within 60 days of the date of relinquishment shall result in an automatic resignation from the Medical Staff or Allied Health Staff.

(f) Requests for reinstatement shall be reviewed by the chairman of the Credentials Committee, the President of the Medical Staff, the CMO, and the CEO. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the 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.

6.D.3. Failure to Provide Information:

Appointment and clinical privileges shall be deemed to be relinquished upon the occurrence of:

(a) discovery of a misstatement or omission on an application for initial appointment or reappointment, determined by the President of the Medical Staff and CEO or their designee to be material and without good cause after considering any written or oral explanation provided by the individual;

(b) failure to notify the President of the Medical Staff or CEO of any change in any information provided on an application for initial appointment or reappointment, determined by the President of the Medical Staff and CEO to be material and without good cause after considering any written or oral explanation provided by the individual; or

(c) failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request specifying the time frame for response from the Credentials Committee, the MEC, the CEO, or any other committee authorized to request such information, until the information is provided to the satisfaction of the requesting party.

6.D.4. Failure to Attend Special Conference:

(a) Whenever there is a concern regarding an individual's clinical practice or professional conduct, Medical Staff leaders may require the individual to attend a special conference.

(b) Special notice shall be given at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory.

(c) Failure of the individual to attend the conference shall be reported to the MEC. Unless excused by the MEC upon a showing of good cause, such failure shall result in the automatic relinquishment of all or such portion of the individual's clinical privileges as the MEC may direct. Such relinquishment shall remain in effect until the individual attends the special conference.

6.D.5. Failure to Meet Supervision Requirements:

If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the Advanced Dependent Practitioner fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician

as defined in this Policy, the Advanced Dependent Practitioner's clinical privileges will be automatically relinquished, unless another Supervising Physician is approved as part of the credentialing process.

6.E. LEAVES OF ABSENCE

6.E.1. Initiation:

(a) A leave of absence of up to one year must be requested in writing to the President of the Medical Staff and CEO, stating the beginning and ending dates of the leave and the reasons for the leave. Except in extraordinary circumstances, this request shall be submitted at least 30 days prior to the anticipated start of the leave.

(b) The CEO shall determine whether a request for a leave of absence shall be granted, after consulting with the President of the Medical Staff and the Chair of the Credentials Committee. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

(c) Members of the Medical Staff or Allied Health Staff must report to the Medical Staff Office and the CEO anytime they are away from Medical Staff or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the CEO, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence.

(d) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, or where reinstatement is denied for reasons other than professional competence or conduct, the determination shall be final, with no recourse to a hearing and appeal.

6.E.2. Duties of Member on Leave:

During the leave of absence, the individual shall not exercise any clinical privileges and shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). All medical records must be

completed as soon as reasonably possible. The obligation to pay dues shall continue during a leave of absence except that a member granted a leave of absence for U.S. military service shall be exempt from this obligation.

6.E.3. Reinstatement:

(a) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the Chairman of the Credentials Committee, the President of the Medical Staff, the CMO or CEO, and in accordance with the practitioner health policy, if applicable.

(b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if 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. If any request for reinstatement is not granted for reasons related to clinical competence or professional conduct, and if a report to the National Practitioner Data Bank is determined to be required, the individual shall be entitled to request a hearing and appeal.

(c) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges shall expire at the end of the appointment period, and the individual shall be required to apply for appointment.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

(a) For the purpose of Article 7 of this Policy, "applicant" pertains only to an applicant to the Medical Staff and "member" pertains only to Medical Staff members. Allied Health members are not entitled to any hearing and appeal

rights set forth in this article. The sole and exclusive procedural rights to which a member of the Allied Health Staff is entitled are set forth in Article 8.

(b) An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations based upon the individual's professional competence or professional conduct which affects or could affect adversely the health or welfare of a patient or patients:

(1) denial of initial appointment, reappointment or requested clinical privileges;

(2) revocation of appointment to the Medical Staff or clinical privileges;

(3) suspension of clinical privileges for more than 30 days;

(4) restriction of clinical privileges, meaning a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or

(5) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

(c) No other recommendations shall entitle the individual to a hearing.

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

7.A.2. Actions Not Grounds for Hearing:

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

(a) a letter of guidance, counsel, warning, or reprimand;

(b) conditions, monitoring, proctoring, or a general consultation requirement;

(c) a lapse or failure to renew temporary privileges;

(d) automatic relinquishment of appointment or privileges;

(e) a requirement for additional training or continuing education;

(f) precautionary suspension of less than 30 days in accordance with Section 6.C;

(g) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;

(h) determination that an application is incomplete;

(i) determination that an application shall not be processed due to a misstatement or omission; or

(j) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

7.A.3. Notice of Recommendation:

The Medical Staff President or CEO shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Article.

7.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing, in writing, to the President of the Medical Staff and CEO, including the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

7.A.5. Notice of Hearing and Statement of Reasons:

(a) The President of the Medical Staff or CEO shall schedule the hearing and provide, by special notice, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who shall give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members and Presiding Officer if known; and

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity to review and respond with additional information.

(b) 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.

7.A.6. Witness List:

(a) At least 15 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list shall include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.A.7. Hearing Panel:

(a) Hearing Panel:

The CEO or the President of the Medical Staff shall appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel shall consist of at least three members, one of whom shall be designated as chairman.

(2) The Hearing Panel may include any combination of:

(i) any member of the Medical Staff, or

(ii) physicians not connected with the Hospital (i.e., physicians not on the Medical Staff).

(3) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.

(4) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.

(5) The Panel shall not include any individual who:

(i) is in direct economic competition with the individual requesting the hearing;

(ii) is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing;

(iii) is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(iv) actively participated in the matter at any previous level.

(b) Presiding Officer:

(1) The CEO or President of the Medical Staff shall appoint a Presiding Officer who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.

(2) The Presiding Officer shall:

(i) schedule and conduct a pre-hearing conference;

(ii) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(iii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

(vi) rule on all matters of procedure and the admissibility of evidence; and

(vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

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

(c) Objections:

Any objection to any member of the Hearing Panel or the Presiding Officer shall be made in writing, within ten days of receipt of notice, to the CEO. A copy of such written objection must be provided to the President of the Medical Staff and must include the basis for the objection. The President of the Medical Staff shall be given a reasonable opportunity to comment. The CEO shall rule on the objection and give notice to the parties. The CEO may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.A.8. Counsel:

The Presiding Officer and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.

7.B.2. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. 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 patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the MEC;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the MEC.

The provision of this information is not intended to waive any privilege.

(c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(d) Ten days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits.

(e) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the MEC's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital shall advise the individual who requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.B.3. Pre-Hearing Conference:

(a) The Presiding Officer shall require the individual or a representative (who may be counsel) for the individual and for the MEC to participate in a pre-hearing conference.

(b) All objections to documents or witnesses shall be submitted in writing five days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(c) At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses.

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

(e) The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination and to any opening and closing statements.

(f) It is expected that the hearing shall be conducted in an expeditious manner, with each side being afforded a reasonable opportunity to present its case, in terms of both direct and cross-examination of witnesses as determined by the Presiding Officer. The Presiding Officer may, after considering any objections, grant limited extensions to present evidence upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.B.4. Stipulations:

The parties shall use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

7.B.5. Provision of Information to the Hearing Panel:

The following documents shall be provided to the Hearing Panel in advance of the hearing:

(a) a pre-hearing statement that either party may choose to submit;

(b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and

(c) stipulations agreed to by the parties.

7.B.6. Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, shall govern the timing of pre-hearing procedures:

(a) the pre-hearing conference shall be scheduled at least 14 days prior to the hearing;

(b) the parties shall exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

7.C. HEARING

7.C.1. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be forwarded to the Board for final action.

7.C.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken on oath or affirmation administered by any authorized person.

7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:

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

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness;

(4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case;

(5) to submit a written statement at the close of the hearing; and

(6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, or request documentary evidence.

7.C.4. Order of Presentation:

The MEC shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.C.5. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is 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. 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 clinical privileges.

7.C.6. Persons to Be Present:

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the CEO or the President of the Medical Staff.

7.C.7. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the CEO on a showing of good cause.

7.C.8. Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. Basis of Hearing Panel 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 Panel shall recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.D.2. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel shall render written findings, conclusions and its recommendation, accompanied by a report, which shall contain a statement of the basis for its recommendation.

7.D.3. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the CEO and the President of the Medical Staff. The CEO or the President of the Medical Staff shall send by special notice a copy of the report to the individual who requested the hearing.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

(a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the CEO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Policy or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by credible evidence.

7.E.3. Time, Place and Notice:

Whenever an appeal is requested, the chairman of the Board shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the chair of the Board may appoint a Review Panel, composed of members of the Board.

(b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the

findings and recommendations of the MEC and Hearing Panel and any other information that it deems relevant, and recommend final action to the Board.

(c) The hearing before the Review Panel shall be an appellate and not an evidentiary hearing. 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 an oral presentation. The Review Panel may limit the amount of time for any such presentation.

(d) The Review Panel may (i) affirm the recommendation of the Hearing Panel, (ii) reverse the recommendation of the Hearing Panel, or (iii) refer the recommendation back to the Hearing Panel for further consideration with reasons for doing so. If the decision is to refer the matter back, the Hearing Panel shall give the matter further consideration and respond to the directions of the Review Panel and may, in its discretion, hold a further hearing or act on the record and make a further recommendation to the Review Panel, which shall thereupon, without further notice to the individual or a hearing, take final action.

7.F. BOARD ACTION

7.F.1. Final Decision of the Board:

(a) The decision of the Board, acting, in its discretion, as a whole or through the appointed Review Panel, shall be final after it either (i) considers the appeal as a Review Panel, or (ii) receives the Hearing Panel's report when no appeal has been requested.

(b) The Board or Review Panel shall render its final decision in writing, including the basis for its decision, and shall send special notice to the individual. A copy shall also be provided to the President of the Medical Staff.

(c) The final decision of the Board or Review Panel shall be effective immediately and shall not be subject to further review.

7.F.2. Right to One Hearing and One Appeal Only:

No individual shall be entitled to more than one hearing and one appeal on any matter. If the Board denies initial appointment or reappointment or revokes appointment or clinical privileges, that individual may not apply for appointment or clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 8
PROCEDURAL RIGHTS FOR
ALLIED HEALTH PRACTITIONERS

8.A. PROCEDURAL RIGHTS FOR LICENSED INDEPENDENT PRACTITIONERS AND ADVANCED DEPENDENT PRACTITIONERS

(1) In the event that the MEC recommends that a Licensed Independent Practitioner or Advanced Dependent Practitioner (hereinafter, for the purpose of this Section only, "Allied Health Practitioner") not be granted privileges or that the privileges granted be terminated or not renewed, the Medical Staff President or CEO shall give notice of the recommendation to the affected Allied Health Practitioner. The notice shall state that the Allied Health Practitioner has a right to request a hearing.

(2) If the Allied Health Practitioner wants to request a hearing, the request must be made in writing, directed to the Medical Staff President and CEO, within 30 days after receipt of the notice of the adverse recommendation. The hearing will be convened as soon as practical, but no sooner than 30 days after the CEO receives the Allied Health Practitioner's request for a hearing, unless an earlier hearing date has been specifically agreed to by the parties. The Allied Health Practitioner will be informed of the nature of the information supporting the adverse recommendation at least 30 days prior to the hearing.

(3) The hearing to review the adverse recommendation will be held before the MEC or a subcommittee of the MEC ("Hearing Committee"). The Hearing Committee will not include any individual who is in direct economic competition with the

affected Allied Health Practitioner or his/her Supervising Physician(s). Employment by, or a contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Hearing Committee.

(4) The Allied Health Practitioner and his/her Supervising Physician shall both appear personally before the Hearing Committee.

(5) The record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the Allied Health Practitioner's individual expense.

(6) The hearing will last no longer than three hours. The Allied Health Practitioner may present affidavits, but no more than four, as evidence in support of his/her case.

(7) Both the Allied Health Practitioner and the MEC may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, in no event will counsel present evidence, direct any questions to either party or present the case.

(8) At the hearing, the Allied Health Practitioner and his/her Supervising Physician shall be provided with an opportunity to refute the recommendation and the reasons supporting it. The Allied Health Practitioner will have the burden of demonstrating that the recommendation was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.

(9) The Allied Health Practitioner will have the right to submit a memorandum, for consideration by the Hearing Committee, at the close of the hearing.

(10) The Hearing Committee shall forward its recommendation, along with all supporting information, to the CEO. The CEO shall give notice of the recommendation to the affected Allied Health Practitioner.

(11) The Allied Health Practitioner shall have 30 days from the receipt of the notice of the Hearing Committee's recommendation to request an appeal, and such a request must be in writing to the CEO and the President of the Medical Staff. If a written request for appeal is not submitted by the Allied Health Practitioner to the CEO within the 30-day time frame specified herein, the Hearing Committee's

recommendation shall be forwarded by the CEO to the Board for final action. If a timely request for appeal is submitted by the Allied Health Practitioner, the CEO shall then forward the Hearing Committee's recommendation, supporting information and the request for consideration to a three-person appeal panel appointed by the CEO ("Appeal Panel"). In no event will the members of the Appeal Panel be practitioners in economic competition with the affected Allied Health Practitioner or his/her Supervising Physician(s). Employment by, or a contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Appeal Panel.

(12) The appeal shall be performed by the Appeal Panel, and the Appeal Panel will consider the record upon which the adverse recommendation was made and may accept additional written information, provided the information is new and relevant and was not made available to the Hearing Committee during its consideration of the matter. The Allied Health Practitioner and the MEC will each have the right to submit a written statement to the Appeal Panel. At the sole discretion of the Appeal Panel, the Allied Health Practitioner and a representative of the MEC may also appear personally to discuss their position.

(13) Upon completion of the review, the Appeal Panel may recommend that the Board affirm, modify or reverse the recommendation of the Hearing Committee. Alternatively, the Appeal Panel may recommend that the matter be referred back to the Hearing Panel for further clarification, with a written explanation of the need for the clarification. Thereafter, the Hearing Panel will report to the Appeal Panel in 30 days.

(14) The final recommendation of the Appeal Panel shall be forwarded by the CEO to the Board for final action.

A**RTICLE 9**

CONFLICTS OF INTEREST

(a) When performing a function outlined in this Policy, the Bylaws, the Organization Manual, or the Rules and Regulations, if any member has or reasonably could be

perceived as having a conflict of interest or a bias, that member shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.

(b) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the President of the Medical Staff (or the President of the Medical Staff-Elect if the President of the Medical Staff is the person with the potential conflict) or committee chairman. The President of the Medical Staff or committee chairman shall make a final determination as to whether the provisions in this Article should be triggered.

(c) The fact that a Credentials Advisor or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment 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 member has a right to compel disqualification of another member based on an allegation of conflict of interest.

(d) The fact that a Credentials Advisor or 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.

ARTICLE 10
HOSPITAL EMPLOYEES

(a) Except as provided below, the employment of an individual by the Hospital shall be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship or written contract. To the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals

and descriptions and terms of the individual's employment relationship or written contract shall apply.

(b) A request for appointment, reappointment or clinical privileges, submitted by an applicant or Member who is employed by the Hospital, shall be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications shall be made to Administration or Human Resources (as appropriate) to assist the Hospital in making employment decisions. Such report shall consist of the patient's status as a member of the Medical Staff but shall not include peer review material.

(c) If a concern about an employed member's clinical conduct or competence originates with the Medical Staff, the concern shall be reviewed and addressed in accordance with this Policy, after which a report shall be provided to Human Resources.

ARTICLE 11
AMENDMENTS

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

ARTICLE 12
ADOPTION

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

Adopted by the Medical Staff: **September 12, 2016**

Michael Harper, MD
President, Medical Staff Indiana University Health Tipton Hospital

Approved by the Board: **September 22, 2016**

Michael Harlowe, MHA, MS, FACHE
President and CEO Indiana University Health Tipton Hospital

Steven Wertz
Chairman, Board of Directors Indiana University Health Tipton Hospital

GLOSSARY

The following definitions apply to terms used in this Policy:

(1) "ADVANCED DEPENDENT PRACTITIONERS" means all those Allied Health Practitioners who are licensed or certified under state law, are granted clinical privileges, and function in the Hospital under the supervision of a practitioner(s) appointed to the Medical Staff. The Supervising Physician(s) is responsible for the actions of the Advanced Dependent Practitioner in the Hospital.

(2) "ALLIED HEALTH PRACTITIONERS" ("AHPs") means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services.

(3) "BOARD" means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.

(4) "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA"), the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, upon an individual, as applicable, who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the individual's area of clinical practice.

(5) "CHIEF EXECUTIVE OFFICER" ("CEO") means the individual appointed by the Board to act on its behalf in the overall management of Hospital.

(6) "CHIEF MEDICAL OFFICER" ("CMO") means the individual appointed by the Board to act as the CMO of the Hospital, in cooperation with the President of the Medical Staff.

(7) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Staff leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

(8) "COMPLETED APPLICATION" means that all questions on the application form have been answered, all supporting documentation has been supplied, and

all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete [30] days after the applicant has been notified of the additional information required shall be deemed to be withdrawn.

(9) "CREDENTIALS POLICY" means the Hospital's Medical Staff Credentials Policy.

(10) "DAYS" means calendar days unless otherwise specified.

(11) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(12) "DEPENDENT PRACTITIONERS" means all those Allied Health Practitioners who are permitted to practice in the Hospital only under the supervision of a practitioner(s) appointed to the Medical Staff and who function pursuant to a defined scope of practice. The Supervising Physician(s) is responsible for the actions of the Dependent Practitioner in the Hospital.

(13) "HOSPITAL" means IU Health Tipton Hospital and any related outpatient facilities for which Medical Staff privileges are required or appropriate.

(14) "HOUSE STAFF" or "Resident" or "Fellow" means all physicians who are assigned for graduate medical education and will ordinarily carry the title of resident or fellow.

(15) "LICENSED INDEPENDENT PRACTITIONERS" means all those Allied Health Practitioners who are licensed or certified under state law, authorized to function <u>independently</u> in the Hospital, and granted clinical privileges. These individuals require no formal or direct supervision by a physician.

(16) "MEDICAL STAFF" means all physicians and dentists who have been appointed to the Medical Staff by the Board.

(17) "MEDICAL EXECUTIVE COMMITTEE" or "MEC" means the MEC of the Medical Staff.

(18) "MEMBER" means any physician or dentist who has been granted Medical Staff appointment to the Medical Staff and/or any allied health practitioner who has

been granted appointment to the Allied Health Staff, by the Board, to practice at the Hospital.

(19) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail.

(20) "PATIENT CONTACTS" includes any direct interaction between a physician and a patient in the hospital (including outpatient areas that are included in the hospital licensure) setting excluding any diagnostic outpatient orders and specifically including performance of History and Physicals, diagnosis treatment, and interpretation of diagnostic studies.

(21) "PEER REVIEW COMMITTEES" includes professional review bodies, as defined in the HCQIA, that is, a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the Medical Staff of such an entity when assisting the governing body in a professional review activity.

(22) "PERMISSION TO PRACTICE" means the authorization granted to Allied Health Practitioners by the Board to exercise a scope of practice or clinical privileges. For ease of use, when applicable to an Allied Health Practitioner, any reference in this Policy to "appointment" or "reappointment" shall be interpreted as a reference to initial or continued permission to practice.

(23) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(24) "PROFESSIONAL REVIEW ACTION" has the meaning defined in the HCQIA, that is, an action by the Board or recommendation of the MEC taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual, which conduct affects or could affect adversely the health or welfare of a patient or patients, and which affects (or may affect) adversely the clinical privileges, or appointment, and includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence, and also includes professional review activities relating to a professional review action.

(25) "PROFESSIONAL REVIEW ACTIVITY" has the meaning defined in the HCQIA, that is, activity to determine whether an individual may be granted, to determine the scope or conditions of, or to change or modify, appointment or clinical privileges. All such activity is also intended to be encompassed within the scope of any applicable federal or state privilege, and includes but is not limited to credentialing, privileging, reappointment, ongoing and focused professional practice evaluations, collegial intervention, performance improvement plans, investigations and hearings.

(26) "SCOPE OF PRACTICE" means the authorization granted by the Board or CEO, as applicable, to perform certain clinical activities and functions under the supervision of, or in collaboration with, a Supervising Physician.

(27) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(28) "SUPERVISING PHYSICIAN" means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise a Dependent Practitioner or an Advanced Dependent Practitioner and to accept full responsibility for the actions of the Dependent Practitioner or Advanced Dependent Practitioner while he or she is practicing in the Hospital.

(29) "SUPERVISION" means the supervision of, or collaboration with, an Advanced Dependent Practitioner or a Dependent Practitioner and a Supervising Physician that generally does not require the actual presence of the Supervising Physician, but that does require that the Supervising Physician be readily available for consultation, unless otherwise required by law or Hospital policy.

APPENDIX A

CONDITIONS OF PRACTICE APPLICABLE TO

ALLIED HEALTH PRACTITIONERS

A.1. Oversight by Supervising Physician:

(a) Advanced Dependent Practitioners and Dependent Practitioners may function in the Hospital only so long as they have a Supervising Physician.

(b) Any activities permitted to be performed at the Hospital by an Advanced Dependent Practitioner or Dependent Practitioner will be performed only under the oversight of the Supervising Physician.

(c) If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the Advanced Dependent Practitioner or Dependent Practitioner fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in this Policy, the Advanced Dependent Practitioner or Dependent Practitioner's clinical privileges or scope of practice will be automatically relinquished, unless another Supervising Physician is approved as part of the credentialing process.

(d) As a condition of clinical privileges or scope of practice, an Advanced Dependent Practitioner or Dependent Practitioner and his or her Supervising Physician must provide the Hospital with notice of any revisions or modifications that are made to the agreement between them. This notice must be provided to the CMO or Medical Staff Office within three business days of any such change.

A.2. Questions Regarding the Authority of an Advanced Dependent Practitioner or Dependent Practitioner:

(a) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an Advanced Dependent Practitioner or Dependent Practitioner to act or issue instructions outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the Advanced

Dependent Practitioner or Dependent Practitioner. Any act or instruction of the Advanced Dependent Practitioner or Dependent Practitioner will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges or scope of practice granted to the individual.

(b) Any question regarding the conduct of an Advanced Dependent Practitioner will be reported to the President of the Medical Staff, the Chair of the Credentials Committee, or the CEO or their designee for appropriate action. Any question raised about the conduct of a Dependent Practitioner will be reported to MEC and the CMO for appropriate action. The individual(s) to whom the concern has been reported will also discuss the matter with the Supervising Physician.

A.3. Responsibilities of Supervising Physicians:

(a) Physicians who wish to use the services of an Advanced Dependent Practitioner or Dependent Practitioner in their clinical practice at the Hospital must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy or the relevant Medical Staff process before the Advanced Dependent Practitioner or Dependent Practitioner participates in any clinical or direct patient care of any kind in the Hospital.

(b) The number of Advanced Dependent Practitioners or Dependent Practitioners acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician will make all appropriate filings with the state regarding the supervision and responsibilities of the Advanced Dependent Practitioner or Dependent Practitioner, to the extent that such filings are required.

(c) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the Advanced Dependent Practitioner or Dependent Practitioner in amounts required by the Board. The insurance must cover any and all activities of the Advanced Dependent Practitioner or Dependent Practitioner in the Hospital. The Supervising Physician

will furnish evidence of such coverage to the Hospital. The Advanced Dependent Practitioner or Dependent Practitioner will act in the Hospital only while such coverage is in effect.

APPENDIX B

GUIDELINES FOR DETERMINING THE NEED FOR NEW CATEGORIES OF ALLIED HEALTH PRACTITIONERS

B.1. Review of Need:

(a) Whenever an Allied Health Practitioner requests to practice at the Hospital, and the Board has not already approved the category of practitioner for practice at the Hospital, the Credentials Committee will evaluate the need for that category of Allied Health Practitioner. The Credentials Committee shall report to the MEC, which shall make a recommendation to the Board for final action.

(b) As part of the process of determining need, the Allied Health Practitioner shall be invited to submit information about the nature of the proposed practice, the reason access to the Hospital is sought, and the potential benefits to the community of having such services available at the Hospital.

(c) The Credentials Committee may consider the following factors when making a recommendation as to the need for the services of a specific category of Allied Health Practitioner:

(1) the nature of the services that would be offered;

(2) any state license or regulation which outlines the specific patient care services and/or activities that the Allied Health Practitioner is authorized by law to perform;

(3) any state "nondiscrimination" or "any willing provider" laws that would apply to the Allied Health Practitioner;

(4) the patient care objectives of the Hospital, including patient convenience;

(5) the community's needs and whether those needs are currently being met or could be better met if the services offered by the Allied Health Practitioner were provided at the Hospital;

(6) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;

(7) the availability of supplies, equipment, and other necessary Hospital resources;

(8) the need for, and availability of, trained staff to support the services that would be offered; and

(9) the ability to appropriately supervise performance and monitor quality of care.

B.2. Additional Recommendations:

(a) If the ad hoc committee makes a recommendation that there is a need for the particular category of Allied Health Practitioner at the Hospital, it shall also recommend:

(1) any specific qualifications and/or training that must be possessed beyond those set forth in this Policy;

(2) a detailed description of a scope of practice or clinical privileges;

(3) any specific conditions that apply to practice within the Hospital; and

(4) any supervision requirements, if applicable.

(b) In developing such recommendations, the Credentials Committee shall consult the appropriate Credentials Advisor and consider relevant Indiana law and may contact professional societies or associations. The Credentials Committee may also recommend the number of Allied Health Practitioners that are needed.

APPENDIX C

ALLIED HEALTH PRACTITIONERS

The Allied Health Practitioners currently practicing at the Hospital as Licensed Independent Practitioners are as follows:

Psychologist

Podiatrist

The Allied Health Practitioners currently practicing at the Hospital as Advanced Dependent Practitioners are as follows:

Certified Registered Nurse Anesthetist

Certified Nurse Specialist

Nurse Practitioner

Physician Assistant - Certified

The Allied Health Practitioners currently practicing at the Hospital as Dependent Practitioners are as follows:

Certified Surgical Technologist

Certified First Assist

Certified Ophthalmology Technician/Assistant

Dental Assistant

Licensed Practical Nurse

Medical Assistant

Orthopedic Technologist/Assistant

Registered Nurse

MEDICAL STAFF BYLAWS, POLICIES, AND

RULES AND REGULATIONS

OF

INDIANA UNIVERSITY HEALTH

TIPTON HOSPITAL

ORGANIZATION MANUAL

Approved – November 17, 2016

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ARTICLE 1
GENERAL

1.A. DEFINITIONS

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

1.B. TIME LIMITS

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

1.C. DELEGATION OF FUNCTIONS

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

ARTICLE 2
ADVISORS AND PHYSICIAN DIRECTORS

2.A. LIST OF ADVISORS & PHYISICAN DIRECTORS

The Medical Staff shall have the following

1. Advisors:

    (a) Anesthesia

    (b) Continuing Medical Education (CME)

    (c) Intensive Care Unit

    (d) Physical Medicine

    (e) Surgery

    (f) Credentials Advisors:

        i. Medicine

        ii. Surgery

2. Physician Directors:

    (a) Cardiology
    (b) Emergency Department
    (c) IU Health Tipton Physicians
    (d) Laboratory
    (e) Oncology
    (f) Orthopedics
    (g) Radiology
    (h) Rehabilitation Services
    (i) Sleep Medicine
    (j) Sports Medicine
        i. Tipton
        ii. Tri Central

2.B. FUNCTIONS AND RESPONSIBILITIES OF ADVISORS AND DIRECTORS

The functions and responsibilities of adivsors and directors are set forth in Article 4 of the Medical Staff Bylaws.

ARTICLE 3
MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees of Indiana University Health Tipton Hospital that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Procedures for the appointment of committee chairmen and physician members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

(3) Unless otherwise provided, all Hospital and administrative representatives on the committees shall be appointed by the Chief Executive Officer or designee, in consultation with the Medical Staff as appropriate.

3.B. MEETINGS, REPORTS AND RECOMMENDATIONS

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

3.C. CREDENTIALS COMMITTEE

3.C.1. Composition:
The committee shall consist of at least 2 members of the Active Medical Staff appointed annually by the chief of staff. The chairman shall be one (1) of the physicians on the committee and shall be appointed by the chief of staff.

3.C.2. Duties:

The Credentials Committee shall:

(a) in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff and Allied Health Professionals appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

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

(c) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital.

(d) Pursuant to 844 IAC 5-1-2, the committee shall serve as an Impaired Physician Committee to counsel and monitor the progress of any physician who voluntarily places himself or herself under the supervision of the committee.

3.C.3. Meetings:

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

3.D. MEDICAL STAFF EXECUTIVE COMMITTEE (MEC)

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

3.E. PATIENT CARE REVIEW COMMITTEE

3.E.1 Composition

The members of this committee shall consist of 7 members of the Active Medical Staff appointed by the Chief of Staff. One of the active Medical Staff members, other than the chairman, shall be the Pathologist. The chairman shall be 1 of 7 physicians on the committee and shall be appointed by the Chief of Staff. The committee members shall also include representatives of Hospital administration named by the Chief Executive Officer.The committee members also shall include representatives of Hospital administration named by the Chief Executive Officer [Nursing, and Quality Improvement/Risk Management].

3.E.2. Duties

(a) GENERAL RESPONSIBILITIES.

The general responsibilities of the Patient Care Review Committee shall include the following:

1. Medical Records: The committee shall be responsible for the review of selected medical records of both inpatients and outpatients, the goal of which review shall be to accomplish timely completion of medical records, clinical pertinence, and overall adequacy. The committee shall determine the format of the complete medical record and the forms used in it.

2. Medical Care Review: The committee shall establish mechanisms and procedures to assess the quality and appropriateness of medical care provided by the Medical Staff and allied health care practitioners and shall monitor the quality and appropriateness for such care.

3. Surgical Case Review: The committee will conduct review for each surgical case, whether or not a surgical specimen was removed, based on criteria established by the committee.

4. Blood Utilization Review: The committee will review all blood transfusions and the utilization of blood and blood products based on criteria established by the committee.

5. Emergency Services Review: The committee shall perform timely review and evaluations of the quality and appropriateness of patient care provided in the emergency room.

6. Pharmacy and Therapeutics Review: The committee shall, in conjunction with the Pharmacy and Therapeutics Committee and nursing, evaluate drug usage to ensure the appropriate, safe and effective use of drugs.

7. Utilization Review: The committee will establish criteria and mechanisms to evaluate the standards of patient care being provided in the Hospital with a goal to providing high quality patient care in a cost effective manner. They shall develop a Utilization Review Plan for such purposes subject to the approval of the Medical Staff, Chief Executive Officer, and the Board of Directors.

8. Anesthesia Services: The committee shall review and evaluate all facets of

anesthesia services throughout the Hospital. The committee shall make recommendations for action regarding policies and procedures to the Executive Committee. (Approved July 1988)

9. Intensive Care Services: the committee shall evaluate the quality, safety, and appropriateness of patient care in ICU.

3.E.2. Meetings

The Patient Care Review Committee meetings may be called by the Chair of the committee, as often as deemed necessary, and at such intervals as may be set in the Rules of the Medical Staff.

3.F. PHARMACY AND THERAPEUTICS COMMITTEE

3.F.1. Composition:

(a) The members of this committee shall consist of at least 1 member of the Active Medical Staff who shall be appointed by the chief of staff annually. The committee members also shall include representatives of pharmacy, nursing, administration, and quality assurance.

3.G.2. Duties:

The Pharmacy and Therapeutics Committee shall:

(a) The committee shall develop and conduct surveillance of all drug policies and practices within the Hospital in order to assure optimum clinical results with a minimum of potential hazards.

(b) The committee shall develop and maintain a drug formulary.

(c) The committee shall evaluate drug usage to ensure the appropriate, safe, and effective use of drugs.

(d) The committee shall review all significant untoward drug reactions.

3.G.3. Meetings:

The Pharmacy and Therapeutics Committee shall meet at least six months each year.

3.H. CANCER COMMITTEE

3.H.1. Composition:
Composition of the committee must be multidisciplinary and shall consist of Medical Staff representatives from surgery, pathology, radiology, oncology, family practice and the American College of Surgeons liaison physician. The committee must also include representatives from nursing, social services, rehabilitation, cancer registry, administration, and quality improvement.

3.H.2. Duties
Responsible for planning, initiating, stimulating, and assessing all cancer-related activities in the Hospital including:

(a) Providing consultative services to patients;

(b) Making certain that educational programs include major cancer sites;

(c) Evaluating the quality of care of the patients with cancer;

(d) Supervising the cancer data system;

(e) Following recommendations of the American College of Surgeons Cancer program;

The Cancer Committee cannot be dissolved except by action of the Medical Staff.

3.H.3. Meetings:

The committee shall meet on call of the chairman, at least quarterly

ARTICLE 4
AMENDMENTS

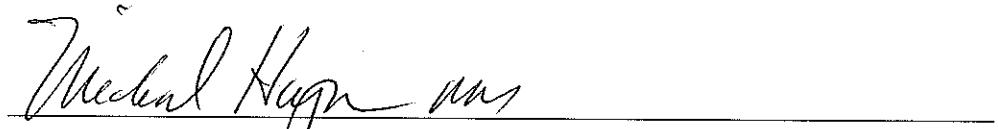
This Manual may be amended in accordance with Article 8 of the Medical Staff Bylaws.

ARTICLE 5
ADOPTION

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

Organization Manual of Indiana University Health Tipton Hospital

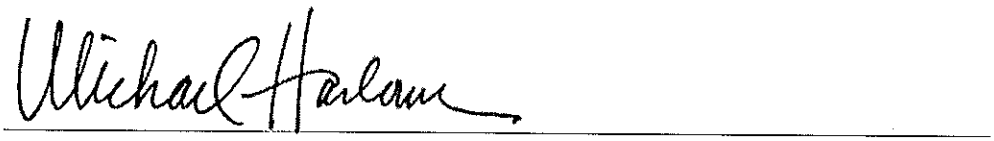
Adopted by the Medical Staff on: November 14, 2016



Michael Harper, MD

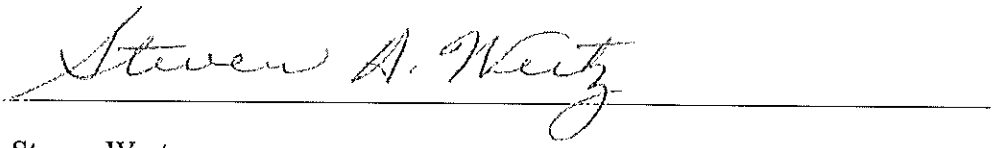
President of the Medical Staff Indiana University Health Tipton Hospital

Approved by the Board on: November 17, 2016



Michael Harlowe, MHA MS, FACHE

President and CEO Indiana University Health Tipton Hospital



Steven Wertz

Chairman, Board of Directors Indiana University Health Tipton Hospital

RULES AND REGULATIONS OF THE MEDICAL STAFF AND ALLIED HEALTH PROVIDERS OF INDIANA UNIVERSITY HEALTH TIPTON HOSPITAL

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RULES AND REGULATIONS OF THE MEDICAL STAFF AND ALLIED HEALTH CARE PROVIDERS OF INDIANA UNIVERSITY HEALTH TIPTON HOSPITAL

ARTICLE I. PROFESSIONALISM

1.1 These rules and regulations are intended to provide comprehensive information to members of the IU Health Tipton Hospital Medical Staff and Allied Health Care Providers in order for them to fulfill their commitment and responsibility to provide quality and safe patient care. In addition, members of the Medical Staff and Allied Health Care Providers are obliged to carry themselves in a manner, which exemplifies the utmost respect and professionalism toward patients, families, visitors, staff and employees of IU Health Tipton Hospital.

ARTICLE II. DELINEATION OF PRIVILEGES

2.1 Categories of Privileges:
A complete listing of all Medical Staff Privileges approved by the Board of Directors will be maintained in the Medical Staff Services Policy Manual.

2.2 The required qualifications for the privilege to perform each procedure or to treat each condition shall be predetermined by members of the Credentials Committee, the physician advisors, and directors of hospital services.

2.3 Practitioners will be granted privileges when his/her credentials file contains data and supporting information demonstrating current clinical competency.

2.4 Only practitioners who have been duly appointed to membership by the Medical Staff by the IU Health Tipton Hospital Board of Directors or who have been granted temporary privileges, and are in good standing, are eligible to serve as the admitting/attending physician for patients within the hospital. When a medical staff member is granted privileges he/she will automatically be granted privileges to perform the following within the scope of his/her individual privileges:

a. Admit patients.
b. Perform histories and physicals (dentists & podiatrist cannot perform H&Ps).
c. Order diagnostic and therapeutic services.
d. Chart in patient medical records.
e. Make referrals and request clinical consultations.
f. Provide consultations as requested.
g. Use all skills normally learned during medical school or residency except those specifically identified as privileges outside the scope of the privileges granted to him/her.
h. Render any care in a life-threatening emergency.
i. Discharge patients.

Note Exception: Affiliate staff members, Emergency department physicians, radiologists, anesthesiologists, pathologists, dentists, and podiatrists may not admit patients for inpatient service nor discharge them.

2.5 Reporting Requirements

In addition to reporting requirements at the time of initial application and reapplication to the IU Health Tipton Hospital Medical Staff, all members of the Medical staff are to immediately report to the Medical Staff President (or his/her designee when off premises) any circumstances involving the following:

a. suspension or any action (censure, reprimand, and/or fine) regarding their professional license
b. loss, suspension or other actions (excludes routine renewal) regarding state or federal prescribing of controlled substances
c. loss, suspension or limitation (excludes routine non-renewal) of clinical privileges at another health care facility
d. filing of notice of exclusion/debarment from any federal health care program including Medicare/Medicaid
e. filing of any criminal charge by state or federal authorities (excludes minor motor vehicle accident)

2.6 When the Executive Committee determines that a physician must have a proctor, the following rules apply:

a. Proctors will be voluntary and agreed to by at least two-thirds (2/3) vote of the members present at any Medical Executive Committee meeting.
b. Proctors will not have a conflict of interest.
c. The proctor will prospectively and concurrently review with the physician the types of cases he/she is admitting and how he/she is doing. Also, on a nonspecific basis, the proctor will caution the physician if he/she appears to be having cases beyond his/her ability.
d. The proctor has no duty or responsibility to intervene in the care of the patient. If the attending physician has any questions regarding a particular case, he/she may consult with the proctor who may then refer the matter to the Medical Staff President Staff. The Medical Staff President may intervene in the case or request another qualified physician (including the proctor) to intervene.
e. Proctors will retrospectively review all medical records of all cases involved after discharge of the patient and then discuss them with the physician being proctored.
f. Retrospective review will be completed using a form determined by the Credentials Committee.
g. The proctor will make a report to the Credentials Committee every three (3) months for a period of not less than six (6) months. The report will recommend one of the following:

    1. Recommend a three (3) month continuation for:

a. Six (6) months of proctoring not completed, or
b. Inconclusive data demonstrating clinical competency; or
c. Failure to admit or otherwise provide services to a minimum of twenty-five (25) patients.

2. Recommend full privileges and status in the area being proctored.
3. Recommend termination of privileges and/or status in the areas being proctored.

2.7 All initial appointments and privileges are probationary. All activity between initial appointment and first reappointment is subject to review by the Credentials Committee.

At the first reappointment following the probationary period, a report of all clinical activities (number, type and outcome) will be prepared for the Credentials Committee. The committee will evaluate the appointee's clinical competence and will render a written report of such to the Medical Executive Committee. The report may:

a. Recommend:
Medical Staff: Awarding full medical staff status and granting privileges as requested until the next regularly scheduled time for evaluation of reapplication for privileges.
Allied Health Care Providers: Awarding full allied health care provider status and granting privileges as requested until the next regularly scheduled time for evaluation of reapplication for privileges.

b. Recommend:
Medical Staff: Termination of medical staff appointment and privileges.
Allied Health Care Providers: Termination of allied health care provider status and privileges.

c. Recommend a six (6) month continuation of probationary status for either:
Medical Staff: Failure to admit or otherwise provide services to a minimum of twenty-five (25) patients; or inconclusive data demonstrating clinical competence.
Allied Health Care Providers: Failure to provide services; or inconclusive data demonstrating clinical competence.

2.8 Focused Professional Practice Evaluations (FPPE) and Ongoing Professional Practice Evaluations (OPPE)
Ongoing Professional Practice Evaluations will be performed regularly for Provisional, Active and Associate Medical Staff Members and Allied Health Care Providers. Please refer to Medical Staff Policy 769.143 regarding this process.

ARTICLE III. ADMISSIONS

3.1 Admission of Patients
Active, Associate, and Provisional Medical Staff members may register patients for admission to the hospitals. The physician who admits the patient will be designated as the attending physician and will provide a provisional clinical diagnosis. The admitting physician will be considered the attending physician unless an order is written to transfer care to another physician who has agreed to accept responsibility for the patient's care management. Such transfer of attending physician status is to occur only after physician to physician discussion of the patient's care and comprehensive discussion of the status of the patient's clinical needs.

3.2. Patients admitted to the hospital shall be the responsibility of the attending physician. Those patients admitted on an emergency basis and who have no preference for a physician shall be assigned to the Active Medical Staff member who is on call.

3.3 Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever, or to assure protection of the patient from self-harm.

ARTICLE IV. Patient Care

4.1 Attending Physician Requirements
Patients admitted to the hospital must be seen within twenty-four (24) hours after admission by the attending physician. The attending physician is in charge of the patient's overall care management, including but not limited to review of orders, request of necessary consultations, determination of the patient's resuscitation status, planning for discharge, completion and signing of medical records documentation.

The attending physician shall be the primary physician during that hospitalization and shall be responsible for documentation (i.e., history and physical, orders, progress notes, and discharge summary). In the case of an elective surgery patient, the surgeon shall be the attending physician.

Inpatient and observation patients shall be seen daily by the attending physician or the attending physician will effectively delegate that responsibility to an associate/partner of the attending physician.

4.2 Patient/Family Complaint Procedures
Hospital patients shall be provided with appropriate channels to communicate dissatisfaction with medical care and treatment, safety and security, and be

provided a timely and appropriate response upon conclusion of the investigation into the concern. Members of the Medical Staff must fully cooperate in such investigations.

4.3 Consultations

To promote effective consultation among practitioners of various specialties involved in the treatment of patients, it is recommended that the attending physician, or his/her designee (nurse practitioner, physician assistant, other physician partner) directly discuss with a consultant practitioner the need to examine, discuss, or otherwise provide an opinion regarding a patient's care management.

Consultation should be considered:

a. Where the diagnosis is obscure, or
b. Where doubt exist as to the best therapeutic measures to be taken, including cases where the disorder or complications are not in the field of the attending physicians' practice, or
c. Patient not responding to treatment as expected, or
d. Patient or family requests clinical consultation or second opinion, or
e. Other circumstances deemed necessary that are not listed.

Orders for consultation should include the reason for the consultation, extent and involvement in care expected from the consultant and notation that the consultant has been previously contacted by the ordering practitioner or his/her designee.

The consultation should be documented in the medical record and include discussion of background information and specific questions about the patient. The consultant must make and sign a report of findings, opinions and recommendations that reflects an actual examination of the patient and review of the patient's medical record. Consultation notes will be documentedin the chart and a full typed or dictated consultation note should be created within 24 hours after seeing the patient. The consultant's report of findings will become part of the medical record.

4.4 Delegation of Practitioner Responsibilities

In order to insure quality health care to all patients, certain responsibilities must be performed by a physician and are not to be delegated to non-physicians without proper oversight. These responsibilities are as follows:

a. Admission of patients to the hospitals – physician only.
b. Physician must obtain and review the history of the present illness and perform the initial physical examination or review and countersign if performed by a credentialed physician assistant or nurse practitioner.
c. Dictation of operative notes.
d. Completion of discharge summary and/or death notes.

e. Performance of surgery, which the practitioner has agreed to perform.
f. Signatures of reports, orders or other medical record entries.

4.5 Care Management

Care Management is a hospital-wide, interdisciplinary process that plans, organizes, and provides health care services in a timely, cost-effective manner while maintaining quality patient care consistent with the mission of IU Health Tipton Hospital. As an integral member of the team process, practitioners support effective and efficient utilization of hospital facilities and services through the following actions:

a. Communicate with patient care coordinators and practitioner leaders to help improve inefficiencies in care and safely move the patients to a lower level of care when medically appropriate.
b. Obtain specialty consultation early and frequently.
c. Support evidence based medicine such as in the treatment of DVT, pneumonia, AMI and CHF patients.
d. Review medicines and orders daily:
    i. Discontinue interventions that are not medically necessary (examples: telemetry and Foley catheter)
    ii. Change medicines from IV to oral when appropriate (examples: antibiotics and pain meds)
    iii. Advance diet and activity when appropriate.
e. Discuss daily with your patients (and families) those objectives that will need to be accomplished before discharge is possible.
f. Keep your patient, the family and the interdisciplinary team informed of potential discharge plans and the expected date of discharge.
g. When patient medically meets criteria for discharge and further testing is needed, discharge patient and finish workup as an outpatient
h. Consider end of life issues where Palliative care, Hospice or Geriatric services may be appropriate for the patient.
i. Compare your utilization, LOS and cost performance to your peers.
j. Participate in communication between certification nurse and physician advisor if available to help resolve concurrent verbal denials for continued hospital stay.

The Medical Executive Committee and the IU Health Tipton Hospital Quality Council are responsible for the review of care including Utilization Management functions. Utilization Management issues will be reported at least quarterly or more frequently as deemed appropriate to these committees.

These committees may appoint practitioners outside of the committees to perform concurrent or retrospective chart reviews for Utilization Management. These practitioners will be available to assist and counsel personnel responsible for utilization functions and to consult with peers to resolve issues. Peer review protection applies in accordance with Indiana Peer Review Statue I.C. 34-4-

12.6.1.

4.6 Discharge of Patients

Patients are to be discharged only by order of the attending physician or his/her designee. Telephone orders for discharge may be utilized at the discretion of the attending physician or designee. The attending physician or designee is obligated to communicate to the referring practitioner all appropriate medical information. In the event that patient is being transferred to another agency or institution, the physician is to ensure the same information is documented on approved discharge/transfer forms and an immediate discharge summary is dictated.

Whenever possible, as part of the discharge process, the attending physician or designee is to identify the practitioner who will provide follow-up care after discharge from IU Health Tipton Hospital. Comprehensive communication to the practitioner conducting follow-up by the attending physician or designee is to include the patient's hospital course, medications upon discharge, and need for continuing care.

It is the responsibility of the attending physician or designee to ensure discharge of patients in a timely fashion. Discharge planning is multidisciplinary and practitioner designees are to engage nursing, case management, and other health care disciplines as needed in the process. Care conferences may be necessary to address challenging patient or family issues that could negatively affect discharge. Practitioner is to avail themselves to participate in such conferences or give input when needed.

4.7 Leaving Against Medical Advice

If a patient desires to leave the hospital against the advice of the attending physician or designee without proper discharge, the attending physician or designee will be notified and the patient will be requested to sign the appropriate release form, attested by the patient or legal representative of the patient and a competent third party. Such departure from the hospital is to be noted in the medical record by the attending physician or designee. Child Protective Services shall be contacted if parents or guardians of minors remove or threaten to remove a minor patient against medical advice.

ARTICLE V. CONSENT

5.1 Informed Consent Process

A separate Consent for Procedure form should be completed by the patient and his/her treating practitioner for proposed health care procedures, which involve medically significant risks or medically significant alternatives, for example:

a. procedures using general anesthesia

b. procedures performed in the operating room, treatment room, and endoscopy room
c. procedures which involve such a risk or result that the patient would attach significance to the risks, or results when deciding whether or not to proceed with the proposed procedures, and
d. blood product transfusion

Each clinical department may determine which procedures performed by department members require a Consent for Procedure Form. In addition to discussing the proposed procedures with the patient and completing the written Consent for Procedures form, the treating practitioner should include a note in the patient's medical record to the effect that the practitioner spoke with and advised the patient of the nature of the proposed care, treatment, services, medications, interventions, or procedures; potential benefits, risks, or side effects including potential problems related to recuperation; likelihood of achieving care, treatment and service goals; reasonable alternatives to the proposed care, treatment and service; relevant risks, benefits and side effects related to alternatives, including the possible results of not receiving care, treatment and services; and when indicated, any limitations of the confidentiality of information learned from the patient. The attestation statement in the Consent for Procedure form may serve as the treating practitioner's written note.

The Treating Practitioner should attempt to complete the form at the time of the informed consent discussion with the patient or the patient's representative.

ARTICLE VI. Medical Records

6.1 Handwritten entries and Use of Abbreviations

All entries in the medical record must be legible and in black or blue ink. Pencil entries are not permitted. Entries are to be dated and timed. The date and time of the note will be the date and time of the entry, regardless of whether the content of the note relates to a previous date or time. Documentation throughout the medical record regarding medication orders must be written without the use of unsafe abbreviations.

In order to promote coordination of patient care, all practitioners contributing to care of a patient will be responsible for recording in the medical record: Diagnosis, observation, and patient instruction.

6.2 Authentication of entries

All entries in the medical record must be confirmed by written or electronic signature, identifying the credentials of the authro. Reports dictated and

transcribed through Health Information Management require physician and/or surgeon/procedural practitioner authentication or 3M's Electronic Signature Authentication.

a. A Physician Assistant who is employed/supervised by Attending Physician and who is granted privileges per Medical Staff Bylaws may make appropriate entries in the patient's medical record. Such entries shall be countersigned by the Employing/Supervising attending physician within twenty-four (24) hours thereafter. Supervising physician must be physician physically present or immediately present for consultation at all times.
b. A medical student (including Physician Assistant and Nurse Practitioner students) who has been cleared by Medical Staff Services may round with his or her supervising physician and make appropriate entries in the medical record under the supervision of said physician. These entries must be immediately countersigned by the supervising physician. Any orders that are not countersigned immediately should NOT be taken off the patient's chart without a verbal restatement of the order from the supervising physician.

6.3 Orders

All orders for treatment shall be in writing (electronic or on paper). Initial admission, diagnostic, treatment and discharge orders may be written by the attending physician, dentist or podiatrist (dentists and podiatrists cannot admit). The physician must write an admission status order (inpatient or observation) for each patient receiving services on a nursing unit. Admission orders are required no later than the patient arrival on the unit.
Orders occurring prior to a procedure will not be automatically resumed after the procedure. To ensure patient safety, orders must be rewritten after major procedures to ensure changes to the patient clinical status are taken into full consideration; however, a transfer order summary is available in Cerner which allows the physician/dentist to select orders for renewal. This should be placed on the patient chart by the unit secretary.

Verbal orders are to be reserved as much as possible for emergent situations.

a. A verbal order shall be considered to be in writing if telephoned or dictated by the physician (or authorized member of the physician's office staff), dentist, podiatrist, or psychologist to the following authorized hospital staff:

Registered nurses	All orders
Licensed practical nurses	All orders
Laboratory technicians	Laboratory orders only
Radiology technicians	Radiology orders only
Respiratory therapy tech.	RT orders only
Physical therapist	PT orders only
Occupational therapist	OT orders only

Dietitian	Diet orders only
Registered pharmacists	Pharmacy orders
Specialty Care Center assistants	Outpatient tests and scheduling orders

b. Authorized hospital staff members shall write such verbal orders in the medical record. The name of the ordering practitioner and/or authorized office staff member per his or her own name and title must be written in the order along with the name and title of the authorized staff member who received the order.
c. The authorized hospital staff member who took the order shall repeat and verify the order with the ordering practitioner. The fact that the order was repeated and verified shall be documented on the order within the patient's medical record and appropriately signed and dated by the authorized staff member that took the order.
d. All verbal orders not repeated and verified shall be signed and dated by the practitioner within forty-eight (48) hours. All verbal orders that were repeated and verified shall be signed and dated by the ordering practitioner within 30 days of discharge.
e. Written verbal and telephone orders may be signed by another practitioner in the same call group if an Authentication Agreement is on file with Health Information Management.

Physicians who authorize personnel in their offices to communicate their orders must maintain a current list of those authorized individuals, and titles, with the hospital administration.

The medical staff may adopt and, from time to time change, standing orders where there is a specific diagnosis and only in specialized care areas such as Surgery and ICU. Such orders are to be signed by the practitioner who uses the orders. Standing orders must be reviewed and re-authenticated at least annually by the medical staff. Hospital administration shall be notified promptly of the adoption of the standing orders and changes therein and shall notify all personnel concerned.

A verbal or written time-limited order with specific start and stop times is required for each use of restraint or seclusion. The type of restraint must be included in this order. Physician must consider and reject all other alternative treatments as a reason for restraint. The use of PRN orders for restraints or seclusion is prohibited.

6.4 History and Physical

Requirements for History & Physical Examinations can be found in the Appendix of the IU Health Tipton Hospital Medical Staff Bylaws.

6.5 Progress Notes

Progress notes shall give a pertinent chronological report of the patient's course in the hospital and reflect any change in condition, the results of treatment, and discharge planning.

Progress notes must be recorded at the time of observation and be sufficient to permit continuity of care and transferability of the patient. Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

Progress notes must be typed daily, dated and timed, and be authenticated by the practitioner making the note.

The attending physician may make prior arrangements with another member physician for daily rounds, progress notes and management of care in their absence.

A Physician Assistant who is employed/supervised by Attending Physician and who is granted privileges per Medical Staff Bylaws may round on behalf of the Employing/Supervising attending physician and is required to make appropriate entries including progress notes in the patient's medical record. Such entries shall be countersigned by the Employing/Supervising attending physician within twenty-four (24) hours thereafter. Supervising physician must be physician physically present or immediately present for consultation at all times.

A medical student (including Physician Assistant and Nurse Practitioner students) who has been cleared by Medical Staff Services may round with his or her supervising physician and make appropriate entries including progress notes and orders in the medical record under the supervision of said physician. These entries must be immediately countersigned by the supervising physician.

6.6 Operative/Procedure Notes

Operative reports must be dictated immediately following any surgical or invasive procedure. The operative report must be dictated within 24 hours using the hospital's dictation system or the responsible physician/surgeon can provide the completed typed operative report to the facility within 48 hours of the procedure. The reports must contain the preoperative diagnosis, the postoperative diagnosis, name of the primary surgeon and any assistants, detail the technical procedures used, the description of findings, blood loss, specimens removed, and the condition of the patient at the conclusion of the procedure

The practitioner must enter an operative progress note in the medical record immediately after the procedure, providing sufficient and pertinent information for any practitioner required to attend to the patient until the operative report is

available.

6.7 Tissue and Examinations Reports

Tissue removal procedures are directed through the Medical Staff Policy on Tissue/Surgical Case Review. All surgery pathology reports prepared by the Pathology Department shall have a code inserted by the pathologist to convey one of the following:

1. **Code 0:** Insufficient clinical information concerning pre-operative diagnosis for coding purposes.
2. **Code 1:** Tissue removed for diagnostic purposes.
3. **Code 2:** Tissue removed for therapeutic purposes with no major discrepancy between the pre-operative (clinical) and post-operative (pathological) diagnosis.
4. **Code 3:** A major discrepancy exists between the pre-operative (clinical) and the post-operative (pathological) diagnosis.
5. **Code 4:** Referral or consultation case originating at another institution.

Through audit efforts of the Tissue Review Committee, cases of concern will be channeled for peer review.

6.8 Cancer Staging

AJCC (American Joint Committee on Cancer) Staging is assigned by the managing physician based on primary site, histology, and clinical and pathologic staging criteria for all eligible analytic cases. The managing physician includes the surgeon(s), hematology/oncologist, radiation oncologist, or other specialist(s) involved in diagnosing or treating the cancer patient. The AJCC TNM (Tumor-Nodes-Metastasis) staging classification system is a tool for physicians to stage different types of cancer based on anatomic location and specific standard criteria.

Staging allows for determination of appropriate treatment, and serves as a prognostic indicator. Physician staging of cancer provides a means of comparison of internal experience with national data, and is a recognized benchmark of quality in cancer patient care. Refer to the Oncology Policy/Procedure Manual staging policy, ONC - 01 for complete details and definitions.

6.9 Discharge Summary

The discharge summary is the responsibility of the attending physician. The discharge summary must be completed upon discharge of the patient from the hospital. The discharge summary must include documentation of the provisional diagnosis or reason(s) for admission, the principal and additional or associated diagnoses established by the time of discharge, significant findings, procedures performed and treatment rendered, condition of the patient on discharge, and specific instructions given to the patient and/or family (especially relating to

physical activity, diet, medications, and follow-up care). A final progress note may be used for patients staying less than 48 hours (inpatient or observation) if it includes data necessary to support the diagnosis and the treatment given, with reports of procedures and tests, and their results, clinical observations, including the results of therapy, and anesthesia given, if applicable. A discharge summary is required for a deceased patient whose stay was less than 48 hours.

6.10 Autopsy

Every member of the Medical Staff is expected to attempt to secure autopsies in all deaths that meet the criteria adopted by the medical staff. No autopsy shall be performed without written consent of a relative or legally authorized agent. All autopsies shall be performed by the hospital pathologist or by a physician delegated this responsibility. The attending physician shall be notified when an autopsy is being performed.

When one or more of the following criteria are present the medical staff will make a concerted effort to secure autopsy permission:

a. Deaths in which autopsy may help to explain unknown and unanticipated medical complications of the attending physician.
b. All deaths in which the cause of death or major diagnosis is not known with certainty on clinical grounds.
c. Cases in which autopsy may help to allay concerns of the family and/or the public regarding the death and to provide reassurance to them regarding same.
d. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical procedure and/or therapies.
e. All obstetric deaths.
f. All neonatal and pediatric deaths.

The following deaths must also be reported to the coroner; however, a coroner's forensic autopsy will not necessarily be performed:

a. Violent deaths whether apparent homicide, suicide or accident, including but not limited to deaths due to thermal, chemical, electrical, or ionizing radiation injury; and deaths due to illegal abortion, whether apparently self-induced or not.
b. Deaths from suspicious, unusual or unnatural circumstances.
c. Deaths in patients not recently seen by a physician.
d. Deaths related to disease that might constitute a threat to public health such as hepatitis, AIDS, or other communicable diseases. This category overlaps the duties of the County Health Officer requiring the cooperation between the Coroner and Health Officer.
e. Deaths that occur in the course of a therapeutic or diagnostic procedure.
f. Deaths related to disease resulting from employment or to an accident while employed; including disease related to injury.
g. Deaths of transplant surgery donors that are the result of trauma.

h. Sudden or unexpected death of child, including sudden infant death syndrome.
i. Deaths of poisoning/overdoses.

6.11 The inpatient record shall include identification data, report of the medical history and relevant physical examination, diagnostic and therapeutic orders, evidence that the physician has discussed with the patient the proposed surgery or other treatment, the risks and alternatives, and that a written informed consent has been secured, clinical observations, including results of therapy, reports of procedures, tests and results, a summary of the termination of hospitalization, including plans for follow-up, discharge medications, diet, and instructions to the patient in regard to physical activity limitations, and a provisional and final diagnosis.

6.12 The emergency department records shall include patient identification, time and means of arrival, pertinent history of the illness or the injury and physical findings, including vital signs, emergency care given to the patient prior to arrival, diagnostic and therapeutic orders, clinical observations, including results of treatment, reports of procedures and tests, diagnostic impression, final disposition of the patient condition on discharge or transfer, instructions given to the patient (or other responsible person) for follow up care, and signed consent for treatment.

6.13 The ambulatory care record shall include patient identification, relevant history of illness or injury and physical findings, diagnostic and therapeutic orders, clinical observations, including results of treatment, reports of procedures, tests and results, diagnostic impression, patient disposition and any pertinent instructions given to the patient (or other responsible person) for follow up care, and signed consent for treatment.

6.14 The outpatient surgery record shall include patient identification, appropriate history, physical examination, and any required laboratory and x-ray examination, preoperative diagnosis established prior to surgery, reports of procedures, tests and results, postoperative diagnosis, dismissal order by physician releasing patient from the hospital, postoperative care including patient care guidelines for post-anesthesia recovery, disposition of the patient and written instructions for follow up care for the patient (or other responsible person), directions for obtaining an appropriate physician for postoperative problems, and signed consent for treatment.

ARTICLE VII: On-Call Responsibilities

7.1 All primary care physician (i.e., general practitioners, family practitioners, and internists) members of the Active Medical staff practicing in this hospital will

participate in the emergency call service with the exception of the following: (Approved Board of Trustees 4/11/88).

a. All specialists.
b. Individual cases subject to consent of the medical staff.

7.2 The staff physician will be assigned based on the group's call schedule. Responsibility begins at 6:00 a.m. each day and ends at 6:00 a.m. the following day unless an exception is noted on the call schedule.

7.3 The scheduled physician must be available on his scheduled days or be responsible for contacting another to act as his substitute. In case of substitution, the originally scheduled physician is responsible for notifying the hospital switchboard of the substitution.

7.4 When covering on-call services at the hospital, the physician on call is required to respond promptly to all pages or phone calls. The physician on-call must be physically within a reasonable distance from the hospital in order to promptly report to the hospital when needed.

7.5 The physician scheduled for the day will be called when:

a. The ED physician determines that an ED patient should be admitted for inpatient service or needs outpatient follow up and the patient has no area physician or his attending physician or the physician covering his practice cannot be reached.

7.6 No patients will be admitted from the ED for inpatient services until the staff physician who will treat the patient is notified.

7.7 Associate staff physicians will be responsible for the care of their patient admitted to the hospital unless they have made prior arrangements with an Active staff member.

ARTICLE VIII. AVAILABILITY

8.1 Physicians should be readily available to respond to calls from the hospital. It is the responsibility of all members of the Medical Staff who provide patient care at IU Health Tipton Hospital to quickly and accurately resolve immediate and urgent clinical concerns.

8.2 The following criteria are applicable to calls from the hospital:

a. During office hours, the physician's office should be called initially.
b. STAT pages or phone messages should be answered or returned within 10 minutes. **They will be coded as a "1" on numerical pagers or "STAT" on text pagers when the physician is paged.**
c. STAT pages or calls also should be utilized when nursing personnel deem

an emergency situation exists regarding patient care.

d. All other pages or calls shall be answered within 30 minutes.
e. If a physician does not answer within the above time frame, a repeat page should be undertaken and an additional number be called (i.e., home phone).
f. If a physician does not respond to a second page or call, an alternate physician should be contacted, as delineated below. This physician should be contacted if the second page or call is not answered within 5 minutes for a STAT page or 15 minutes for a routine call.

   ALTERNATIVE PHYSICIANS (in order of calling sequence, depending on availability):

   1. ON CALL PHYSICIAN
   2. OTHER MEMBERS OF CALL GROUP
   3. MEDICAL STAFF PRESIDENT
   4. MEDICAL STAFF VICE PRESIDENT

g. Summary of steps will be followed when pages or calls are not promptly answered:

STAT	*ROUTINE*
No answer in 10 min. - repeat call.	*No answer in 30 minutes. - repeat call.*
No answer in 5 min.	*No answer in 15 minutes.*
- call alternate physician at this point.	

h. Lack of availability may result in disciplinary action.

ARTICLE IX. QUALITY/PATIENT SAFETY

9.1 Quality Measurement and Improvement

Medical Staff Members and Allied Health Providers are expected to participate in quality activities for the clinical service in which the practitioner practices. Trending of aggregate data on clinical processes and outcomes, professionalism, administrative and utilization data is shared with the practitioner. Practitioner is expected to examine their individual performance as compared to peers among their service in order to identify opportunities for improvement in their clinical practice.

Practitioner will at intervals be asked to participate on performance improvement teams.

9.2 Peer Review Activities

Assessment of individual episodes of patient care management is triggered through various mechanisms, such as routine quality reviews, care management, medical staff committee activities and risk management activities. Peer review

will be conducted as part of quality improvement efforts. Practitioner is to respond promptly to queries from peer practitioners regarding interventions for individual episodes of care.

9.3 Root Cause Analysis (RCA) and Risk Management Activities
Practitioner may be requested to participate in at intervals in activities to promote patient safety and reduce risk to patients and improve processes throughout IU Health Tipton Hospital. Root causes analysis (RCA) sessions will be conducted on any sentinel event, serious event with the systems implication of a sentinel event, or a near miss event. The Risk Management Department, or in some cases, the Quality Department, will contact the practitioner to determine a meeting time to conduct a systems review. Practitioners are asked to make attendance at such meetings a priority.

Additionally, Practitioners are to promptly report patient errors or other patient-related safety issues to the Risk Management Department by completing an incident report or by contacting the Risk Management Director.

ARTICLE X. MEDICAL STAFF MEETINGS

10.1 The regular meetings of the Medical Staff shall be held on the second Monday of every other month at 12:00 noon and shall be conducted in accordance with the bylaws.

10.2 Medical Executive Committee (MEC) will meet on the second Monday of every month and shall be conducted in accordance with the bylaws. MEC will meet immediately following each Medical Staff Meeting. On the months that full Medical Staff does not meet, MEC will meet at 12:00 noon.

10.3. The Annual Medical Staff meeting shall be the November regular Medical Staff meeting.

ARTICLE XI. GENERAL RULES/EXPECTATIONS

11.1 Confidentiality
In keeping with state and federal laws as well as IU Health Tipton Hospital policy, all medical records, patient-specific information, peer review materials, risk management materials, credentialing records and files, minutes of relevant Medical Staff and hospital meetings, are the property of IU Health Tipton Hospital.

Access to confidential materials by Medical Staff is permissible only when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, credentialing or other authorized activity. This requirement applies to information in electronically stored or hard copy format.

11.2 Adherence to IU Health Tipton Hospital Policy and Procedures
All members of the Medical Staff are expected to adhere to established policies and procedures for IU Health Tipton Hospital. This includes adherence to all health care regulatory and accreditation requirements. Breach of policies, standards or regulations by individual practitioners will be handled through peer review mechanisms of the Medical Staff.

11.3 Drugs and Pharmacy
Physicians shall follow the Pharmacy and Therapeutics guidelines. Exceptions to the guidelines must have the approval of the Pharmacy and Therapeutics Committee chairman.

11.4 Emergency Care
Individuals who "come to the dedicated emergency department" (as defined within 42 CFR §489.24) will receive a medical screening examination appropriate to their presenting signs and symptoms and consistent with the capability and capacity of the hospital to determine whether or not an emergency medical condition exists. This screening shall occur regardless of the patient's ability to pay and shall be conducted
in whole or in part by the following individuals designated as "Qualified Medical Personnel" (QMPs) within the statutory definition:

- Credentialed Physicians or Dentists
- Credentialed Allied Health Practitioners
- Emergency Department Triage Nurses
- Psychiatric Professionals/Assessment Team Members
- Labor and Delivery Nurses

When non-Credentialed staff members assist with or perform the medical screening examination, their assessments are consistent with established policies and protocols or are in collaboration and consultation with appropriate Credentialed practitioners as necessary. The patient's primary physician/dentist, if applicable, will be notified of the patient's condition. If, based on the patient's condition, the Emergency Department
physician/dentist determines that consultation of a specialist is required; the Emergency Department physician/dentist will contact a specialist in accordance with the primary care physician/dentist's normal referring pattern.

Patients received in the Emergency Department without referral by, or not under the care, of a private physician/dentist will be assigned to a physician/dentist on-call as deemed appropriate by the Emergency Medicine Physician/dentist. The Emergency Department physician/dentist will contact an appropriate primary/specialty care physician/dentist guided by the on-call schedule established by each section.

11.5 Each Medical Staff member and Allied Health Care Provider shall be familiar with the Internal/External Disaster Alert Policies and, should such an emergency occur, actively participate under the direction of the Medical Staff President and Incident Command.

11.6 Members of the medical staff are encouraged to attend medical education meetings on a local, state, and national level and report to the staff of the points of interest.

11.7 Appropriate psychiatric counseling will be offered to patients who are emotionally ill, who become emotionally ill while in the hospital, or who suffer the results of alcoholism or drug abuse. Restraints will be used in accordance with hospital policy as well as Medical Staff Rules and Regulations, Article VI, 6.3.

11.8 A member of the medical staff, having surgery privileges but who is not located closely enough to the hospital to provide continuous care to his/her surgical patients must, prior to any inpatient surgery he/she wishes to perform, make arrangements with a properly qualified member of the medical staff for coverage of the inpatient surgical patient from admission until the patient's discharge from the hospital. Such arrangement must be noted in the patient's chart and such notation shall be initialed by the surgeon and covering medical staff member.

11.9 The medical staff shall have input into developing and reviewing hospital policies and procedures related to patient care. Physician advisors and physician directors of hospital services shall review (and sign) hospital and nursing policies related to their respective service on a yearly basis. A summary, with particular note of significant change, will be reported.

11.10 All Medical Staff Members and Allied Health Care Providers shall be assessed dues. The dues shall be collected annually in January in the amount established annually by the Medical Staff.

11.11 In the event that the practitioner's patients' records become delinquent while he/she is out of town, on vacation, or ill (at least for a 5 day period), he/she shall have seven (7) days following his/her return to correct the delinquency.

11.12 All records, including x-ray films and tissue file and tissue slides, are the property of the hospital and shall not be removed without an appropriate court order, subpoena, or statutory authorization. In case of readmission of a patient all previous records shall be available for the use of the attending physician and/or practitioner.

11.13 Free access to all medical records of all patients shall be afforded to practitioners

in good standing for study and research as approved by the Executive Committee, consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the Chief Executive Officer, former members of the medical staff shall be permitted free access to the information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

11.14 Every three years, these rules as a whole shall be reviewed and revised as necessary by the Medical Executive Committee. They shall be presented for adoption by the Medical Staff and shall be presented to the Board of Directors for their approval.

11.15 These rules may be amended and adopted at any regular meeting of the medical staff by a two-thirds (2/3) vote of those members of the Active Medical Staff present at the meeting, and such amendments shall become effective when approved by the governing board of the hospital.

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Approved at a regular meeting of the Executive Committee/Medical Staff on 1/9/2017.

Michael Hagan MD
Medical Staff President

1/9/17
Date

Approved by the Board of Directors on 1/26/17.

Steven A. Katz
Chairman, Board of Directors

1/26/17
Date