PARKVIEW

# PARK CENTER, INC.

# Medical Staff Bylaws

**Reviewed and Approved 11/16/21**

Revision dates listed at end of document

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Copies of Medical Staff Bylaws, Rules and Regulations, and all Medical Staff Policies are available through Medical Staff Services upon request of any Medical Staff member and are available on Team Parkview http://parkviewhealth.sharepoint.com/sites/Teams/clinical/MedStaff.

## DEFINITIONS

As used in these Bylaws, the following terms are defined as follows:

**"Active staff"** or **"Active Medical Staff"** means those practitioners whom the Medical Staff Executive Committee (MSEC) determines are located closely enough to the Hospital to provide continuous care to their patients, and who assume all the functions and responsibilities of appointment on the Active Medical Staff and consultation assignments. Reference Article IV.

**"Ad Hoc Hearing Committee"** shall mean the Medical Staff hearing committee described in Article VII, Section 1 below.

**"Allied Health Practitioners"** means individuals who are not otherwise eligible for membership on the Medical Staff, but who, by documented experience and/or training, applicable licensure or certification,and demonstrated competence are qualified to provide services needed or desired by the Medical Staffand who are approved by Parkview Hospital. Allied Health Practitioners may be either Dependent, (e.g.RN, CST, etc.), or Advanced Practitioner (e.g. Advanced Practice Nurses, Physician Assistants, Psychologists). For individuals performing service as Advanced Practitioners, the Medical Staff Executive Committee must recommend them for clinical privileges to the Hospital Board of Directors.

**"Associated Policies"** or **"Policies"** means documents describing a definite course or method of action to guide and determine present and future decisions. These Policies must be approved by the Medical Staff Executive Committee and are attendant to the Bylaws of the Medical Staff, as are the Medical Staff Rules and Regulations. All Medical Staff Policies approved by the Medical Staff ExecutiveCommittee must be communicated to the entirety of the Medical Staff in a timely fashion.

**"Board"** or **"Board of Directors"** of the Hospital means the legally constituted and elected Board of Directors of Park Center, Inc.

**"Bylaws"** mean these Medical Staff Bylaws.

**"Center/Hospital"** means the hospital and mental health center of Park Center, Inc.

**"CEO"** means the Chief Executive Officer of Park Center, Inc. appointed by the Board of Directors to act on its behalf in the management of the Center/Hospital. The CEO may be designated by the Board of Directors under another title, for example: Administrator, President or Executive Director.

**"Clinical Privileges"** or **"Privileges"** means the permission granted to a Practitioner to provide specific services to patients, and to perform specific clinical functions in the Hospital with reasonable access toHospital equipment, facilities and personnel necessary to effectively exercise such privileges inaccordance with these Bylaws.

**"Conduct"** refers to a Practitioner's interactions with Hospital personnel, patients, visitors, and other Practitioners in a positive, non-disruptive manner. Examples of unacceptable conduct would include abusive behavior, racial or sexual harassment.

**"Consulting staff"** means those Practitioners who possess specialized skills needed at the Hospital for a specified project or on an occasional basis when requested by members of the Medical Staff.

**"Contract Practitioner"** means a Practitioner who provides professional medical services to the Hospital and/or its patients pursuant to a direct contract with the Hospital. Such a Practitioner may or may not be an employee of the Hospital but shall in either event be required to fulfill the requirementsof the Medical Staff and Staff category to which he/she is assigned.

**"Courtesy staff"** or **"Courtesy Medical Staff"** means those Medical Staff members who do not intendto use the Hospital as their primary Hospital for practicing medicine, but who upon occasion, because of their

association with Active staff members and/or place of practice, need access and may choose to utilize the Hospital to accommodate their patients and colleagues.

**"Days"** unless otherwise specified, any reference to number of days refers to calendar days.

**"Ex-Officio"** means by virtue of an office or position held. Unless otherwise expressly provided, an Ex-Officio Department/Committee member does not possess voting rights.

**"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996 and any regulations promulgated thereunder.

**"Hospital"** means Park Center, Inc. as embodied by the Board of Directors.

**"Licensed Independent Practitioner"** means any individual permitted by law and the Hospital to provide care, treatment, and services without direction or supervision. These include licensed allopathicor osteopathic physicians, dentists, or podiatrists who are members of the Medical Staff, and if applicable privileged to attend patients in the Hospital.

**"Medical Director** or **Chief Medical Officer"** means the physician appointed by the Hospital Presidentand confirmed by the Medical Staff Executive Committee, to act as the liaison officer between the Hospital's administration and the Medical Staff and to assist the Medical Staff leadership in carrying out its duties.

**"Medical Staff"** or **"Staff"** means licensed allopathic or osteopathic physician, advance practice nurse (APN), Physician Assistant (PA) or clinical psychologist (HSPP) who are members of the Medical Staff, and if applicable, privileged to care for patients in the Hospital.

**"Medical Staff Executive Committee"** or **"MSEC"** means the Medical Staff Executive Committee appointed pursuant to these Bylaws.

**"Medical Staff Member"** or **"Member"** means a physician, advance practice nurse (APN), Physician Assistant (PA) or clinical psychologist (HSPP) who has successfully applied and been accepted to the Medical Staff. Other staff working within Park Center, Inc. who provide patient care are not Members and provide care under the supervision of Members.

**"Park Center, Inc."** means the areas under the scope of the Hospital's organizational chart and the licensure obtained from the Indiana State Department of Health. See also "Hospital."

**"Personnel of a Peer Review Committee"** means not only members of such committee but also allthe committee's representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves on a peer review committee in any capacity whether such person isacting as a member or is under a contract or other formal agreement with the committee, and any person who participates with or assists the committee with respect to its actions.

**"Policies"** or **"Associated Policies"** means documents describing a definite course or method of action to guide and determine present and future decisions. These Policies must be approved by the Medical Staff Executive Committee and are attendant to the Bylaws of the Medical Staff, as are the Medical Staff Rules and Regulations. All Medical Staff Policies approved by the Medical Staff ExecutiveCommittee must be communicated to the entirety of the Medical Staff in a timely fashion.

**"Precautionary"** means action done without delay or formality as an interim step and does not imply any final finding.

**"Prerogative"** means a participatory right granted, by virtue of Staff category or otherwise, to a Staff appointee and is exercisable subject to the conditions imposed in these Bylaws, Medical Staff Rules and Regulations, and in other Hospital/Center and Medical Staff policies.

**"President of the Hospital"** means the individual appointed by the Board of Directors to act in its behalf of the

overall management of the Hospital.

**"Professional Citizenship"** means maintaining the responsibilities of Medical Staff members as delineated in Article III, Section 4.

**"Professional Review Action"** means any action of a professional review committee taken to evaluateeither the qualifications, the patient care provided, or the merits of a complaint against a Practitioner, provided that the evaluation of any such complaint shall include a determination or recommendation concerning the complaint.

**"Professional Review Committee"** or **"Peer Review Committee"** means the governing body or any committee of the governing body, any committee of the Hospital, the Medical Staff and any Administrative Committee, Special Committee, or ad hoc committee of the Medical Staff, which conductsprofessional review activity.

**"Residents"** refers to all practitioners in training who are assigned to clinical rotations by residency programs that are affiliated with the Hospital.

**"Rules and Regulations"** means statements that exert control and direction. It includes the policies of the Medical Staff as defined in Article 15 and appended to these Bylaws. Rules and Regulations are attendant to the Bylaws of the Medical Staff, as are the Medical Staff Policies. Any amendments tothe Rules and Regulations must be communicated to the entire Medical Staff in a timely fashion.

**"Service Area"** means the eleven counties in northeast Indiana, including Adams, Allen, DeKalb, Huntington, Kosciusko, LaGrange, Noble, Steuben, Wabash, Wells, Whitley, and Northwest Ohio.

**"Specialty"** most commonly means the subject area or branch of medical science for which a member has trained and, with the exception of those who have not requested clinical privileges, demonstrated current competence.

**"Specialty Representative"** or **"Specialty Rep"** means the individual elected by members of a specific Specialty to represent the perspective of the Specialty to the Medical Staff.

**"State"** means the State of Indiana.

**"Telemedicine"** means the exchange of information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services.

**"Temporary Privileges"** means Clinical Privileges granted to a practitioner for a specified period of time and under prescribed circumstances as defined in Article V, Section 8.

## ARTICLE I: NAME

The name of this organization shall be "The Medical Staff of Park Center, Inc." The words "Staff"or "Medical Staff" will be used herein to abbreviate the official title. This Medical Staff is an integral and constituent part of the Hospital and not a separate entity.

## ARTICLE II: PURPOSES, RESPONSIBILITIES, DUTIES AND OBLIGATIONS

### Section 1: Purposes

The purposes of the Medical Staff are:

1. To be the formal organizational structure and collegial body of professionals through which: (a) the benefits of membership are obtained by individual professionals and (b) the obligations of Medical Staff membership are fulfilled.
2. To self-govern Medical Staff activities and accountability to the governing body including the oversight of care, treatment, and services. To provide oversight of the quality of care, treatment and services delivered by practitioners who are credentialed and privileged via the Medical Staff process.
3. To endeavor to provide quality professional services in a highly ethical manner to all patients according to recognized professional standards.
4. To provide advice and recommendations to the Board of Directors of the Hospital concerning the appointment, reappointment, and delineation of Clinical Privileges that each Practitioner may exercise in the Hospital.
5. To perform the responsibilities of the Medical Staff to support clinical and scientific work of the Hospital.
6. To provide advice to the Board of Directors of the Hospital regarding professional matters and Policies.
7. To review the professional practices in the Hospital for the purpose of reducing morbidity and mortality and for the improvement of the care of patients in the Hospital.
8. To participate in the educational process in a manner that will lead to continuous advancement in professional knowledge and skill; to cooperate as may be appropriate with affiliated medical schools and other educational institutions with which the Hospital is affiliated in undergraduate, graduate, and continuing medical education.
9. To initiate and maintain rules, regulations, and policies for governance of the Medical Staff; and to maintain a harmonious relationship between members of the staff, the Board of Directors of the Hospital, Administration, and personnel of the Hospital.
10. To provide a means or method by which members of the Medical Staff can formulate recommendations for the Hospital's policy making and planning processes, and through which such Policies and plans are communicated to and observed by each member of the Medical Staff.
11. To perform the Medical Staff's responsibilities to the Board of Directors of the Hospital as may be provided by State law.
12. To provide leadership for, and collaborate with, the organization's performance improvement activities.

### Section 2: Responsibilities

The responsibilities of the Medical Staff are:

1. to account to the Board for the patient care processes and outcomes rendered by all Members and non-members authorized to provide patient care in the Hospital/Center through the following means:
   a. a credentialing program, including procedures for appointment and reappointment that matches

verified qualifications, performance, and competence with the Clinical Privileges sought to be exercised or of specified services to be performed;

b. continuing medical education based, in part, to the degree reasonably possible, upon the needs demonstrated through the quality management program;

c. ensuring a utilization review/case management program to allocate medical and health services based upon clinical determinations of individual treatment needs;

d. ensuring a procedure for monitoring patient care practices, including intake, assessment, treatment plans, treatment plan reviews, and restraint and seclusion;

e. active involvement in the measurement, assessment, and improvement of patient care processes and outcomes through a valid and reliable quality management program consistent with the requirements of The Joint Commission;

f. recommending to the Board of Directors policies and procedures that define the trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a practitioner's performance and evaluation of a practitioner's performance by peers. The information relied upon to investigate a practitioner's professional conduct and practice may include (among other items or information), internal or external chart reviews, prospective, concurrent and/or retrospective monitoring of actual practice, monitoring of clinical practice patterns, proctoring, and consultations with physicians, assistants, nurses or Administrative personnel involved in the care of patients; and

g. a procedure to ensure that each Member provides professional services within the scope of individual Clinical Privileges granted.

2. to recommend to the Board action with respect to appointments, reappointments, Staff membership and status, Clinical Privileges, corrective action, hearing procedures;

3. to account to the Board for patient care processes and outcomes through regular reports and recommendations made concerning the results of quality management activities;

4. to initiate and pursue corrective action with respect to Members as provided in these Bylaws;

5. to assist in identifying community needs and in setting appropriate organizational goals and implementing programs to meet those needs;

6. to exercise the authority granted by these Bylaws as necessary to fulfill adequately the foregoing responsibilities;

7. to monitor, enforce, review, and, if necessary or desirable, recommend amendments to these Bylaws and Rules and Regulations and Hospital/Center policies;

8. to uphold Park Center, Inc.'s policies on ethical practices; and

9. to participate in the development and to monitor the Hospital/Center's educational programs.

**Section 3: Duties and Obligations**

The purposes of the Medical Staff organization are:

1. Conduct outcome-oriented performance evaluations of its members at least once every two years. To endeavor to provide quality professional services to all patients according to recognized professional standards.

2. Examine credentials of candidates for appointment and reappointment to the Medical Staff by using sources in accordance with policy and applicable state and federal law. Credentials examined shall include, and not be limited to, a request for clinical privileges, current licensure, training and professional education, documented experience, and supporting references of competence.

3. Make recommendations to the Board of Directors on the appointment or reappointment of the applicant.
4. Maintain a separate and reasonably accessible hard copy or electronic file for each member of the Medical Staff.
5. Review these Medical Staff Bylaws at least once every three years.

## ARTICLE III: GENERAL QUALIFICATIONS OF MEDICAL STAFF MEMBERSHIP

### Section 1. Medical Staff Membership

Membership on the Medical Staff is an authorization to exercise only such Clinical Privileges with the facility as are specifically granted, if any, and shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws and associated rules, regulations, and Policies of the Medical Staff and Hospital.

An applicant or member must never have been convicted of, entered a plea of guilty to, or no contest to, a felony relating to controlled substances, illegal drugs, insurance or health care fraud, or abuse, or violence and, if so, must be able to show that he/she does not have a demonstrated pattern of illegal activity or misdemeanor convictions relating to the same. In addition, he/she has taken appropriate steps to prevent future occurrences. Should such incidents occur during appointment to the Medical Staff, appointment and Clinical Privileges will be automatically relinquished. Indictment for such allegations will result in review by the MSEC to determine if the allegations could reflect adversely on the reputation of the Hospital and the other Medical Staff members in the community and/or raise question about the member's continued eligibility for Medical Staff membership. In addition, he/she has taken appropriate steps to prevent future occurrences.

An applicant or member must not have restrictions of any kind against any professional license, controlled substance registration, or Federal Drug Enforcement Administration (DEA) registration. If a member, during appointment to the Medical Staff, is convicted of, enters a plea to, or no contest to, a felony of any kind, or has a restriction placed upon any professional license, controlled substance registration, or DEA registration, s(he) will report it to a Medical Staff Officer immediately.

### Section 2. Qualifications for Membership

Only practitioners who meet and continually maintain the following requirements are qualified for appointment to the Medical Staff:

1. physician (MD or DO), APN, PA or Health Services Provider in Psychology (HSSP psychologist)
2. unrestricted license to practice in the State of Indiana
3. can document the following sufficiently to assure the Medical Staff and the Board that any patient treated by them in the Hospital will be given quality care:
   a. background, qualifications, education, professional experience, relevant training, clinical judgment, physical/mental/emotional capability as related to privileges, and current competence
   b. ability to safely perform any privileges requested
   c. strict adherence to the ethics of their profession
   d. good reputation and character
   e. ability and willingness to work collegially and cooperatively with others
4. attain Board Certification or Board-Eligibility in their primary specialty by a Board recognized by the ABMS, (or other equivalent recognized by these Boards) within five (5) years of initial opportunity to initiate eligibility/admissibility to their respective Boards. Those members not meeting the Board Certification or Board-Eligibility requirement, but who have been privileged to practice at Park Center prior to its affiliation with Parkview Health System are "grandfathered" under the requirements in effect at that time. Those Medical Staff members who were at that time board certified or subsequently obtained board certification are required to maintain certification in their

primary specialty.

5. Exceptions may be made for residents working at Park Center. Exceptions will be made for general dentists for which a Board Certification does not exist and Non-Voting, Membership Only members; and shall fulfill such other criteria as may be established by the Board from time to time.

No practitioner shall be entitled to appointment on the Medical Staff or to the exercise of certain Clinical Privileges in the Hospital merely because he/she is duly licensed to practice in Indiana or in any other state, or that he/she is a member of any professional organization, or that he/she had in the past, or presently has, such privileges at this Hospital or another Hospital.

**Section 3. Nondiscrimination**

No aspect of any decision to grant, deny, or renew Medical Staff membership and/or Clinical Privileges will be based on gender, race, age, national origin, color, ethnicity, creed, religion, physical or mental disability, gender identity or expression,sexual orientation, or any other legally protected characteristic.

**Section 4. Responsibilities of Medical Staff Membership**

In addition to the other obligations in these Bylaws, each applicant applying for or granted membership is obligated to:

1. Provide their patients with timely and appropriate care of a professionally accepted level of quality and efficiency and delegate the responsibility for diagnosis, treatment or supervision of care of patients only to those who have Clinical Privileges to undertake that responsibility.
2. Abide by the Bylaws, rules, regulations, and associated Policies of the Medical Staff and of the Hospital, and codes of ethics of the American Medical Association and board-certifying bodies applicable to each member's credentials as they exist now or in the future.
3. Provide emergency medical care for any patient following accepted guidelines of their respective department and specialty. Any member with delineated Clinical Privileges may provide emergency care to any patient in a life-threatening emergency or a situation that threatens serious harm, provided that the care provided is within the scope of the individual's license.
4. Agree to and recognize the Hospital's obligation to query and report adverse actions to the National Practitioner Data Bank as established by federal statute. Information obtained by query of the Data Bank will be used in evaluating the practitioner's qualification for initial and/or continued membership, and privileges, if applicable.
5. Provide appropriate and timely care to patients for whom they are assigned as attending or consulting physician, and that this care is provided by an appropriate level of physician coverage.
6. Make appropriate arrangements for coverage of patients to ensure continuous care.
7. Maintain professional medical liability insurance coverage to cover the scope of privileges requested and in accordance with the Indiana Medical Malpractice Law (Indiana Code 34 - 18).
8. Inform the Medical Staff in a timely manner of any changes made, or formal action initiated that could result in a change to license, state or federal controlled substance registration, professional medical liability insurance coverage, and voluntary or involuntary reduction of Clinical Privileges at other health care institutions. Final judgments or settlements for any malpractice activity must be reported.
9. Work with other individuals and organizations in a cooperative, professional and civil manner, refraining from any activity that is disruptive of Hospital or Medical Staff operations.
10. Cooperate with and participate in performance improvement, peer review, utilization review, whether related to self or others.
11. Complete all medical records for patients provided care in the Hospital in a timely manner.
12. Abide by all applicable federal and state laws, rules, and regulations and comply with the applicable standards of The Joint Commission.
13. Refuse to engage in improper inducements for patient referral or any other unethical behavior.
14. Pay Medical Staff dues and assessments, if applicable.

15. Exercise privileges only as specifically granted by the Board of Directors.
16. Assume medical and legal responsibility for Allied Health Practitioners performing duties on behalfof the Practitioner via employed or contracted relationship with the Practitioner, and as describedin associated Policies.
17. Appropriately supervise residents rendering patient care under his or her authority and credentials.
18. Reflect the Hospital's customer service ideals, as reflected in its Mission, Vision, and Values statement.
19. Ensure all hospitalized patients are visited daily by their attending physician or by another Medical Staff member designated by the attending physician, unless otherwise exempted by otherrules and regulations of the Medical Staff.

Compliance with the above is necessary to apply for and/or maintain Medical Staff membership, and privileges if applicable.

**Section 5. Contract Practitioners**

The Hospital may enter exclusive contracts with individual practitioners or groups of practitioners, in accordance with that policy or policies jointly developed by the Hospital and Medical Staff. The policy or policies may not be unilaterally amended by either the Hospital or the Medical Staff. They may only be amended by a vote with a ballot that has a return of at least twenty-five percent (25%) of the voting membership and a two-thirds 2/3 majority of those voting.

## ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be divided into Active, Courtesy, and Consulting categories.

**Section 1. The Active Medical Staff**

The Active Medical Staff shall consist of practitioners whom the Medical Staff Executive Committee determines are located closely enough to the Hospital to provide continuous care to their patients, and who assume all the functions and responsibilities of appointment on the Active Medical Staff and consultation assignments.

The Prerogatives generally available to an Active Medical Staff Member, subject to Staff category restrictions, are to:

1. Admit patients consistent with approved Clinical Privileges.
2. Exercise Clinical Privileges which have been approved.
3. Vote on any Medical Staff matter including Bylaw's amendments, officer selection, and other matters presented at any general or special Staff meetings.
4. Hold office in the Medical Staff; and
5. Serve on committees and vote on committee matters.

The rights and responsibilities of Active staff members are, in addition to those described in other Articles of these Bylaws:

1. To assume responsibility for the professional and scientific Policies and their development in the Hospital.
2. To assist in the clinical and administrative work conducive to a successful Hospital and Medical Staff operation, including quality improvement, risk management and patient safety, as well as utilization management.
3. To serve on committees and in leadership positions if elected or appointed.
4. To vote and to participate in respective specialty-specific activities, in accordance with the Rules and Regulations of that committee and in all general Medical Staff affairs.
5. To attend at least the minimum number of Staff meetings specified in the rules and regulations; and

6. To accept for care and treatment a reasonable proportion of unassigned patients in need of emergency care who are unable to pay all or a portion of the costs of care.

Failure to comply with any of the above obligations may result in change in a practitioner's staff category from Active to Courtesy.

A Practitioner in the Active Category may be determined as "Low or No Volume" who performs minimal patient encounters, defined as inpatient care involving admission, procedure, treatment, or consult. Verifications and/or case logs from facilities where the applicant demonstrates clinical activity, as well as peer references, may be obtained as evidence of current competence in accordance with the "Medical Staff Quality Plan."

Automatic Transfer or Termination of Membership. An Active Staff Member who is not regularly involved in patient care may be automatically transferred to the Courtesy Staff at their next reappointment unless the member does not meet the qualifications for membership for either Staff category, in which case shall be deemed to have voluntarily resigned his/her membership and voluntarily relinquished his/her privileges, effective immediately upon determination of the failure to meet the applicable qualifications. Such voluntary resignation and relinquishment shall not constitute an adverse action or summary professional review action and shall not entitle the Member to pursue the administrative remedies available under these Bylaws.

**Section 2. The Courtesy Medical Staff**

The Courtesy staff shall consist of those practitioners who do not utilize Park Center as their primary facility, are in the same geographical proximity to the Hospital as Active staff and can demonstrate that they are on the Active staff of a licensed hospital within the Hospital's service area, and that hospital requires participation in quality management activities consistent with those of this Hospital. The Courtesy staff shall consist of those practitioners authorized by the Medical Staff Executive Committee to receive training, proctoring, or mentoring in a Hospital facility on a short-term basis not to exceed six (6) months. For good cause shown, this term may be extended by the MSEC upon written request by the practitioner granted such Courtesy privileges.

A Practitioner in the Courtesy Category may be determined as "Low or No Volume" who performs minimal patient encounters, defined as inpatient care involving admission, procedure, treatment, or consult. Verifications and/or case logs from facilities where the applicant demonstrates clinical activity, as well as peer references, may be obtained as evidence of current competence in accordance with the "Medical Staff Quality Plan."

Courtesy Staff shall have no rights or responsibilities except as outlined here and described in other Articles of these Bylaws, including the right to exercise delineated privileges.

**Section 3. The Consulting Medical Staff**

Consulting staff shall consist of those practitioners who need not be in the same geographical proximity to the Hospital as Active Staff, but have a written agreement describing coverage from an Active or Courtesy Staff member for when they are out of the required coverage area. Waiver of this requirement may be granted, as outlined in the Rules and Regulations. Waiver may be reviewed by Medical Staff Officers to determine appropriateness and must be approved by Medical Staff Executive Committee.

Consulting staff shall have no rights or responsibilities except as outlined here and described in other Articles of these Bylaws.

A Practitioner in the Consulting Category may be determined as "Low or No Volume" who performs minimal patient encounters, defined as inpatient care involving admission, procedure, treatment, or consult. Verifications and/or case logs from facilities where the applicant demonstrates clinical activity, as well as peer references, may be obtained as evidence of current competence in accordance with the "Medical Staff Quality Plan."

### Section 4. Leave of Absence (LOA)

Any member of any category may request a Leave of Absence (LOA) from the Medical Staff as described in the Medical Staff LOA policy.

### Section 5. Residents

Although residents are not members of the Medical Staff, the Medical Staff acknowledges and supports the presence and activities of residents. The residents are physicians in training who are authorized to perform patient care activities under the supervision and credentials of attending physicians, as outlined by specific agreements between Parkview Center, Inc. and selected programs. The Medical Staff shall establish such Policies as necessary to assure appropriate patient care by resident physicians.

## ARTICLE V: MEDICAL STAFF CREDENTIALING

### Section 1. Applicant Requirements

For consideration for initial appointment, reappointment, and Clinical Privileges, all applicants, must:

1. Meet the Qualifications for Medical Staff Membership (Article III. 1-2), the general qualifications appropriate to the specialty in which privileges are requested, and the specific qualifications for requested privileges.
2. Accept and comply with the Responsibilities for Medical Staff Membership (Article III. 4), as well as the responsibilities appropriate to the staff category requested.
3. Accept the burden of producing adequate information for a proper evaluation of competence, character, ethics, any reasonable evidence of current ability to perform the privileges requested, and other qualifications as outlined in associated Medical Staff Policies and application forms, including but not limited to:
    a. previously successful or currently pending challenges to any licensure or registration, DEA certificate, or voluntary relinquishment of such licensure or registration
    b. voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at another Hospital or other health care organization
    c. involvement in professional liability actions, reporting at minimum final judgments or settlements
4. Signify willingness to appear for interviews regarding the application.
5. Authorize consultation with members of the Medical Staff of other institutions with which the applicant has been associated and with any others who may have information bearing on competence, character and ethical qualifications, and ability to carry out the Clinical Privileges requested. (Note: Article V, Section 1, Paragraphs 3, 4, 5 do not apply to those Telemedicine Practitioners that are credentialed by proxy, as described in the Telemedicine policy.)
6. Release from any liability all representatives of the Hospital and Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and their credentials, and all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for Staff appointment, and Clinical Privileges, including otherwise privileged or confidential information.
7. Have sufficient patient care contact within the practitioner's practice to permit the Hospital to assess the practitioner's current clinical competence for any Clinical Privileges requested or already granted.

### Section 2. Assessment

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

1. Relevant training, experience, demonstrated current competence, including medical/clinical knowledge technical and clinical skills and clinical judgment, and an understanding of the contexts and systems with which care is provided
2. Adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession
3. Good reputation and character
4. 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
5. Ability to safely and competently perform the Clinical Privileges requested
6. Recognition of the importance of, and willingness to, support the Hospital's commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care

In addition, the following factors will be evaluated as part of the reappointment process:

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. Results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that other practitioners will not be identified)
4. Any focused professional practice evaluation
5. Verified complaints received from patients and/or staff
6. Other reasonable indicators of continuing qualification

The Clinical Privileges recommended to the Board will be based on consideration of the following:

1. Education, relevant training and experience, demonstrated current competence, including medical and clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to the same
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, performance, improvement, and other peer review activities, if applicable
5. Availability of qualified staff members to provide coverage in case of the applicant's illness or unavailability
6. Adequate professional liability insurance coverage for the Clinical Privileges requested
7. Available Hospital's resources and personnel
8. Any previously successful or currently pending challenges to any privileges, licensure or registration, or the voluntary or involuntary relinquishment of such privileges, 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
12. Professional liability actions, especially an unusual pattern orexcessive number of actions

Appropriate verifications will be obtained from the primary source according to associated Medical Staff Policies and will include current licensure, relevant education, training and experience, to determine current competence to perform the privileges requested. Review and recommendation will be provided by the appropriate Specialty Representative or Officer.

**Section 3. Delegation**

The Medical Staff may delegate the verification portion of the credentialing process to other resources, including Central Verification Organizations (CVO's) such as credentialing verification services, or in the case of Telemedicine Practitioners to the hospitals where said Practitioners are active members in good standing of their medical staffs, while maintaining authority for final approval of review and recommendations for membership and privileges.

**Section 4. Clinical Privileges**

Every initial or reappointment application must contain a written request for specific requested Clinical Privileges which will be evaluated as described in Section 2 of this Article with focus on current competence. An application shall not be processed that contains a request for only privileges that are covered by an exclusive contract, unless the applicant is a member of the group holding the exclusive contract.

In processing a request for Telemedicine privileges, the applicant may be credentialed by proxy or considered in accordance with the provisions of this Article in the same manner as any other applicant, as described in the Telemedicine policy.

In addition, requests for Clinical Privileges at reappointment and the increase or reduction of same shall be based upon documented experience in categories of treatment areas or procedures, results of treatment, and conclusions drawn from organization performance improvement activities when available.

Notwithstanding any other provisions of these Bylaws, to the extent that any requested Clinical Privileges are not available within the Hospital/Center (whether because of exclusive contract, lack of space, equipment, staffing, or financial resources, policy decision of the Board, or otherwise), the request shall be rejected. Rejection of a request under such circumstances shall not constitute a summary professional review action or an adverse action and shall not entitle the applicant to pursue the administrative remedies available under these Bylaws.

**Section 5. Processing**

1. All applicants for initial appointment, reappointment, and Clinical Privileges will be processed thoroughly and as expeditiously as possible, as outlined in associated Medical Staff Policies. In the event of unwarranted delay (70 days from the date of initial presentation of a completed, verified application) on the part of the Medical Staff Executive Committee, the Board of Directors may act without such recommendation based on documented evidence of the applicant's or Staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.
2. Recommendations for the granting or revocation of the following will progress per timeframes outlined in associated policy unless otherwise executed via the Disciplinary Procedures and Hearing and Appeal Procedures in Articles VI and VII of these Bylaws:
    a. professional criteria for Clinical Privileges
    b. qualifications for membership
    c. Medical Staff membership
    d. Clinical Privileges
    e. renewal of Medical Staff membership

These recommendations will be forwarded to the Hospital Board of Directors for approval, only after there has been a recommendation from the Medical Staff Executive Committee as provided in these Bylaws and associated Policies.

**Section 6. Provisions of Appointment**

1. Appointment to the Medical Staff does not guarantee Clinical Privileges but shall confer on the appointee only such Clinical Privileges as have been specifically recommended by the Medical Staff Executive Committee and granted by the Board of Directors, in accordance with these Bylaws and associated Policies.
2. Appointments for membership and Clinical Privileges shall be made for a period of not more than two (2) years.
3. Initial appointment to the Medical Staff, regardless of the Staff category, and granting of Clinical Privileges, will be provisional.
4. During the provisional period, the individual's exercise of the relevant Clinical Privileges will be evaluated by the Specialty representative or designee in which the individual hasClinical Privileges through the Medical Staff Quality Plan. The evaluation may include chart review, monitoring of the individual's practice patterns, proctoring, external review and information obtained from other physicians and Hospital employees. The number and types of cases to be reviewed shall be determined by the Credentials Committee.
5. The duration of the provisional period for initial appointment and privileges will be from up to 12 to 24 months, and as recommended by the Credentials Committee.
6. 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 CMO or by other designatedphysicians.
7. A new member of the Medical Staff shall automatically relinquish their appointment and privileges if that new member fails, during the provisional period, to fulfill all requirements, including cooperation with monitoring and review conditions.
8. If a member of the Medical Staff who has been granted additional Clinical Privileges fails during a focused review period to participate in the required number of cases or cooperate with the monitoring and review conditions, the additional Clinical Privileges shall be automatically relinquished at the end of the focused review period.
9. The duration of the focused review period will be as recommended by the Credentials Committee.
10. When, based on evaluation performed during the provisional period, Clinical Privileges are terminated, revoked, or restricted for reasons related to clinical competence or professional conduct, the individual shall be entitled to hearing and appeal.

**Section 7. Fair Hearing and Appeal Process**

Current Medical Staff members, with or without Clinical Privileges, are entitled to a fair hearing and appeals process as outlined in Article VII of these Bylaws.

Initial applicants may appeal any adverse recommendation relating to membership and, if applicable, privileges made by the Medical Staff Executive Committee, as outlined in Article VII of these Bylaws.

**Section 8. Disaster and Temporary Privileges**

Disaster and Temporary privileges may be granted by the President of the Hospital or designee with the approval of the President of the Medical Staff or designee, in accordance with associated Medical Staff Policies.

## ARTICLE VI: COLLEGIAL INTERVENTION and DISCIPLINARY PROCEDURE

**Section 1. Collegial Intervention**

Collegial and educational efforts by Medical Staff leaders and Hospital administration are encouraged to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

Collegial efforts may include, but are not limited to, the process outlined in the Medical Staff Quality Plan, the Medical Staff Code of Conduct, as well as counseling, sharing of comparative data, monitoring, and requesting additional training or education.

All collegial efforts by Medical Staff leaders and Hospital administration are part of the Hospital's performance improvement and professional and peer review activities.

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

Collegial efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

The Medical Staff Officers may delegate or handle a matter in accordance with policy, such as the Medical Staff Code of Conduct Policy, or direct it to the Medical Staff Executive Committee for further determination.

**Section 2. Intervention Activities**

Interventional activities may be taken whenever collegial efforts have been made and determined to not be effective or have been waived at the discretion of Medical Staff leadership. This may also be requested by any Practitioner of the Medical Staff, by the President of the Hospital, or by any member of the Board of Directors whenever the activities or professional conduct of any Practitioner with Clinical Privileges are considered to be lower than the standards or aims of the Medical Staff or to undermine a culture of safety within the organization.

1. All requests for disciplinary action shall be in writing, shall be made to the CMO and shall be supported by reference to the specific activities or conduct which constitute grounds for the request.
2. The MSEC shall review all requests for interventional activity and, depending on the subject matter of the request, may dismiss the complaint, undertake collegial efforts, or appoint a preliminary inquiry committee (collectively referred to as "Inquiry Body") to review such request. Such activity constitutes initiation of an Investigation. Notification of an InquiryBody will be sent promptly to the affected practitioner.

   The Medical Staff President, in collaboration with the Chief Medical Officer, will select committee members and a chair of the Inquiry Body. The Chair of the Inquiry Body shall promptly call a meeting to review the matter.
3. Within forty-five (45) days after the receipt of the request for disciplinary action, the Inquiry Body shall issue a report of its review to the Chief Medical Officer. The MSEC shall consider the report at its next regularly scheduled meeting. Prior to the making of such report, the Practitioner against whom disciplinary action has been requested shall be invited for an interview with the Inquiry Body. At such interview, the Practitioner shall be invited to discuss, explain, or refute the basis of the request for interventional action. This interview shall not constitute a hearing and shall be a preliminary inquiry in nature. An accurate record of such interview shall be made by the Inquiry Body and included with its report to the Committee. The mechanism for recording such interview may be accomplished by use of a stenographer, electronic recording unit, or by taking of adequate minutes.
4. Within thirty (30) days following receipt by the Chief Medical Officer of a report from an Inquiry Body, the MSEC shall take action upon the request and report. The affected Practitioner shall be invited to make an appearance before the Committee, prior to the Committee acting on the request. This appearance shall not constitute a hearing and shall be preliminary in nature. An accurate record of such appearance shall be made. The mechanism for recording such interviewmay be accomplished by use of a stenographer, electronic recording unit, or by taking of adequate minutes.
5. In the event a recommendation to suspend, or revoke all or any portion of Clinical Privileges, or for the suspension or revocation of Medical Staff appointment shall be considered, a Practitioner who has appeared before any other group will still be entitled to an appearance before the MSEC, if he/she so desires.

6. The action of the MSEC on a request for disciplinary action may be to reject the request for intervention, to issue a warning, to write a letter of reprimand, to impose specific conditions or a requirement for consultation, assessment, and/or additional training, to recommend suspension, or revocation of all or any portion of the Clinical Privileges of the Practitioner or to recommend that the Practitioner's Medical Staff appointment be suspended or revoked, or other actions deemed appropriate.

7. Any recommendation to issue a warning, a letter of reprimand, or the imposition of specific conditions or requirement for consultation or additional training shall not entitle the affected Practitioner to the hearing and appeal procedure provided by these Bylaws. Provided however, the affected Practitioner shall be entitled to place a letter in the Practitioner's peer review file setting forth a Practitioner's position as to any such recommendation for future reference. Any recommendation for suspension or revocation of all or any portion of Clinical Privileges, or for suspension or revocation of Medical Staff appointment must be reviewed by the MSEC. Should the MSEC continue such recommendation, the affected Practitioner shall be entitled to the hearing and appeal procedure set forth in these Bylaws.

**Section 3. Precautionary Suspension**

1. Any two of the following (one of whom must be a Medical Staff Executive Committee member) may initiate a precautionary suspension: (1) any officer of the Medical Staff or their designee who must be a member of the MSEC; (2) the President of the Hospital or (3) the Chief Medical Officer shall have the authority to suspend all or any portion of theClinical Privileges of a Practitioner of the Medical Staff whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual. Such precautionary suspension shall be deemed an interim precautionary step in the quality improvement and professional review activity related to the ultimate professional review action that may be taken with respect to the suspended Practitioner but is not a complete professional review action in and of itself. The precautionary suspension shall not imply any final finding of responsibility for the situation that gave rise to the suspension.

2. The precautionary suspension shall become effective immediately upon imposition and shall be reported to the President of the Hospital, the President of the Medical Staff and to the Chair of the Credentials Committee. The Chair of the Medical Staff Executive Committee shall assign to another Practitioner of the Medical Staff with appropriate Clinical Privileges the responsibility for the care of the suspended Practitioner's patients in the Hospital. The wishes of the Practitioner and the patient shall be considered in the selection of the Practitioner assigned to provide such care.

3. Within a reasonable time, not to exceed 72 hours, from the imposition of a precautionary suspension, an ad hoc committee of at least three active members of the Medical Staff shall be appointed by the Chair of the Medical Staff Executive Committee, which committee shall convene for the purpose of reviewing the precautionary suspension. This ad hoc committee shall be composed of no member who is in direct competition with the affected Practitioner or who has actively participated in the precautionary suspension. This ad hoc committee shall make a recommendation to the Medical Staff Executive Committee, who shall meet within 5 days of the ad hoc meeting to receive the recommendation for the modification, termination, or continuance of the precautionary suspension.

4. If, because of such ad hoc committee review and recommendation, the Medical Staff Executive Committee does not recommend immediate termination of the Precautionary Suspension, the Precautionary Suspension will continue, and the affected Practitioner shall be entitled to the procedural rights of the hearing and appeal procedure as set forth in these Bylaws. The terms of the Precautionary Suspension as continued or as modified by the Medical Staff Executive Committee shall remain in effect until the formal hearing and appeal process is completed.

**Section 4. Automatic Suspension**

A Practitioner of the Medical Staff may be suspended in the following instances without affording the Practitioner the procedural rights to a hearing and appeal procedure as provided in these Bylaws:

1. A temporary suspension in the form of withdrawal of a Practitioner's admitting privileges, effective until medical records are completed, may be imposed automatically after warning of delinquency for failure to complete medical records.

2. Action by the State Board of Medical Examiners revoking or suspending a Practitioner's license, or placing such license on probation, shall automatically suspend all of Practitioner's Hospital privileges.
3. Loss or a failure to maintain 1) professional liability insurance coverage in the amounts required to cover the scope of privileges requested and in accordance with the Indiana Medical Malpractice Law (IC 34-18) if the member possesses Clinical Privileges; 2) DEA and/or CSR, if the member is prescribing or is likely toprescribe; and/or 3) license to practice medicine in the State of Indiana.
4. Failure by a Practitioner to provide information reasonably requested such as:
   a. Information regarding a professional review action or resignation from another facility or agency.
   b. Information from a Practitioner's private office that is necessary to address questions that have arisen during credentialing and/or peer review processes.
   c. Information pertaining to professional liability actions or claims involving the Practitioner.
5. Failure to pay dues or assessments.
6. Failure by a Practitioner to meet any special appearance request made by the Medical Staff Executive Committee.

The affected Practitioner shall be notified in writing, via certified mail, return receipt requested, of the initiation of an Automatic Suspension. The notification must outline what response is required to relieve the Practitioner of the suspension, as well as the timeframe and consequences if the Practitioner fails to respond. Items 2, 4, or 6 of Section 4, above, may require referral to an Inquiry Body as described in Section 2 of this Article.

## ARTICLE VII: HEARING AND APPEAL PROCEDURE

### Section 1. Right to Hearing and Appeal Procedure

1. When the Medical Staff Executive Committee makes any of the following recommendations with respect to a Practitioner's staff appointment: (1) change Practitioner's status to a lower category of membership for other than automatic reasons; (2) revoke all or any portion of a Practitioner's Clinical Privileges; (3) reject Practitioner's application for Staff appointment or reappointment; (4) grant an applicant for Staff appointment or reappointment with less Clinical Privileges than Practitioner requests; (5) deny a Staff Practitioner's request for increased Clinical Privileges, such recommendation shall entitle the Practitioner to a hearing before an Ad Hoc Hearing Committee of the Medical Staff as described in Section 3 of this Article.
2. In the same manner, should the Board of Directors make a determination to take any of the following actions: (1) terminate a Practitioner's staff appointment; (2) change Practitioner's status to a lower category of membership for other than automatic reasons; (3) revoke all or any portion of a Practitioner's Clinical Privileges; (4) reject Practitioner's application for Staff appointment or reappointment; (5) grant an applicant for Staff appointment or reappointment with less Clinical Privileges than Practitioner requests; (6) deny a Staff Practitioner's request for increased Clinical Privileges, such recommendation shall be forwarded to the Chair of the Medical Staff Executive Committee, and shall likewise entitle the Practitioner to a hearing before an Ad Hoc Hearing Committee of the Medical Staff as described in Section 3 of this Article, if such has not already occurred.
3. Upon receiving notice of an adverse decision of the Medical Staff Executive Committee (as described in Section 1.1 above) or the Board of Directors (as described in Section 1.2 above), the Practitioner shall be given notice from the Chair of the Medical Staff Executive Committee by certified mail, return receipt requested or hand delivery, stating: (1) an adverse action against the Practitioner has been proposed; (2) the reasons for the proposed adverse action, specifically indicating the reasons for such proposed action, and specifically indicating the criteria upon which Staff members are evaluated, as well as the precise manner in which the Practitioner failed to meet the criteria; (3) the Practitioner's right to request a hearing concerning the proposed action; (4) the time limit within which the Practitioner must request a hearing; and (5) a summary of the Practitioner's rights in the hearing.
4. The members and chair of the Ad Hoc Hearing Committee shall be appointed by the President of

the Medical Staff or its designee, or Chief Medical Officer. This Ad Hoc Hearing Committee shall be composed as follows: Not less than five (5) members, who may or may not be members of the Medical Staff, with no member who has actively participated in the consideration of the adverse recommendation, nor the person who made the original request, nor any member of the Medical Staff Executive Committee, nor any member of the Board of Directors of the Hospital.

5. Failure of a Practitioner to demand a hearing to which Practitioner is entitled by these Bylaws within thirty (30) days from the date of mailing of the notification to the Practitioner shall be deemed a waiver of Practitioner's right to such hearing and to such appellate review to which Practitioner might otherwise have been entitled on the matter. A Practitioner who desires to claim his/her right to a hearing must provide such request in writing via certified mail or hand delivery.
6. Within ten (10) days after receipt of the demand for hearing from a Practitioner entitled to the same, the Medical Staff Executive Committee shall schedule and arrange for such a hearing and shall, through the President of the Hospital or his/her designee, notify the Practitioner of the time, place and date so scheduled by certified mail, return receipt requested. The hearing date shall not be less than thirty (30) days from the receipt ofnotice by the Practitioner notifying him/her of the date, time and place. A hearing for a Practitionerwhose privileges are already under suspension shall be held as soon as arrangements may reasonably be made but not later than ten (10) days from the date of receipt of such Practitioner's request for hearing. The Practitioner and the Medical Staff Executive Committee or its designee may mutually agree to waive any of the hearing deadlines set forth in this Section and schedule such hearing on a date that is mutually acceptable to both parties.

**Section 2. Pre-Hearing Conference**

Prior to the conduct of the hearing, the chair of the Ad Hoc Hearing Committee shall provide reasonable notice to the Medical Staff Executive Committee and to the affected Practitioner of a date and time for a pre-hearing conference. This conference shall be scheduled a reasonable time prior to the conduct of the hearing. Prior to the pre-hearing conference, the Practitioner shall identify Practitioner's attorney or other person who is to be Practitioner's representative at the hearing. At the pre-hearing conference, the chair of the ad hoc committee and counsel or representatives of the Medical Staff Executive Committee and the affected Practitioner shall convene for the purposes as follows:

a. Resolution of any procedural matters
b. Exchange of witness lists
c. Exchange of documents to be submitted at the hearing
d. Discussion of anticipated time required for witnesses and evidence
e. Resolution of any pre-hearing objections or questions

Failure by the Practitioner to raise an objection regarding any matter discussed at the pre-hearing conference, including the members of the Ad Hoc Hearing Committee, shall be deemed a waiver, unless otherwise later approved by the Chair.

**Section 3. Conduct of Hearing**

1. There shall be at least a majority of the members of the Ad Hoc Hearing Committee present when the hearing takes place, and no member may vote by proxy. At the discretion of the Chair of the Ad Hoc Hearing Committee, a representative of the Hospital administration may be invited to be present without vote.
2. An accurate record of the hearing must be kept. The mechanism shall be established by the Ad Hoc Hearing Committee and may be accomplished by use of a stenographer, electronic recording unit, or by taking of adequate minutes. Copies of the proceedings shall be made available to the Practitioner upon payment of any reasonable charges.
3. A Practitioner who fails without good cause to appear at such a hearing shall be deemed to have waived Practitioner's rights in the same manner as provided in these Bylaws and to have accepted the recommendation or decision involved and the same shall there upon become and remain in effect as provided in these Bylaws.
4. Postponement of scheduled hearings shall be made only with the approval of the Chair of the Ad Hoc Hearing Committee. Granting of such postponement shall be only for a good cause and at the

sole discretion of the Chair of the Ad Hoc Hearing Committee

5. The affected Practitioner shall be entitled to call, examine, and cross-examine witnesses, to present evidence relevant to the hearing, and to submit a written statement at the close of the hearing.
6. The Practitioner and the Hospital/Medical Staff may be represented by attorneys of their choosing during the proceedings, but the attorney shall not be entitled to call, examine, and cross-examine witnesses, or to present evidence, unless otherwise agreed by the parties and approved by the Ad Hoc Hearing Committee Chair.
7. The Chair of the Ad Hoc Hearing Committee or Chair's designee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.
8. Upon conclusion of the presentation of oral and written evidence, the Ad Hoc Hearing Committee may, without special notice, recess the hearing and reconvene at another time for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The Ad Hoc Hearing Committee may thereupon at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened. After the ad hoc committee has had a reasonable opportunity to conduct its deliberations and arrive at a recommendation, not to exceed 30 days from the date of the hearing, the hearing shall be finally adjourned.
9. Within ten (10) days after the final adjournment of the hearing, the hearing committee shall make a written report and recommendation signed by the Chair and shall forward the same together with the hearing record and all the documentation to the Medical Staff Executive Committee. The report may recommend confirmation, modification, or rejection of the original adverserecommendation of the Medical Staff Executive Committee or the decision of the Board of Directors.
10. The affected Practitioner shall be entitled to receive the hearing committee's written report and recommendation.
11. If the recommendation of the Medical Staff Executive Committee following such hearing is still adverse to the affected Practitioner, Practitioner shall be entitled to an appellate review by the Board of Directors before the Board of Directors makes a final decision on the matter.

**Section 4. Appeal to Board of Directors**

1. Within thirty (30) days after receipt of a notice by an affected Practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, the Practitioner may do the following by written notice to the Board of Directors delivered through the President of the Hospital by certified mail, return receipt requested:
   a. Demand an appellate review by the Board of Directors.
   b. Demand that the appellate review be held only on the record on which the adverse recommendation or decision is based.
   c. Demand that oral argument be permitted as part of the appellate review.
   d. Submit a written statement on Practitioner's behalf, regarding those factual and procedural matters with which Practitioner disagrees, and which statement shall specify the reasons for such disagreement. This written statement may cover any matter raised at any step in the procedure to which the appeal is related.
   e. A similar statement may be submitted by the Medical Staff Executive Committee within fifteen (15) days after receipt of Practitioner's statement. If a statement is submitted by the Medical Staff Executive Committee, the Medical Staff President shall also provide a copy thereof to the Practitioner by certified mail, return receipt requested. The affected Practitioner shall have access to the report and record (and any electrical and manualtranscription) of the Ad Hoc Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against the Practitioner.
2. If such appellate review is not demanded within thirty (30) days, the affected Practitioner shall be deemed to have waived Practitioner's right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately when acted upon by the Board of Directors.

3. Within ten (10) days after receipt of such notice of demand for appellate review, the Chair of the Board of Directors shall schedule a date for such review and shall through the President of the Hospital, by written notice sent by certified mail, return receipt requested, notify the affected Practitioner of the same. The date of appellate review shall not be less than fifteen (15) days nor more than thirty (30) days, from the date of receipt of the notice of demand for appellate review except that when the Practitioner demanding the review is under suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may be reasonably made, but not more than ten (10) days from the date of receipt of such notice. Postponement of appeal beyond the timeframes set forth in these Bylaws shall be made only for a good cause and at the sole discretion of the Chair of the Appellate Review Body.

4. The Appellate Review shall be conducted by the members of the Board of Directors or by a duly appointed committee of members of the Board of Directors of not less than three members, hereafter called the "Appellate Review Body". The majority of the members of the Appellate ReviewBody shall be present when the appellate review takes place, and no member may vote by proxy. At the discretion of the Chair of the Appellate Review Body, a representative of Hospital administration may be invited to be present without vote

5. If oral argument is demanded as a part of the review procedure:

   a. Prior to the conduct of the appeal, the Chair of the Appellate Review Body shall provide reasonable notice to the Medical Staff Representative and to the affected Practitioner of a date and time for a pre-appeal conference. This conference shall be scheduled at a reasonable time prior to the conduct of the Appellate Review.

   b. Prior to the pre-appeal conference, the Practitioner and the Medical Staff Representative shall identify their respective attorneys or counselors, if any, for the appeal. At the pre-appeal conference, the Chair of the Appellate Review Body, the affected Practitioner, the Medical Staff Representative, and their respective Counselors shall convene for the purposes as follows:

      (1) Resolution of any procedural matters.
      (2) Discussion of anticipated time required for oral statement(s).
      (3) Resolution of any pre-appeal objections or questions.

   c. The affected Practitioner shall be present at such appellate review and shall be permitted to speak against the adverse recommendation or decision and shall answer questions put to Practitioner by any member of the Appellate Review Body. The Medical Staff Executive Committee or the Ad Hoc Hearing Committee, whichever is appropriate, shall also be represented by an individual, hereafter called "Medical Staff Representative", who shall be permitted to speak in support of the adverse recommendation and who shall answer questions posed to the Medical Staff Representative by any member of the Appellate Review Body. Cross-examination of the Practitioner and the Medical Staff Representative shall not be permitted.

   d. The Practitioner and the Medical Staff Representative may each be counseled by an attorney or other person of his/her choosing during the proceedings, but theseCounselors shall not be entitled to call, examine, and cross-examine witnesses, or to presentevidence. The Appellate Review Body may seek counsel in fulfilling their duties, including, but not limited to, the Hospital's in-house legal counsel or external legal counsel.

   e. The Appellate Review Body may call any witnesses it deems necessary. Should witnesses be called, reasonable time shall be provided to both the Practitioner and to the Medical Staff Representative to prepare to cross examine the witnesses. Witnesses shall also answer questions put to them by any member of the Appellate Review Body.

6. New or additional matters or arguments not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances and the Appellate Review Body shall determine whether such new matters shall be accepted.

7. The Appellate Review Body shall review the record created in the proceedings and shall consider the written statements submitted pursuant to subpart 1 of this Section. The Appellate Review Body shall not review the matter *de novo* as if no prior hearing or recommendation had been made.

Rather, the Appellate Review Body shall determine whether the adverse recommendations or decisions against the affected Practitioner were not arbitrary, unreasonable, or capricious. The Appellate Review Body shall affirm the recommendation and subsequent decision of the Medical Staff Executive Committee if the recommendation is supported by substantial evidence in the record of the hearing, if the recommendation will improve the quality of health care, if a reasonable effort was made to ascertain the facts before the recommendation was made, and if the procedures used in reaching the recommendation substantively complied with the Bylaws. If the Board of Directors or its appointed review committee determines that any of these review standards have not been met, it can either correct the deficiency or refer the matter to the Reconciliation process outlined in Section 4.10 of this Article.

8. The appeal procedure shall not be deemed concluded until all the procedural steps provided in this Section have been completed or waived. Whether permitted by the Bylaws or the Board of Directors, all action required of the Board of Directors may be taken by a committee of the Board of Directors duly authorized to act.

9. Within fifteen (15) days after the conclusion of the appeal procedure, the Board of Directors shall make its decision in the matter and shall send written notice thereof to the Medical Staff Executive Committee and through the President of the Hospital to the affected Practitioner by certified mail, return receipt requested. If this decision is in accordance with the Medical Staff Executive Committee's last recommendation in the matter it shall be immediately effective and final and shall not be subject to further hearing or appellate review. If this decision is contrary to the Medical Staff Executive Committee's last such recommendation, the Board of Directors shall refer the matter to a reconciliation committee comprised of three (3) members of the Board of Directors, three (3) members of the Medical Staff and three (3) members of the Hospital administration chosen by those bodies for further review. This review and a recommendation shall be made by the reconciliation committee within fifteen (15) days. The notice to the affected Practitioner shall inform him/her of the Board's decision and astatement that a final decision will not be made effective until after the reconciliation committee's recommendation has been received. At its next meeting after receipt of the reconciliation committee's recommendation, the Board of Directors shall make its final decision with like effect and notice as first above provided in this paragraph.

10. Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to more than one (1) evidentiary hearing and one (1) appellate review on any matter which shall have been the subject of action by the Medical Staff, by the Board of Directors, or by a duly authorized committeeof the Board of Directors orboth.

## ARTICLE VIII: OFFICERS

### Section 1. Officers

Unless amended as described in Section 5 of this Article, the Officers of the Medical Staff shall be:

1. President (Chair of Medical Staff Executive Committee),
2. President Elect, and
3. Vice President.

### Section 2. Qualifications

Medical Staff Officer candidates should have a proven track record of distinguished leadership and service to the medical community and be willing to commit to a program of further leadership development. All Medical Staff Officers must possess and maintain the qualifications defined below. Failure to do so shall automatically remove the member from the office involved.

1. Active Medical Staff members in good standing.
2. Board certified in an appropriate specialty in accordance with Bylaws Qualifications for Membership.
3. Not serving as a Medical Staff Officer, Department Chair, Board member or paid Executive at any Lutheran Health Network Hospital or any successor; and
4. Will faithfully discharge the duties and responsibilities of the position to which elected or appointed.

**Section 3. Nomination and Election**

1. The Medical Staff Officers shall annually review members of the Active Staff demonstrating proven leadership capability and meeting the qualifications described in this Article to determine a slate of at least one nominee for President Elect.
2. The slate shall be presented to the MSEC for approval after which the slate will be posted in the physicians' lounge for twenty (20) days.
3. Additional nominations will be accepted during the twenty (20) day period by written petition to the Medical Staff President and signed by two (2) members of the Active Medical Staff. At conclusion of the 20 days, the slate shall be closed.
4. The election of the President Elect shall be by confidential mailed or faxed or other electronic transmission ballot to all members of the Active Medical Staff. Such ballots will be returned within the time period specified in the ballot mailing. A majority vote of all ballots returned, with a minimum of ten percent (10%) required for election. If fewer than ten percent (10%) of ballots are returned, a repeat election shall occur under the direction of the MSEC. In the event of a non-majority vote when the slate contains more than two (2) candidates, if the candidate receiving the majority of the votes has received at least forty percent (40%) of the ballots returned, no additional runoff election is required. In the event no candidate receives at least forty percent (40%) of the ballots returned, voting will be repeated between the two candidates receiving the most votes. The President Elect will be announced following confirmation of the election at the next scheduled MSEC.

**Section 4. Term of Office**

Commencing on January 1st following election, the President and President Elect shall each serve for two years unless the Officer resigns or is removed from office. At the end of the two-year term, the President Elect shall automatically assume the office of President and Chair of MSEC. The new President Elect shall be elected as described in Section 3 above.

**Section 5. Vacancies/Removal from Office**

1. Vacancies
   a. Should the President or President Elect resign his/her position, such resignation must be tendered in writing to the President of the Hospital or his/her designee.
   b. Vacancies in the offices of President or President Elect shall be addressed by recommendation of the remaining Officers, and approved by the MSEC, and voted upon by the Medical Staff at a special election held for that purpose. The special election shall be initiated within 20 days of MSEC approval and will follow the standard election process described in these Bylaws. The recommendation may modify the number of officers serving and/or the responsibilities of each office.
   c. Should both the offices of President and President Elect be vacated simultaneously, the President of the Hospital shall select members of the active Medical Staff to assume those duties and authorities until the provisions described in this section are completed.
2. Removal from Office
   a. An Officer who is found by the Board to no longer meet any of the qualifications set forth in Section 2 of this Article shall automatically relinquish his/her office.
   b. An Officer may be removed as set forth in Article X. Section 6.

**Section 6. Responsibilities**

Unless amended as described in Section 5 of this Article the following are responsibilities of the Medical Staff Officers:

1. <u>All Officers</u>

   While these responsibilities are primarily those of the President of the Medical Staff, they are also expectations of the other Medical Staff Officers. All Officers shall:
   a. support the Medical Staff's provision of safe and quality patient care.

b. represent the views, Policies, needs and grievances of the Medical Staff to the Board of Directors and to the Administration of the Hospital.
c. receive and interpret the Policies of the Board of Directors to the Medical Staff.
d. act in coordination and cooperation with Administration in all matters of mutual concern within the Hospital and Parkview Health System.
e. lead the Medical Staff in collaboration with the Hospital on Performance Improvement activities and see to their implementation.

2. The President shall:
   a. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.
   b. chair the Medical Staff Executive Committee, assuming oversight authority of the responsibilities of the MSEC.
   c. aid in coordinating the activities of the administration and of nursing and other patient care services with those of the Medical Staff.
   d. communicate and represent to the Medical Director, the CEO, and the Board the opinions, policies, concerns, needs, and grievances of the Medical Staff.
   e. serve on the Hospital Board of Directors with vote.
   f. serve as member of all other Administrative Committees without a vote.
   g. appoint members to all standing, special and multi-disciplinary Medical Staff committees except the MSEC.
   h. be the spokesperson for the Medical Staff in its external professional and public relations.

3. The President Elect shall:
   a. assume all the responsibilities and have the authority of the President in the absence of the President in the event of his/her temporary inability to perform due to illness, absence from the community or unavailability for any other reason.
   b. serve as a member of the MSEC and the Board of Directors with vote.
   c. automatically succeed to the office of the President during the third year following election; and perform such responsibilities as assigned by the President.
   d. cause to be kept accurate and complete minutes of all Medical Staff meetings.
   e. collect staff dues and funds, if assessed, and oversee disbursements as described in the Policies, and report annually on the financial status of the Medical Staff.
   f. call Medical Staff meetings on order of the President.

4. The Vice President shall: In the absence of the President, the Vice President shall assume the duties and have the authority of the President and shall serve as a member of the MSEC performing such additional duties as may be assigned by the President or MSEC.

## ARTICLE IX: ADMINISTRATIVE COMMITTEES

Administrative Committees of the Medical Staff will be designated by the MSEC. All meetings of committees of the Medical Staff shall be considered peer review meetings. As such all minutes and correspondence of a peer review committee shall be confidential and all members and personnel of the peer review committee shall enjoy the rights, responsibilities, and protections of the Indiana peer review statute.

The Chairs of Medical Staff administrative committees shall be Active Staff members, meeting the same qualifications as Medical Staff Officers. They, as well as the committee members, will be appointed annually by the President of the Medical Staff, except for the MSEC. Each committee will ensure rules, regulations, and Policies document meeting frequency, attendance requirements, if any, voting mechanisms, record keeping, responsibilities, and other key elements. A Board member appointed by the Chair of the Board may serve on administrative committees without voting rights.

**Section 1. Medical Staff Executive Committee**

The Medical Staff Executive Committee has primary authority for activities related to providing oversight of Quality of Care, treatment, services delivered by practitioners who are credentialed and privileged via the Medical Staff process, self-governance of the Medical Staff and for performance improvement of the professional services provided by the Medical Staff. Their ultimate priority is to support the Medical Staff's provision of safe and quality patient care.

The Medical Staff Executive Committee shall consist of the Medical Staff Officers (President, President Elect, and Vice President, and up to the next five (5) past presidents who are members of the Active staff; the Chair of the Credentials Committee, and a designee from Parkview Behavioral Health, all of whom serve with vote. The President of the Medical Staff mayhave the flexibility to appoint additional members of the Medical Staff. Other Committee Chairs may serve without vote. No Medical Staff member actively practicing in the Hospital is ineligible for membership solely because of his/her professional designation or discipline. The Chair of the Board ofDirectors, Hospital President and the Chief Medical Officer shall be non-voting members. In the absence of the President of the Medical Staff, the President Elect or his/her appointee, shall act as chair.

Responsibilities: The responsibilities of the Medical Staff Executive Committee shall be to:

1. represent and to act on behalf of the Medical Staff, including the authority to act on behalf of the Medical Staff between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.
2. make recommendations to the Board of Directors regarding the Medical Staff's structure and the process used to review credentials and delineate Clinical Privileges and reviewing and acting on reports of the Medical Staff committees, and other groups as appropriate.
3. review and recommend amendments to the Medical Staff Bylaws with actual Amendments to the Bylaws made as described in Article XVII of this document.
4. approve and coordinate the activities and general Policies of the various Specialties, Committees, receiving and acting upon reports and recommendations from Medical Staff committees, departments and specifically assigned groups.
5. recommend those serving in Medical Staff leadership positions for Board of Director confirmation.
6. establish or abolish Medical Staff Divisions and Committees, and resulting MSEC membership, by a two-thirds (2/3) vote.
7. review and recommend amendments to the Rules and Regulations and Medical Staff Policies/Procedures as described in Article XIV of this document.
8. uphold the Bylaws and implement the approved rules, regulations, and Policies and procedures of the Medical Staff based on the recommendations of Specialties and Committees.
9. recommend action to the Board of Directors and the President of the Hospital on Hospital/Center management matters (i.e. long range planning, etc.).
10. fulfill the Medical Staff's accountability to the Board of Directors for the care provided to patients.
11. be responsible for Medical Staff compliance with Indiana Department of Health regulations, accreditation standards of The Joint Commission, and standards of the Division of Mental Health & Addiction, and other relevant accrediting organizations.
12. review all applicants for initial appointment, reappointment, and Clinical Privileges as recommended by the Credentials Committee; and then to make recommendations to the Board of Directors for Staff appointment and delineation of Clinical Privileges.
13. take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.
14. lead the Medical Staff in collaboration with the organization's performance improvement activities.
15. keep Staff apprised of MSED activities on an ongoing basis.

The Committee members have an attendance requirement of fifty percent (50%). The Chair of the committee shall determine the time and date of each meeting. A minimum of three (3) members shall constitute a quorum. A simple majority of those present and voting at a meeting in which quorum is present shall be the action of the Committee. The President of the Medical Staff, the President Elect, or any three (3) or more members of the Committee may request a meeting. Such a request must be complied with and must be held within a period of one (1) week following such notification to the Chair of the Executive Committee. A record of all proceedings shall be made and retained.

**Section 2. Credentials Committee**

The Credentials Committee shall be appointed by the President of the Medical Staff, shall meet as necessary, and shall consist of five (5) or more members of the Active Medical Staff. Ad hoc committees may be appointed as needed to complete special projects. Policies may be developed on various issues as designated by the President of the Medical Staff to further describe the work of the committee.

Responsibilities:

1. Mechanism/Policy Development
    a. to approve and monitor the mechanisms used to verify and evaluate information used in the formation of credentialing recommendations, in accordance with Article V of these Bylaws.
    b. to approve and monitor the qualifications, criteria, and other requirements for consideration of credentialing recommendations, as well as review and act upon requests for development of cross-specialty privilege criteria, as described in associated Medical Staff Policies and in accordance with Articles III-V of these Bylaws.
    c. to assure quality patient care through approving and monitoring the mechanisms used to evaluate the quality and appropriateness of the clinical activities of all individuals with delineated Clinical Privileges through a Hospital-wide quality assurance/performance improvement program.
2. Credentialing/QA Recommendations
    a. to review the credentials of all applicants for appointment and reappointment and to make recommendations to the Medical Staff Executive Committee for membership and delineation of Clinical Privileges, as described in Article V of these Bylaws.
    b. to review at least biennially the current competence, quality of care, clinical/technical skills, professional judgment, and professional citizenship of members, and as a result of such reviews to make recommendations to the Medical Staff Executive Committee for granting reappointment and renewed Clinical Privileges.
    c. to receive reports regarding QA/PI activities, conduct fact finding and investigative activities related to individual members' performance, and form recommendations for remedies to QA/PI concerns.
    d. to review reports that are referred by the Medical Staff Executive Committee and respond as appropriate.

**Section 3. Multidisciplinary Committees**

The Medical Staff or Hospital will develop Multidisciplinary committees for designated purposes, with Medical Staff members appointed by the Medical Staff President. Each committee will document its purpose and responsibilities in rules, regulations, and Policies as appropriate, and retain a record of its proceedings for at least ten (10) years. These committees will report to the MSEC as necessary, provide leadership and resources, and approve busines related to their responsibilities. (Article IX, Section 1). A listing of these committees will appear on the annual Medical Staff roster, to include but not limited to:

- Clinical Care Committee
- Health Information Management (HIM)
- Infection Control and Prevention
- Pharmacy & Therapeutics Committee (P&T)
- Bylaws

### Section 4. Committees for Special Services or Functions

Other committees for special services or functions may be established by the MSEC, as described in this Article. Each committee will ensure Policies document meeting frequency, attendance requirements, if any, quorum, voting mechanisms, record keeping, and other key elements.

## ARTICLE X: MEDICAL STAFF LEADERSHIP MATTERS

### Section 1. Organization

All meetings of leadership committees or other ad hoc groups if applicable, shall be considered peer review meetings. As such, all minutes and correspondence of a peer review committee shall be confidential, and all members and personnel of the peer reviews committee shall enjoy all the rights, responsibilities, and protections of the Indiana peer review statute.

### Section 2. Responsibilities of Leadership

The ultimate responsibility of the Medical Staff and its leaders is to provide safe and quality patient care.

1. It will endeavor to ensure the competence, skill, professional judgment, quality of care, and professionalcitizenship of all members and others who may provide services independently through:
    a. Formation of recommendations related to qualifications and criteria for specific clinical and other activities, as well as application of such information to individual requests for initial appointment, reappointment, change of privileges, etc.
    b. Surveillance and assessment of the professional performance of all members as described in the Medical Staff Quality Plan.
    c. Undertaking proactive measures and interventions with members whose performance in any area is in question, referring issues as appropriate to the Medical Staff Executive Committee for their review.
    d. Encouragement of orientation and continuing education.
2. Endeavor to ensure the smooth function and effective integration of each practitioner with the rest of the Medical Staff organization and Hospital operations through:
    a. Provision of opportunity for members to contribute their professional views and insights into the formulation of Medical Staff and Hospital Policies and plans, including service lines, capital expenditures, orientation, Continuing Medical Education, etc.
    b. Collaboration with the rest of the Medical Staff and Hospital on the identification of performance improvement opportunities, including patient care, treatment and services, and their implementation.
    c. Coordination and integration of the provision of care provided by practitioners with other Medical Staff members, Hospital staff, contracted and off-site sources of patient care.
    d. Development of recommendations as needed and appropriate regarding sufficient numbers and qualifications and competency assessments for care providers who are not licensed independent practitioners who provide care or services, as well as space and other resource needs.
    e. Development and implementation of Policies and procedures that guide and support the provision of care, treatment, and services.
    f. Provision of continuous patient coverage, including coverage for unattached patients.
    g. Facilitation of effective communication with the Medical Staff, Hospital, and Board.
    h. Planning and facilitation of effective ad hoc and committee meetings.
3. Minutes of all regular and special meetings of any component of the Medical Staff, its specialties and/or any ad hoc meetings, shall be prepared and shall include a record of members in attendance and vote takenon each matter.

**Section 3. Vacancies/Removal from Office**

1. Vacancies in Medical Staff leadership are to be addressed by recommendation of the CMO and approved by the MSEC. Vote is to be presented to the full MSEC and election is determined by majority vote of ballots returned.
2. Removal of an elected Officer or a member of the ExecutiveCommittee may be effectuated by a two-thirds (2/3rds) vote of the Executive Committee, or by the Board for any of the following reasons:

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

3. At least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Executive Committee or the Board prior to a vote on removal.

**Section 4. Quorum**

Quorum is determined by each leadership committee.

**Section 5. Special Meetings**

A special meeting of all or any component of the Medical Staff may be called by or at the request of the CMO, by the President of the Medical Staff, or by the lesser of 10 or one-third (1/3) of the constituency's members. Members will be provided adequate written notification.

**Section 6. Notice of Meetings**

No special notification is required when leadership committee meetings are held at regular intervals and at a fixed time and place. If the meeting schedule varies or affects a constituency that meets on an ad hoc basis, members will be provided with adequate written notification.

**Section 7. Voting**

Unless otherwise provided in this Article, a simple majority of those present and voting at a meeting in the presence of quorum shall be the action of a Department, leadership committee, or Specialty. Voting by proxy is not permitted. Use of mail, phone or videoconference, email, fax, or other forms of electronic transmission, to assist in conducting business is encouraged.

Any action required or permitted to be taken at any meeting of the Medical Staff, or of any committee thereof, may be taken without a meeting by way of written consent to include electronic/e-mail communication if such consent is executed by all members of the Medical Staff or Medical Staff Committee. An electronic/e-mail communication expressing support for the pending action shall be counted as an execution of such consent.

**Section 8. Attendance Requirements**

Departments and committees may establish Attendance Requirements for members.

**Section 9. Record of Proceedings**

A record of all proceedings shall be made and retained for at least ten (10) years.

## ARTICLE XI: MEDICAL STAFF MEETINGS

**Section 1. General Staff Meetings**

The Medical Staff Officers may authorize general staff meetings including notice specifying time, date,

place and business of meeting.

**Section 2. Special Staff Meetings**

Special meetings of the Medical Staff may be called at any time by the President, the President Elect in the President's absence, by the MSEC, or at the written request of ten (10) members of the Active staff. Reason for the special staff meeting shall be stated on the notice of meeting. The agenda shall be limited to Reading of the notice; Calling the meeting; Discussion of the business for which meeting was called; and Adjournment.

**Section 3. Quorum/Voting**

A quorum will exist at a Regular or Special Staff Meeting when twenty-five percent (25%) of the voting membership is present. A majority of those present and voting at a meeting at which quorum is present shall be the action of the Medical Staff. Use of mail, telephone, or videoconference, email, fax, or other forms of electronic transmission, to meet and conduct business is encouraged. Decisions are determined by majority vote of ballots returned Attendance is not required but strongly encouraged. Record of the meeting will be retained for at least 10 years.

**Section 4. Closed Meetings**

At the discretion of the President of the Medical Staff or leader of any meeting of the Medical Staff or its Specialties or Committees, the President or Leader may invite or excuse any or all persons present, not members of the Medical Staff, irrespective of their status, from continuing deliberations of the meeting.

## ARTICLE XII: PRIVILEGE AND IMMUNITY

The Medical Staff, its members, officers, and committees, along with third parties who supply information to the foregoing, shall be afforded all the privileges and immunities provided by applicable state and federal laws.

## ARTICLE XIII: HISTORY AND PHYSICALS

A History and Physical is required for all inpatient admissions, observation patients, and outpatients undergoing invasive procedures. The History and Physical must be completed within 24 hours after admission and before any invasive procedure is performed. A History and Physical performed and documented up to 30 days prior to an admission, readmission, or procedure may be used for that admission, readmission or procedure provided there is an examination and update performed within 24 hours after the admission, or readmission, and prior to any procedure documenting any significant changes. If there are no significant changes, there must be a notation on the original document, in the progress notes, or on a form specifically designed to document an H&P update so stating.

The complete History and Physical must be performed by those Medical Staff Members with Privileges to do so.

Complete details regarding the History and Physical can be found in the Medical Staff Rules and Regulations Inpatient Medical Records Policy.

## ARTICLE XIV: RULES, REGULATIONS, AND MEDICAL STAFF POLICIES

**Section 1. Rules and Regulations Adoption/Revision**

The Medical Staff, through its elected leaders and committees, shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Medical Staff Executive Committee. These shall relate to the proper conduct of Medical Staff, organizational activities, and the level of practice that is to be required of each

Practitioner in the Hospital. Such Rules and Regulations shall be attendant to these Bylaws. The Active Medical Staff shall have the opportunity to review and make recommendations regarding any proposed revisions to the Rules and Regulations prior to any action being taken by the Medical Staff Executive Committee. Any amendments to the Rules and Regulations passed by the Medical Staff Executive Committee and approved by the Hospital Board of Directors must be communicated to the entire Medical Staff in a timely fashion.

Rules, Regulations, and Policies may be created, deleted, or modified by recommendation of the responsible committee, following the rules established for quorum and voting, subject to the approval of the Medical Staff Executive Committee. Those documents relating to the basis for granting membership and privileges shall not become effective until also approved by the Board of Directors. The Medical Staff shall be informed of these activities via their Division or Committee meetings or established Medical Staff publications.

**Section 2. Policies and Procedures Adoption/Revision**

Medical Staff Policies and Procedures consist of statements delineating a guiding principle or philosophy intended to influence decisions to determine a course of action, as well as describe the methodology to achieve the results desired. Medical Staff "Policies" must be approved by the Medical Staff Executive Committee and are attendant to the Bylaws of the Medical Staff, as are the Rules and Regulations. All Medical Staff Policiesthat are approved by the Medical Staff Executive Committee and approved by the Hospital Board of Directors must be communicated to the entirety of the Medical Staff in a timely fashion.

**Section 3. Conflict Management**

Should twenty-five percent (25%) or more Members of the Active Medical Staff be in disagreement with the actions taken by the Medical Staff Executive Committee pertaining to revisions to the Rules and Regulations or Medical Staff Policies, those concerned members shall be invited to the next Medical Staff Executive Committee to resolve the conflict. Ultimately, Medical Staff Rules and Regulations, as well as Medical Staff Policies may be amended, if not approved by the MSEC, using the process set forth in Article XVII for the adoption or revision of Medical Staff Bylaws, in the event that this Conflict Management process is ineffective.

## ARTICLE XV: DUES AND ASSESSMENTS

The Medical Staff has the authority to levy dues and assessments, as described in the appropriate Medical Staff policy.

## ARTICLE XVI: SINGLE UNIFIED INTEGRATED MEDICAL STAFF OPTIONS

Upon approval of the Park Center, Inc. Board of Directors and affirmative majority vote of the Active Medical Staff, the Park Center Medical Staff may elect to join the Medical Staff(s) of any or all other Hospitals affiliated with Parkview Health System, Inc., to form a single, unified, integrated medical staff.

1. To call for a vote to "opt in" to a single Medical Staff, at least three (3) members of the Active Medical Staff must submit a request for a vote to the President of the Medical Staff. Notice of the request for a vote shall be sent to all Active Medical Staff Members no less than four (4) weeks or no more than eight (8) weeks before the vote shall be held.
2. The vote shall be by written/mailed ballot. A voting period of at least fourteen (14) calendar days must be established for the return of ballots. Active Medical Staff Members may hand deliver their vote to the Medical Staff Office prior to the ballot deadline.
3. Should the Active Medical Staff vote affirm the desire to become part of a single Medical Staff, Policies, Rules, and Bylaws shall be developed for the single Medical Staff and said Policies, Rules, and Bylaws shall reflect the unique needs of the medical staff and its members.
4. Should the Active Medical Staff vote not favor becoming part of a single Medical Staff, a new vote

not be taken for at least one year and that vote shall likewise only be taken upon request of three (3) or more Active Medical Staff Members.

5. Should the Medical Staff elect to become part of a single Medical Staff but at a later date wish to "opt out" of that relationship, upon request of three (3) Active Medical Staff Members with privileges at Park Center, a vote to "opt out" of the single Medical Staff shall be taken. Once again, a majority vote of the Active Medical Staff Members shall be required to "opt out". If the Medical Staff does not elect to opt out, a repeat vote cannot be requested for at least one year.

## ARTICLE XVII. AMENDMENTS TO THE BYLAWS

An Amendment to the Medical Staff Bylaws can be made upon a vote of the Active Medical Staff, with majority approval of those Medical Staff members voting or, as an alternative, the Amendment may be presented upon the recommendation of the Bylaws Committee or recommendation of the Medical Staff Executive Committee to propose an amendment to these Bylaws; and, in these cases, upon a vote of the Active Medical Staff with a majority approval of those Medical Staff members voting, an amendment can be made. To be adopted by the Medical Staff, proposed amendments shall be distributed electronically to members of the Active Medical Staff, along with a ballot to be returned to the President Elect or a designee. Voting by proxy shall not be allowed. A voting period of at least fourteen (14) calendar days from the date of distributing the proposed amendments shall be established for the return of ballots. Technical amendments to these Bylaws do not require vote by the Medical Staff. The MSEC and Board may approve such non-substantive changes.

Amendments to these Bylaws that have been adopted by the Medical Staff shall become effective upon approval by the Board of Directors of the Hospital which approval shall be binding on any successor to the Hospital.

The Medical Staff and the Board of Directors of the Hospital acknowledge and agree that neither party may unilaterally amend these Bylaws or the rules, regulations, or Policies attendant to these Bylaws.

## ARTICLE XVIII: ADOPTION

These Bylaws (together with the attendant rules, regulations, and Policies approved by the Medical Staff Executive Committee) shall be adopted at any regular or special meeting of the Medical Staff Executive Committee, following the satisfaction of the conditions described in Article XVII, shall replace any previous Bylaws, and shall become effective when approved by the Board of Directors of the Hospital. A full review of the Bylaws shall be accomplished every three (3) years.

APPROVED: Medical Staff

, President Date 1/24/2022

Park Center, Inc. Medical Staff

APPROVED: Board of Directors

, Chair Date Jan. 17, 2022

Park Center, Inc. Board of Directors

Version Dates: 03/14, 01/15, 01/17, 06/17, 03/18, 11/19, 10/21