



**BYLAWS OF
THE MEDICAL STAFF OF
COMMUNITY HOWARD
REGIONAL HEALTH, INC.**

Approved by the Board of Directors of Community Howard
Regional Health, Inc. on November 24, 2017.

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ARTICLE I

NAME, LAW AND DEFINITIONS

Section 1.1 Name. These Bylaws shall be the Bylaws of the Medical Staff of the Community Howard Regional Health and shall apply to all Members of the Medical Staff. Rules and Regulations and Policies enacted pursuant to these Bylaws apply to all Members of the Medical Staff. These Bylaws, Rules and Regulations, and Policies and those of the Board of Directors are compatible and should be read as a cohesive document.

Section 1.2 Governing Law. These Bylaws, Rules and Regulations, and Policies, as they relate to Professional Review Actions, shall be governed by, and construed in accordance with, the Health Care Quality Improvement Act of 1986 and, to the extent not inconsistent therewith, the Indiana Peer Review Statute, and to the extent not so governed, with the other laws of the State of Indiana.

Section 1.3 Definitions. These Bylaws, Rules and Regulations, and Policies shall be interpreted using these definitions unless stated otherwise.

“Accreditation Body” means any organization which (1) awards an accreditation or certification to or sought by the Hospital in order to obtain reimbursement or improve performance or quality; or (2) provides quality management programs to the Hospital. Such Accreditation Body may require data related to indications and outcomes which Members or Eligible Independent Practitioners exercising clinical privileges in those accredited or certified areas or programs will provide upon request by the Hospital as a condition of their continued ability to exercise clinical privileges in those areas.

“Administration” means those individuals acting on behalf of the Board of Directors in the overall management of the Hospital.

“Advance Practice Nurse” means a nurse practitioner or certified nurse specialist who currently holds a license to practice nursing in the State of Indiana and has matriculated from a graduate program offered by an accredited college or university which prepares registered nurses to practice as a nurse practitioner or clinical nurse specialist.

“Adverse Action” means any action that adversely affects a Member's ability to exercise his/her privileges such as reducing, restricting, suspending, revoking, denying, or failing to renew the Clinical Privileges or Medical Staff Membership.

“Adverse Recommendation” means a recommendation that, if approved by the Board of Directors becomes a Final Adverse Action which shall be reported if it lasts over thirty (30) days and was based on the professional competence, behavior or conduct of the Member.

“Affected Practitioner” means those Members or Applicants against whom an Adverse Recommendation or an Adverse Action has been proposed.

"Allied Health Professional" means any Advance Practice Nurse, Physician Assistant, or clinical psychologist granted Clinical Privileges by the Board.

"Applicant" means a practitioner seeking initial appointment or reappointment to the Medical Staff.

"Application" means the form developed by Medical Executive Committee and any and all supporting documentation required to apply for Medical Staff Membership and/or clinical privileges.

"Approved Residency Program" means a post-graduate training program approved by the Accreditation Committee for Graduate Medical Education, the American Osteopathic Association, the Council of Podiatric Medical Education, or the American Dental Association.

"Board Certification" means the certification board approved by the MEC as referenced in the applicable core privilege form for which an Applicant or Member seeks privileges.

"Board Eligible" means that the Applicant or Member has completed an Approved Residency Program and is eligible and actively participating in the exam process leading to certification.

"Board of Directors" or "Board" means the Board of Directors of Community Howard Regional Health, LLC the governing body of the Hospital.

"Bylaws" means the Medical Staff Bylaws of Community Howard Regional Health, LLC.

"Chief Nursing Officer" means the head nurse executive serving as the vice president of nursing services of the hospital. The term does not include any interim personnel serving in that role.

"Chief of Staff" means the chief officer of the Medical Staff elected by the Members of the Medical Staff.

"Clinical Assistant" is an individual qualified by academic education and clinical experience, or other training, to provide patient care services only under the supervision of a Member with Clinical Privileges.

"Clinical Privilege" means the permission granted to render specific designated services within the Hospital.

"Dentist" means an individual with a D.D.S. or D.M.D. degree who currently holds a valid license in the State of Indiana.

"Department" means an organizational group composed of Staff Members whose primary interests and training qualify them for delivery of health care in a specified medical field or practice.

“Directive to Appear” means an order issued by a Hearing Officer directing a proposed witness in a hearing to appear and specifying the time and place for the witnesses appearance.

“Disaster” means an emergency that due to its complexities, scope, or duration, threatens the Hospital's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

“Division” means an organizational subgroup of a Department.

“Encounter” is defined as patient contact requiring a history and physical exam. Examples of an encounter include an inpatient admission, an observation patient, an inpatient consultation, a surgery or any inpatient or outpatient procedure requiring a history and physical.

“Final Action” means an adverse action taken by the Board after all professional review activity within the Bylaws, Rules and Regulations, and Policies have been exhausted or waived.

“Healthcare Entity” means a hospital or other entity that provides healthcare services and that follows a formal peer review process for the purpose of furthering quality health care.

“Hospital” means Community Howard Regional Health, LLC.

“Indiana Medical Malpractice Act” means Indiana Code § 34-18-3 et seq. or any successor legislation to Title 34, Article 18.

“Indiana Peer Review Statute” means Indiana Code § 34-30-15 et seq.

“Inquiry” means an informal gathering of information to resolve a concern in a collegial manner and determine whether an Investigation is warranted. An inquiry may or may not be performed prior to the initiation of an Investigation by a Peer Review Committee or its representative.

“Investigation” means a formal review of concerns including a gathering of information by an Investigation Committee or the Committee's representative. An investigation continues until the Board of Directors takes a Final Action or formally closes the investigation. A Member who surrenders his/her clinical privileges or resigns while under investigation shall be reported to the National Practitioner Data Bank.

“Investigation Committee” means a peer review committee of the Medical Staff formed to conduct an Investigation as defined under the Bylaws, Rules and Regulations, and Policies. However, the Chief of Staff may appoint an individual to serve as an agent of the Peer Review Committee to conduct interviews on behalf of the Investigative Committee. In conducting such interviews, the individual is serving as the "personnel" of the Peer Review Committee".

“Medical Executive Committee” means the committee of the Medical Staff which shall constitute the governing body of the Medical Staff as described in these Bylaws, Rules and Regulations, and Policies.

“Medical Staff” or “Staff” means the formal organization of all Physicians, Oral Surgeons, Dentists, and Podiatrists who are granted Membership under these Bylaws, Rules and Regulations, and Policies.

“Medical Staff Year” means the period from January 1st to December 31st.

“Member” means a Physician, Oral Surgeon, Dentist or Podiatrist who has been granted Membership on the Medical Staff pursuant to the terms of these Bylaws, Rules and Regulations, and Policies.

“Oral Surgeon” means an individual with a D.D.S. or D.M.D., who has a valid license in Indiana, and who has successfully completed an Approved Residency Program in Oral and Maxillofacial Surgery.

“Peer Review” means, without limitation, the evaluation of patient care, the review and setting of standards of medical care for Members, professional health care providers, and the Hospital; the evaluation of qualifications of Members and other professional health care providers, the evaluation of complaints filed against Members and other individuals who are granted clinical privileges; the receipt, review, analysis and acting upon incident reports; quality and utilization review functions, and other functions and activities related thereto.

“Peer Review Committee” or “Professional Review Body” means the Board, a committee of the Medical Staff, or any committee of the Board that conducts Peer Review functions or activities. It includes those individuals serving as members of the Peer Review Committee and those assisting the Peer Review Committee. Such individuals assisting the Peer Review Committee may include employees, representatives, agents, attorneys, investigators, experts, assistants, clerks, staff and any other person or organization who assist the committee in performing Peer Review functions.

“Physician” means an individual with an M.D. or D.O. degree who currently holds a valid license to practice medicine in the State of Indiana.

“Physician Assistant” means an individual who currently holds a physician assistant license in the State of Indiana, maintains certification by the National Commission on Certification of Physician Assistants, and is supervised by a physician Member.

“Podiatrist” means an individual who currently holds a license to practice podiatric medicine in the State of Indiana.

“Policies” means the Policies and Procedures of the Medical Staff.

“President” means the person appointed by the Board of Directors who supervises the overall day to day operation of the Hospital.

“Professional Staff” means any practitioner authorized to exercise privileges by the Board of Directors and recommendation of the Medical Staff of the Hospital, including Allied Health Professionals.

“Qualified Healthcare Provider” means an individual meeting the requirements of the Indiana Medical Malpractice Statute and paying the surcharge or an individual covered under the Federal Tort Claim Act (FTCA). In that situation, the liability coverage requirement is satisfied by providing documentation of the Notice of Deeming Action (NDA) for the Health Center along with the documentation of confirming employment or contractor status with the deemed entity. The Board may approve an initial applicant, locum tenens applicant, or privileged practitioner seeking to return from a leave of absence contingent on becoming a Qualified Healthcare Provider if the applicant presents sufficient evidence from his professional malpractice carrier that the surcharge will be paid and policy effective prior to the commencement of any services by the individual at the Hospital.

“Rules and Regulations” means the Rules and Regulations of the Medical Staff.

“Sponsor” means the Member responsible for the conduct, services or tasks performed by the Allied Health Professional as if the Sponsor or designee performed the services.

Section 1.4 **Effect of Bylaws.**

These Bylaws shall not be considered nor represent to be a contract between the Medical Staff and Board of Directors. Appointment and continued Medical Staff Membership shall be based upon justification of current qualifications, professional conduct, and other requirements stated herein except as otherwise allowed by these Bylaws or a Member's contract with the Hospital.

ARTICLE II

PURPOSE OF THE MEDICAL STAFF

Section 2.1 **Purpose.** The purpose of the Medical Staff shall be:

- (a) to provide an organized body through which the benefits and obligations of each Member may be fulfilled;
- (b) to provide a means whereby problems of a medical administrative nature can be discussed by the Medical Staff with the Board and Administration;
- (c) to recommend appointment, reappointment, and assignment of clinical privileges to Members of the Medical Staff consistent with the individual's training, experience, other qualifications and professional performance, and to monitor and conduct ongoing review of Members in the Hospital;

- (d) to recommend the appropriate delineation of clinical privileges for members of the Professional Staff, and conduct on-going review and evaluation of the performance of the Professional Staff authorized to exercise clinical privileges in the Hospital;
- (e) to maintain Bylaws, Rules and Regulations, and Policies for the government of the Medical Staff and Professional Staff;
- (f) to provide an appropriate educational system that shall facilitate the maintenance of scientific standards and lead to continuous advancement and improvement of quality;
- (g) to set standards and systems in order to furnish competent care to all patients admitted to the Hospital or treated as an outpatient of the Hospital and to improve the public health of the community which the Hospital serves; and
- (h) to enable this Hospital to conform with all applicable requirements of state and federal laws and regulations, and any Accreditation Body, and any state licensure laws and regulations governing the license of the Member, Eligible Independent Practitioner, or Allied Health Professional.

ARTICLE III

MEMBERSHIP

Section 3.1 Nature of Membership.

Appointment as a Member of the Medical Staff is a privilege. Membership shall be extended only to competent Physicians, Oral Surgeons, Dentists, or Podiatrists who continuously meet the qualifications, standards and requirements set forth for membership in these Bylaws, Rules and Regulations, and Policies of the Medical Staff and Hospital. Appointment shall confer only such prerogatives as has been granted to the Member in accordance with these Bylaws. No Physician, Oral Surgeon, Dentist, or Podiatrist including those in a medical administrative position by virtue of a contract with or employment by the Hospital, shall provide any services to patients of the Hospital unless that Physician, Oral Surgeon, Dentist, or Podiatrist is a Member of the Medical Staff with Clinical Privileges to provide those services or has been granted temporary privileges in accordance with these Bylaws.

Section 3.2 Categories of Membership.

The Medical Staff shall be divided into two (2) categories: active and courtesy.

- (a) Active Staff
 - (i) To be eligible for the active staff, the applicant must
 - a. meet the general qualifications for Membership set forth in this Article and the Appointment Policy;

- b. have offices and residences which, in the opinion of the Medical Executive Committee, are located close enough to the Hospital to provide continuity of quality care based on the nature of the cases to be attended, travel time and distance from the Hospital, and the firm provision for qualified local coverage, if necessary; and
- c. be required to attend Medical Staff meetings as provided in Article IX of these Bylaws.

(ii) The prerogatives of an active staff member shall include

- a. to exercise such Clinical Privileges as are granted pursuant to these Bylaws, Rules and Regulations, and Policies;
- b. participate in the no-assigned-doctor emergency department call schedule unless the Member is party to a contract providing otherwise;
- c. attend and vote on matters present at general and special meetings of the Medical Staff, department, division and committees of which he is a member;
- d. be eligible to hold staff, division or department office; and
- e. serve as a voting Member of committees to which he is duly appointed or elected by the Medical Staff or duly authorized representative thereof.

(iii) An active staff member, who has been active for at least five (5) years and has attained the age of sixty (60) years, may request to be deemed Senior Active Staff Status in order to be exempt from officer duty, no-assigned-doctor emergency department call, and meeting attendance.

(b) Courtesy Staff

(i) To be eligible for courtesy staff, the applicant shall

- a. be limited to only thirty-six (36) Encounters per year
- b. meet the general qualifications for Medical Staff Membership as outlined in this Article and the Appointment Policy;
- c. provide evidence of current active staff membership in another Indiana hospital with participation in the peer review process;
- d. authorize complete access to all information pertaining to the Applicant's personal practice at the other hospital at which active membership is held;

- e. be allowed to participate on the emergency department call schedule;
- f. be ineligible to vote or hold office;
- g. be eligible to attend Staff meetings; and
- h. be allowed to request membership category change only once per year, by written request to the Credentials Committee.

Section 3.3 Modification of Membership Category.

A Member may request or the Credentials Committee may recommend a change in the Medical Staff category, consistent with the requirements of the Bylaws. If a Member's category is involuntarily changed, this action may give rise to hearing rights as set forth in the Fair Hearing and Appeal Policy if related to the provisions of quality care. An involuntary change based on the number of Encounters is automatic and does not give rise to any hearing and appeal rights.

Section 3.4 Limitation of Prerogatives.

The prerogatives set forth under each Membership category are general in nature and may be subject to limitation by special conditions attached to a particular Membership, by other sections of these Bylaws, Rules and Regulations, and Policies.

Section 3.5 Qualifications For Membership.

- (a) Except as provided in subsection (b), each Applicant who seeks or enjoys Medical Staff Membership must continuously demonstrate the following:
 - (i) current valid license issued by the appropriate licensing board in the State of Indiana;
 - (ii) current Board Certification or currently Board Eligible;
 - (iii) graduation from a professional school recognized by the appropriate licensing board in the State of Indiana, worthy in character and matters of professional ethics;
 - (iv) documented training, current professional competence, and physical and mental health stamina to provide care safely so as to demonstrate to the satisfaction of the Medical Staff that the Applicant is professionally and ethically competent and that patients treated by Applicant can reasonably expect to receive quality medical care through three (3) peer references;
 - (v) documentation that he/she is a Qualified Healthcare Provider as defined in Section 1.3;

(vi) the capability to work with and relate to other Members, Professional Staff, Administration, nurses, management and employees, visitors and the community in general, in a cooperative and professional manner that is essential for maintaining an environment appropriate to the delivery of quality patient care;

(vii) the capability to follow the generally-accepted standards of the professional practice and conduct in the community;

(viii) every application for appointment shall be signed by the Applicant and shall contain the Applicant's specific acknowledgement of every Medical Staff Member's obligation to provide continuous care and supervision of his or her patients and extenders; to accept committee and consultation assignments; to participate in and collaborate with the peer review and performance improvement activities of the Medical Staff or the Hospital. These include monitoring and evaluation tasks performed by the Medical Staff and compliance with Hospital efforts to improve performance on quality measures such as those established by the Centers for Medicare and Medicaid Services (CMS), any other governmental agency, payer, or Accreditation Body. This also includes office records concerning indications and outcomes related to procedures performed in the Hospital; and to abide by the Bylaws, Rules and Regulations, Policies and Expectations of the Medical Staff;

(ix) maintain a practice in the community or within a reasonable distance of the Hospital so as not to interfere with adequate outpatient or inpatient care.

(b) Exceptions. Only the Board may create exceptions or waive a qualification for Membership or Clinical Privileges or both after consultation with the Medical Executive Committee. Members continuously on the Medical Staff before May 28, 2009 are exempt from the requirement of (a)(ii).

Section 3.6 Evaluation Process For Membership.

The evaluation process for Applicants seeking appointment to Membership, which is stated more fully in the Appointment Policy, includes a determination of application completeness, determination that the Membership qualifications are met and recommendations by the Department Chief, the Credentials Committee, and the Medical Executive Committee, with the final determination made by the Board. Completed applications for membership are acted on within ninety (90) days.

Section 3.7 Member Responsibilities.

Except for the Honorary Staff, the ongoing responsibilities of each Member shall be:

- (a) to provide patients with the quality of care that meets the professional standards of the Medical Staff;
- (b) to abide by the Medical Staff Bylaws, Rules and Regulations and Policies;

- (c) to discharge in a responsible and cooperative manner such reasonable responsibilities and assignments as imposed by virtue of Medical Staff Membership, including committee assignments;
- (d) to prepare and complete medical records, including medical histories and physical examinations for each patient. Medical histories and physical examinations for each patient must be done no more than 30 days prior to or 24 hours after hospital admission or registration, but prior to surgery or a procedure requiring anesthesia services;
- (e) to work cooperatively with other Members, Professional Staff, nurses, Administration, and others;
- (f) to provide coverage for his/her patients through another Member of the Medical Staff during periods of absence in order to ensure daily continuity of patient care;
- (g) to participate in continuing education programs as determined by the Medical Staff;
- (h) to participate in emergency department coverage, inpatient emergencies, or consultation panels as determined by the Medical Staff;
- (i) to refuse to engage in improper inducement for patient referrals;
- (j) to use reasonable means to secure authorization to perform autopsies in all cases of unusual deaths and complete patient death certificates as applicable;
- (k) to appear for personal interviews in regard to an applicant for initial appointment or reappointment, as requested by the appropriate Medical Staff committee;
- (l) to attest to and agree to the expectations of the Medical Staff; and
- (m) to discharge such other Staff obligations as may be established from time to time by the Board of Directors.

Section 3.8 Effect of Other Affiliations.

No person shall be entitled to Membership on the Medical Staff merely because he holds a certain degree, a license to practice in this or any other state, is a member of any professional organization, is certified by any clinical board, or because such person presently has membership or privileges at another health-care entity.

Section 3.9 Nondiscrimination.

No aspect of Medical Staff Membership or clinical privileges shall be denied on the basis of sex, race, age, creed, color or national origin.

Section 3.10 Leave of Absence.

- (a) At the discretion of the Board of Directors, a Member may obtain a voluntary leave of absence. A Member desiring to take a leave of absence shall submit a written request to the Medical Executive Committee, stating the purpose of the leave, the approximate period of leave desired and his plan/coverage. Before a Member's request shall be considered, all medical records for which the Member is responsible shall be completed. The Medical Executive Committee may require the Member's complete cooperation with any Inquiry or Investigation concerning the competence or conduct of the Member before making a recommendation. The Medical Executive Committee shall make a recommendation to the Board of Directors.
- (b) If the leave of absence is granted, during the period of leave the Member shall not exercise any Clinical Privileges at the Hospital and his/her Membership rights and responsibilities shall be inactive.
- (c) At least thirty (30) days prior to the expiration of the leave of absence, the Member may request activation and reinstatement of his/her Clinical Privileges by submitting a written request to the Medical Executive Committee. Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Membership and Clinical Privileges unless an Investigation was pending at the time the leave was requested. The MEC, with the assistance of the Credentials Chair, shall make a recommendation to the Board, which may include ongoing professional practice evaluation and focused professional practice evaluation.
- (d) Absence based on military duty shall be deemed an automatic leave of absence.

ARTICLE IV

CLINICAL PRIVILEGES

Section 4.1 Core Privileges.

Members and other Eligible Independent Practitioners may seek Clinical Privileges. The Medical Staff utilizes core privileging wherein the Eligible Practitioner seeks authority to provide services in a particular practice area. An Applicant seeking Clinical Privileges must demonstrate that he meets the criteria of the core area. High risk or technically complex conditions and procedures in a particular specialty may need evidence of additional training, experience and current competence. Unless exempt, the Member or Eligible Independent Practitioner must demonstrate current Board Certification or Board Eligibility in the area in which the requested privileges are sought. Any privileged practitioner is authorized in an emergency to do everything necessary to save the life of any patient who is in immediate danger when any delay in administering treatment would increase the danger of acute worsening of the patient's condition; or the likelihood of death.

Section 4.2 Practitioners Eligible for Temporary, Emergency, and Locum Tenens Privileges.

Only Physicians, Oral Surgeons, Podiatrists, and Dentists are eligible to seek Temporary Privileges, Emergency and Disaster Privileges, or Locum Tenens Privileges and are required to abide by the Medical Staff Bylaws, Rules and Regulations, and Policies. However, as non-Members of the Medical Staff, they are not entitled to any of the benefits such as the hearing and appeal rights afforded to Members or other prerogatives and benefits afforded solely to Members.

Section 4.3 Temporary Privileges.

Temporary privileges may be granted to fulfill an important patient care, treatment and service need. The evaluation process for temporary privileges, which is stated more fully in the Temporary Privilege Policy, includes review and approval by the Chief of Staff and President or their designees in consultation with the Department Chief and, if applicable, the Medical Director.

Section 4.4 Emergency and Disaster Privilege.

During a disaster, the Medical Staff authorizes the President of the Hospital or the Chief of Staff or their designees to grant emergency and disaster privileges to volunteer licensed independent practitioners. Before exercising these privileges, the licensed independent practitioners must present a valid government issued photo identification. The evaluation process for applicants seeking emergency and disaster privileges, which is stated more fully in the Emergency and Disaster Policy, includes (upon presentation of appropriate credentials and review by the President or Chief of Staff or their designees), privileges granted, with post verification after the disaster or emergency has stabilized.

Section 4.5 Locum Tenens Privileges.

Locum tenens privileges may be granted to Eligible Independent Practitioners. The evaluation process for applicants seeking locum tenens privileges, which is stated more fully in the Locum Tenens Policy, includes (upon presentation of appropriate credentials) review and approval by the President and Chief of Staff or their designees in consultation with the Department Chief, and if applicable, the Medical Director.

Section 4.6 Allied Health Professionals.

- (a) An Allied Health Professional is any Advanced Nurse Practitioner, Physician Assistant or clinical psychologist granted Clinical Privileges by the Board of the Hospital. Allied Health Professionals are governed by the Medical Staff Bylaws, Rules and Regulations, and Policies. All applicants seeking to become an Allied Health Professional are required to have a sponsoring Member as set out in the Allied Health Professionals Policy. The sponsoring Member shall assume responsibility for the care of the patient. The scope and extent of Clinical Privileges granted to an Allied Health Professional shall be limited by the scope of Clinical Privileges of the sponsor Member.

- (b) The evaluation process for Applicants seeking appointment to be an Allied Health Professional, which is stated more fully in the Allied Health Professional Policy, includes a determination of the application completeness, determination that the membership qualifications are met and recommendations by the Department Chief, the Credentials Committee, and the Medical Executive Committee, with the final determination made by the Board.
- (c) The hearing and appeal procedures for Allied Health Professionals are set forth in the Allied Health Professionals Policy.

Section 4.7 Clinical Assistants.

Any Member may seek the prerogative of requesting scope of service for an eligible individual to serve as a Clinical Assistant of the Member. The supervising Member must serve as the "Sponsor" of the Clinical Assistants unless designated to another Member in the same practice. Clinical Assistants provide only those clinical services that are consistent with the written job description approved by the Medical Staff and Hospital policy. Clinical Assistants are not Members of the Medical Staff, are not privileged through the Medical Staff, but are approved by the Hospital. Nevertheless, the Sponsor or designee will be responsible for the conduct of the Clinical Assistant. All specific functions and tasks delegated to a Clinical Assistant shall be done under the direction of the Sponsor or designee. The Sponsor or designee shall assume responsibility for the care of the patient. The scope and extent of the procedures and tasks performed by the Clinical Assistant shall be limited by the scope of his job description and scope of Clinical Privileges of the Sponsor or designee.

Section 4.8 Evaluation of Clinical Privileges.

The evaluation process for seeking Clinical Privileges is stated more fully in the Appointment Policy, Allied Health Professionals Policy, and Locum Tenens Policy, and includes a determination that the core privilege qualifications are met with recommendations by the Department Chief, the Credentials Committee, and the Medical Executive Committee, and the final delineation of Clinical Privileges made by the Board. Completed applications for privileges are acted on within ninety (90) days. The final decision to grant, limit or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within sixty (60) days.

ARTICLE V

ACTIONS AFFECTING MEMBERSHIP OR PRIVILEGES

Section 5.1 Handling of Complaints and Concerns Related to Members.

Whenever the competence, professional behavior or conduct of a Member is questioned, the President, in consultation with the Chief of Staff in his/her capacity as the Chair of the Medical Executive Committee, may initiate an Inquiry in order to determine whether Medical Staff action or an Investigation is warranted.

- (a) Any concerns raised by anyone relating to the qualifications, competency, professional behavior or conduct of a Member may lead to either an Inquiry or Investigation.
- (b) The discretion to undertake an Inquiry or Investigation shall be left to the Chief of Staff, in consultation with the President, given the nature of the concern.
- (c) An Inquiry is an informal gathering of information and may be designated to any person who is acting as an agent of the Medical Executive Committee in fulfilling its peer review functions.

Section 5.2 Investigations.

- (a) If an Investigation is initiated, the Chief of Staff shall appoint a committee to conduct an Investigation ("Investigation Committee") and outline the concerns for the Investigation Committee to investigate.
- (b) The Investigation Committee may be a subcommittee of the Medical Executive Committee, the full Medical Executive Committee, an ad hoc committee or any other standing committee, if appropriate.
- (c) The Investigation Committee shall investigate the qualification, competence, professional behavior or conduct at issue. The Investigation Committee may designate Members or agents to gather specific information for the Committee. The Investigation Committee, at its discretion, may interview the Member whose conduct is the subject of the Investigation. The Investigation Committee shall make a written report of the information gathered and make recommendations to the Medical Executive Committee for further handling. The Investigation Committee shall also disclose additional concerns the Investigation uncovers. If the MEC conducts the investigation, the investigation results will be detailed in the minutes of the MEC.
- (d) The Medical Executive Committee, at its next meeting, shall recommend the action to be taken based on the Investigation. The Medical Executive Committee may (1) decide no further action is warranted; (2) issue a warning a letter of admonition or of reprimand; (3) impose terms of probation or a requirement for consultation; (4) recommend reduction, suspension or revocation of Clinical Privileges; (5) recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained; or (6) recommend that the Member's Membership be suspended or revoked.
- (e) If the recommendation is an Adverse Recommendation as set forth in (d)(4) through (6) and results or may result in a termination or suspension, the Member may be entitled to hearing and appeal rights under the Fair Hearing and Appeal Policy. If the recommendation does not entitle the Member to the rights under the Fair Hearing and Appeal Policy such as the recommendations set forth under d(1) through (3), the Member may request an audience with the Medical Executive Committee to discuss the recommendation and/or provide a written response to it.

- (f) If the right to a hearing is triggered, the President shall provide written notice of the right within seventy-two (72) hours and advise the Member or Applicant of the thirty (30) days after receipt of the hearing notice deadline in which the hearing must be requested and a summary of hearing rights. If a hearing is not requested within the timeframe, the hearing and appeal is deemed to have been waived. If a hearing request is made, the President shall appoint three active staff Members of the Medical Staff to serve as the hearing panel and provide notice of the hearing date and time, and the identity of witnesses and cases that may be relied upon by the Medical Executive Committee. The hearing and appeal procedures are set forth in the Hearing and Appeal Policy.
- (g) The initiation of an Inquiry or Investigation shall not prevent any authorized committee or individuals, acting as a committee, from imposing a summary suspension.
- (h) Nothing in this Article precludes the Board of Directors from investigating concerns brought to the Board's attention or appointing a committee to investigate on its own behalf.

Section 5.3 Grounds for Precautionary Suspension or Restriction.

- (a) Whenever failure to take action may result in imminent danger to the health or safety of any individual or may disrupt the orderly operation of the Hospital, the Board Directors or the Medical Executive Committee or any two (2) of the following individuals, the President, the Chief of Staff, the Vice Chief of Staff or the appropriate Department Chief is/are authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's Clinical Privileges. The Member shall be notified immediately upon imposition of a precautionary suspension. Within three days of the imposition of a suspension or restriction, the individual shall be provided a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any).
- (b) A precautionary suspension or restriction can be imposed at any time following a specific event, a pattern of events, or a recommendation by the Medical Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension or restriction, the person(s) considering the suspension will meet with the individual and review the concerns.
- (c) A precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It will not imply any final finding of responsibility for the situation that caused the suspension or restriction.
- (d) A precautionary suspension or restriction will become effective immediately upon imposition, will immediately be reported to the President and the Chief of

Staff, and will remain in effect unless it is modified by the Board of Directors or Medical Executive Committee.

Section 5.4 Medical Executive Committee Procedure.

- (a) The Medical Executive Committee will review the reasons for the precautionary suspension or restriction within a reasonable time, not to exceed 14 days. As part of this review, the individual will be given an opportunity to meet with the Medical Executive Committee. This meeting is not intended to be a hearing and the individual will not have the right to call and examine or cross-examine witnesses. The individual may be accompanied by counsel, who may advise the individual, but counsel will not be permitted to address the Medical Executive Committee. A stenographic reporter will be present to make a record of the meeting.
- (b) The individual may propose ways other than precautionary suspension or restriction to protect patients, employees or the orderly operation of the Hospital.
- (c) After considering the reasons for the suspension or restriction and the individual's response, if any, the Medical Executive Committee will determine whether the precautionary suspension or restriction should be continued, modified, or terminated. The Medical Executive Committee will also determine whether to begin an Investigation.
- (d) There is no right to a hearing or appeal based on the imposition or continuation of a precautionary suspension or restriction.
- (e) Upon the imposition of a precautionary suspension or restriction, the Chief of Staff or Vice-Chief of Staff or responsible Department Chief will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of such alternative practitioner.

Section 5.5 Automatic Suspensions.

- (a) Automatic suspensions do not give rise to any hearing or appeal rights, and are imposed by notice to the Member by the appropriate Medical Staff Committee, Medical Executive Committee, or Hospital President. Automatic suspensions are terminated by the Member's compliance with the involved requirement except as provided specifically otherwise. Automatic suspensions will be reported as required by state and federal law.
- (b) An automatic suspension shall be imposed effective upon:
 - (i) verification that a Member has made a false representation to the Medical Staff during the credentialing process;
 - (ii) the Member's license to practice his/her profession is suspended or terminated;

- (iii) the surrender, restriction, suspension or termination of the Member's registration to dispense, prescribe or administer any schedule of controlled substance. The automatic suspension shall be limited to the Member's privileges to prescribe such controlled substance affected by the surrender, restriction, suspension or termination;
 - (iv) the Member fails to maintain status as a Qualified Healthcare Provider;
 - (v) the Member is excluded by the General Services Administration or the Office of Inspector General from any federally funded healthcare program including Medicare or Medicaid;
 - (vi) the Member no longer meets the geographic proximity requirements; or
 - (vii) all or a portion of Clinical Privileges when the Member fails to appear at a meeting for which the Member is given notice and a suspected deviation from standard clinical practice or unacceptable professional behavior is to be discussed;
 - (viii) the Member no longer meets a threshold eligibility requirement for membership or privileges.
- (c) Any suspension based on Member's license or controlled substance registration shall not be lifted until the Medical Executive Committee votes on whether to initiate its own corrective action.
 - (d) An automatic suspension shall be imposed effective immediately of any Allied Health Professional whose legal prescribing authority derives from either a supervising agreement or collaborative agreement with the Member.

Section 5.6 Exclusive Contracts.

A Member who has or who is a Member of a professional group that has, an exclusive contract to provide certain services within the Hospital shall not be entitled to the hearing and appeal rights provided by the Fair Hearing and Appeal Policy upon termination of the contract unless the contract provides otherwise.

ARTICLE VI

OFFICERS

Section 6.1 Officers of the Medical Staff.

The officers of the Medical Staff shall consist of the Chief of Staff, Vice-Chief of Staff (Chief of Staff Elect), and the Immediate Past Chief of Staff.

Section 6.2 Term of Offices.

Officers shall be elected at the annual November meeting of the Medical Staff. The term of office is for twenty-four (24) months, starting on January 1st of the year immediately following their election and running through December 31st of the succeeding year.

Section 6.3 Qualifications.

Officers must be Members of the Active Staff for at least three (3) years at the time of their nomination and election, and remain Members during the term of office. Failure to maintain such a status shall create a vacancy in the office involved.

Section 6.4 Chief of Staff.

(a) Duties.

The Chief of Staff shall serve as the chief officer of the Medical Staff whose duties shall include, but not be limited to:

- (i) enforcing the Medical Staff Bylaws, Rules and Regulations, and Policies, and the state and federal laws and regulations as they apply to Members, Allied Health Professionals, and Mid-Level Professionals, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
- (ii) calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;
- (iii) serving as chairman of the Medical Executive Committee;
- (iv) serving as an ex-officio Member of all other Staff committees, without vote unless his/her membership on a particular committee is required by these Bylaws;
- (v) interacting with the Hospital President and Board of Directors in all matters of mutual concern within the Hospital;
- (vi) appointing, in consultation with the Medical Executive Committee, committee members for all standing and special Medical Staff, liaison or multi-disciplinary committees, except where otherwise provided by these Bylaws and except where otherwise indicated, designating the chairman of these committees;
- (vii) representing the views and policies of the Medical Staff to the Board of Directors and to the Hospital President;
- (viii) being a spokesperson for the Medical Staff in external, professional, and public relations;

- (ix) performing such other functions as may be assigned to him/her by these Bylaws, the Medical Staff, or by the Medical Executive Committee; and
- (x) serving on liaison committees with the Board of Directors and administration as well as outside licensing or accreditation agencies.

Section 6.5 Vice-Chief of the Medical Staff.

The Vice-Chief of the Medical Staff is the Chief of Staff-Elect and shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice-Chief of Staff shall be a member of the Medical Executive Committee, the Joint Conference Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee. The Vice-Chief of Staff shall serve as the Chair of the Medical Audit and Review Committee.

Section 6.6 Immediate Past Chief of Staff.

The Immediate Past Chief of Staff shall serve as a voting advisory member of the Medical Executive Committee and shall perform such other duties as may be assigned by the Chief of Staff or delegated by these Bylaws or the Medical Executive Committee.

Section 6.7 Vacancies.

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or the officer's loss of Membership on the Medical Staff. Vacancies, other than that of the Chief of Staff, shall be filled by the Medical Executive Committee. The appointed officer shall serve out the remainder of the vacated term. If there is a vacancy in the office of the Chief of Staff, the Vice-Chief of Staff shall serve the remainder of the vacated term and shall immediately appoint a nominating committee to nominate a slate of candidates for the office of Vice Chief of Staff. The names of the nominees shall be reported to the Medical Staff. A special election to fill the Vice-Chief of Staff position shall occur at the next regular Staff meeting.

Section 6.8 Removal.

Any Medical Staff officer may be removed from office for cause, by two-thirds (2/3) vote of the Members eligible to vote and present at the special meeting.

- (a) Reasons for removal include, but are not limited, to:
 - (i) failure to meet the minimum requirements of Medical Staff Membership (i.e., suspension of license to practice medicine, failure to maintain malpractice insurance);
 - (ii) failure to fulfill the responsibilities of the elected position;
 - (iii) loss of credibility, trust, and/or leadership ability over peers;

- (iv) failure to abide by the ethics adopted by the American Medical Association or American Dental Association; or
- (v) failure to conduct himself/herself in such a manner as to reflect favorably on the Medical Staff of Community Howard Regional Health.

(b) Initiation of Removal Process.

In the event that 10% of the voting Members of the Medical Staff each sign a petition for removal of an officer, the process for removal shall be initiated. The petition should clearly state the cause or the reasons for removal and may include any other information by way of additional explanation to the Medical Staff Members. The petitioner must acknowledge that they have read the petition and all attachments, if any, in order for their signature to be considered valid. Once the 10% threshold has been achieved, the petition and any attachments and a list of the petitioners shall be forwarded to the Medical Executive Committee. Within thirty (30) days of the Medical Executive Committee’s receipt of the petition, a special meeting shall be scheduled. The Medical Executive Committee shall appoint a committee to preside over the removal vote.

ARTICLE VII

COMMITTEES

Section 7.1 Standing Committees of the Medical Staff.

Certain Medical Staff committees shall be Standing Committees. All Standing Committees shall be appointed by the Chief of Staff unless otherwise stated below. No more than half of the appointed members of the Committee shall be changed in one (1) year. Except for the Pharmacy and Therapeutics Committee and the Utilization Review Committee, the committee chair shall be a Member of the Medical Staff and, when possible, shall have served on the Committee the previous year. Only Medical Staff Members may vote on any issue related to peer review matters, and on other issues on order of the committee chair unless otherwise specified in these Bylaws or Medical Staff Policies. The term of Standing Committee membership shall be from January 1st through December 31st. Each committee member shall be expected to attend at least 50% of all meetings in each year. The Standing Committees are as follows:

- | | |
|-------------------------------------|------------------------------|
| Medical Executive Committee | Bylaws Committee |
| Joint Conference Committee | Cancer Committee |
| Medical Audit and Review Committee | Credentials Committee |
| Pharmacy and Therapeutics Committee | Utilization Review Committee |
| Critical Care Committee | |

Section 7.2 Special Committees.

Special Committees shall be appointed, from time to time, as may be required to properly carry out the duties of the Medical Staff. Such committees shall confine their work to the purposes for which they were appointed and shall report to the Medical Executive Committee. A Special Committee shall not have power of action unless it is specifically granted by the motion which created the Special Committee or is authorized in the Bylaws. Special Committees include the

Medical Staff Aid Committee, the Nominating Committee, and the Emergency Medicine Committee.

Section 7.3 Medical Executive Committee.

- (a) The Medical Executive Committee shall consist of all officers of the Medical Staff; the Department Chiefs; three (3) representatives from the Medicine Department elected by Medicine Department Members; three (3) representatives from the Surgery Department elected by Surgery Department Members, and immediate Past Chief of Staff. The President, the Physician Executive and the Chief Nursing Officer are non-voting members of the Committee. The majority of voting Medical Executive Committee members shall be fully licensed doctors of medicine or osteopathy actively practicing in the Hospital.
- (b) The Medical Executive Committee shall coordinate the activities and general policies of the various Departments and shall represent and act for the Medical Staff as a whole, under such limitations as may be imposed by the Medical Staff. The Medical Executive Committee shall have the authority to interpret these Bylaws, Rules and Regulations, and Policies of the Medical Staff in forming Medical Staff policy. Such policy, statements or interpretations shall be communicated to the general Medical Staff. The Medical Executive Committee shall receive and act upon the reports of the Departments and Standing Committees.
- (c) The Medical Executive Committee shall conduct peer review activities on behalf of the Hospital which shall include, but not be limited to; (1) investigating the credentials of all Applicants for appointment or reappointment with clinical privileges to the Medical Staff and the Professional Staff; (2) investigating any reported breach of ethics; (3) reviewing any record that may be referred by a Department and/or the Medical Audit and Review Committee; and (4) recommending the delineation of privileges and assigning of Members to Departments.
- (d) All peer review activities and functions that the Medical Executive Committee performs on behalf of the Hospital and all of the records and communications to and from the Medical Executive Committee concerning peer review activities shall be maintained in a confidential manner and as privileged information. All other committees of the Medical Staff, when considering peer review information, shall be deemed subcommittees of the Board of Directors. The release of any peer review information will be consistent with the Indiana Peer Review Act and these Bylaws.
- (e) The Medical Executive Committee shall serve as the Accreditation Committee. In this capacity, the Medical Executive Committee shall be responsible for making recommendations to the Medical Staff relative to policies, programs and guidelines for the continued accreditation of the Hospital. The Medical Executive Committee shall carry out this responsibility in conjunction with the regular meetings of the Medical Executive Committee.

- (f) The Medical Executive Committee shall meet a minimum of once a month, maintain a permanent written record of its proceedings and actions, forward its minutes to the Board of Directors, and report at each general Medical Staff meeting.
- (g) The Medical Staff may limit or expand the powers of the Medical Executive Committee at a special or annual meeting with a vote of two-thirds (2/3) members present and eligible to vote.
- (h) An initiation of the process to remove a department representative member of the Medical Executive Committee. At large members of the Medical Executive Committee may be removed by a special meeting of the department and a two thirds (2/3) vote of members present and eligible to vote. Removal of members of the Medical Executive Committee serving by virtue of their office shall be set forth in Section 6.8 or Section 8.8 whichever is pertinent.
- (i) Process for filling a vacancy of elected department representatives to the Medical Executive Committee shall include providing notice to the department from which the representative came to elect a new representative. The department may hold a special meeting to elect a new representative. The Chief of Staff, with input from the department chief, may appoint a representative to fill the vacancy until the next meeting of the department.

Section 7.4 Joint Conference Committee.

The Joint Conference Committee shall serve as the medical-administrative liaison committee and the official point of contact among the Medical Staff, Board of Directors, and the Hospital President. The Joint Conference Committee shall consist of two (2) members of the Board of Directors, two officers of the Medical Staff, and the President of the Hospital. The Hospital President shall serve as the secretary and maintain records and minutes of the Committee. The recommendations of the Joint Conference shall be forwarded to the full Board for action. If the records concern the personal practice of a Member or Eligible Independent Practitioner, then those records of the Joint Conference shall be maintained in the medical staff office. The Joint Conference Committee shall meet on an as-needed basis.

Section 7.5 Medical Audit and Review Committee.

- (a) The Medical Audit and Review Committee shall perform various performance assessment and improvement functions.
- (b) With respect to the medical records, this committee shall:
 - (i) assure that all medical records meet appropriate standards of patient care, are of historical validity, and reflect realistic documentation of medical events;
 - (ii) conduct a review of currently maintained medical records to assure that they properly describe the condition and progress of the patient, the therapy provided, and the results thereof, and the identification of responsibility for

all actions; and are sufficiently complete and medically comprehensive to facilitate a transfer of patient care in the event such transfer is needed; and

- (iii) conduct retrospective review of completed records of discharged patients and other pertinent sources of medical information relating to patient care in order to contribute to the continuing education of the Medical Staff and the Professional Staff for the improvement of patient care.
- (c) The Medical Audit and Review Committee shall serve as the initial reviewing body for reports and information from the Infection Control Subcommittee.
- (i) The Infection Control Subcommittee shall consist of a pathologist, the Hospital Infection Control Practitioner, the Vice President of Nursing (or designee), and the Hospital President (or designee). This subcommittee shall report on surveillance of Hospital infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities. This subcommittee shall meet at least quarterly and shall report two times annually to the Medical Audit and Review Committee.
- (d) With respect to blood utilization, the Medical Audit and Review Committee shall develop criteria for blood product usage and blood product transfusion practices within the Hospital, and review the administration of blood product transfusions, possible transfusions associated infections, and wasted blood products within the Hospital.
- (e) With respect to utilization review, the Medical Audit and Review Committee shall be responsible for overseeing the development and implementation of the Hospital's utilization review plan and for reviewing and evaluating the quality of the medical care provided on the basis of documented evidence to support diagnoses, admissions, treatments, and justified utilization of the Hospital's facilities.
- (f) The Committee shall recommend plans for improving patient care within the Hospital to the Medical Executive Committee for approval. These may include, but are not limited to, mechanisms to:
- (i) establish systems to identify potential problems in patient care;
 - (ii) set priorities for action on problem correction;
 - (iii) refer priority problems for assessment and corrective action to appropriate Departments or committees;
 - (iv) monitor the results of quality assurance activities throughout the Hospital; and
 - (v) coordinate quality assurance activities.

- (g) The Medical Audit and Review Committee shall consist of the Vice Chief of Staff, the Vice Chief of each Department, three (3) representatives of the Departments, three (3) additional appointees appointed by the Chief of Staff to provide balanced representation of various specialties, and appropriate representatives of the Hospital appointed by the President. Physician Executive shall serve on this committee as a non-voting member. The Vice Chief of Staff shall serve as chairperson.
- (h) Process for filling a vacancy of elected department representatives to the Medical Audit and Review Committee shall include providing notice to the department from which the representative came to elect a new representative. The department may hold a special meeting to elect a new representative. The Chief of Staff, with input from the department chief, may appoint a representative to fill the vacancy until the next meeting of the department.

Section 7.6 Pharmacy and Therapeutics Committee.

- (a) The Pharmacy and Therapeutics Committee shall consist of physician members from the medical staffs of the various Affiliated Hospitals of the Community Health Network, pharmacists and other professionals. The Committee will:
 - (i) develop policies and procedures relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials in the Hospital;
 - (ii) develop and maintain the drug formularies or drug lists;
 - (iii) define and review all significant drug reactions;
 - (iv) evaluate protocols concerned with the use of investigational or experimental drugs; and
 - (v) evaluate drug usage to help assure that drugs are provided appropriately, safely and effectively.
- (b) At minimum, two Members of the Medical Staff and a pharmacist working at this Hospital must be on the Pharmacy and Therapeutics Committee. When possible, the Members shall consist of Members representing each Department of the Medical Staff and other hospital staff as deemed appropriate unless otherwise specified in these Bylaws or Medical Staff Policies.
- (c) The Pharmacy and Therapeutics Committee shall meet at least quarterly, shall maintain minutes of the meeting, and shall report to the Medical Executive Committee or the Medical Audit and Review Committee and make recommendations as deemed appropriate unless otherwise specified in these bylaws.

Section 7.7 Critical Care Committee.

The Critical Care Committee shall be responsible for establishing and recommending to the Medical Executive Committee rules, regulations, policies and procedures pertaining to the care of patients in the Intensive Care Unit and any other critical care areas. The committee shall evaluate the death rate for the Intensive Care Unit and conduct other related studies as may be deemed necessary. The Critical Care Committee shall meet on an as-needed basis. The Critical Care Committee shall consist of a board-certified internist and at least two (2) other Members of the Medical Staff, at least one of whom holds Active Membership in the Surgery Department, and the Nursing Director of Special Care. The Committee shall meet on an as-needed basis and shall report to the Medical Executive Committee.

Section 7.8 Bylaws Committee.

The Bylaws Committee shall be composed of at least three (3) Members of the Active Medical Staff. The Bylaws Committee shall be responsible for the development of Bylaws and Rules and Regulations pertaining to the governance of the Medical Staff and Professional Staff. This Committee is responsible to ensure that all changes to the Bylaws and Rules and Regulations are made a permanent part of the master copy of Bylaws, Rules and Regulations and Policies of the Medical Staff.

Section 7.9 Utilization Review Committee.

- (a) The Utilization Review Committee shall consist of physician members from the medical staffs of the various Affiliated Hospitals of the Community Health Network, and other professionals. The Utilization Review Committee shall evaluate the appropriate use of patient care services furnished by the Members of the Medical Staff and Hospital and promote the most efficient use of available health facilities and services. The Utilization Review Committee is a medical staff committee and its functions include, but are not limited to:
- (i) develop and implement a utilization review plan;
 - (ii) conduct review of the appropriateness and medical necessity of inpatient admissions, outpatient observations, continued stays, supportive services, and duration of stays;
 - (iii) supervise discharge planning for all patients with the process improvement recommendations based on review;
 - (iv) make recommendations to the Medical Audit and Review committee to coordinate between utilization review activities and quality assurance activities;
 - (v) refer questions regarding individual practices of and professional services furnished by Members of the Medical Staff to the Medical Audit and Review Committee;

- (vi) research, evaluate, and if appropriate, develop action plans to resolve and respond to utilization improvement activities;
 - (vii) monitor and assess the effectiveness of case management in resolving utilization issues and improving the effectiveness of resource allocation and usage; and
 - (viii) provide support and resources necessary for the hospital to comply with the utilization management provisions of all agreements and/or contracts between the hospital and third party payers.
- (b) At minimum, two Members of the Medical Staff will serve on the Utilization Review Committee. When possible, the Members shall consist of Members representing each Department of the Medical Staff and other hospital staff as deemed appropriate, unless otherwise specified in these Bylaws or Medical Staff Policies. The Chief of Staff may appoint additional Members of the Medical Staff to the Committee. The Committee may also consist of representatives from the departments of Health Information Management, Patient Finance, and the Recovery Audit Contractors Committee.
- (c) The Committee will meet monthly and make periodic reports to the Medical Audit and Review Committee, and Medical Staff Executive Committee.

Section 7.10 Emergency Medicine Committee.

- (a) The purpose of the Emergency Medicine Committee is to:
- (i) supervise the care provided in the Emergency Medicine Division of the Hospital;
 - (ii) review and recommend Emergency Medicine Division rules and policies to be adopted by the Medical Staff;
 - (iii) serve as liaison between the Medical Staff and Hospital Administration to resolve any medical-administrative matters and insure proper functioning of the Emergency Medicine Division.
- (b) The Emergency Medicine Committee shall be composed of the Chief of Surgery, the Chief of Medicine, and the Medical Director of the Emergency Medicine Division who shall serve as chairman of the committee. For the purpose of providing information and assistance to the committee, the Nursing Director of the Emergency Medical Division shall attend the meetings.
- (c) The Emergency Medicine Committee shall meet on an as-needed basis or at the request of the Medical Executive Committee, maintain a record of all meetings, and report to the Medical Audit and Review Committee, and which in turn will report to the Medical Executive Committee.

Section 7.11 Cancer Committee.

- (a) The Cancer Committee may, but is not limited, to (1) planning educational programs for community healthcare professionals and ancillary medical personnel in regard to cancer diagnosis and therapy; (2) developing protocol for cancer patient evaluation studies and ongoing quality control; (3) reviewing the types of cancer treatment and determining needs for specific professional educational programs; and (4) evaluating cancer patient survival in comparison to national data.
- (b) The Cancer Committee shall consist of a chairman and Members of the Medical Staff representing the various specialty areas of cancer diagnosis and management listed below, and such additional Hospital staff involved with cancer patients as determined by the Committee.

Pathologist	Primary Care Physician
Diagnostic Radiologist	Hospital Quality Assurance Representative
Medical Oncologist	Hospital Administration Representative
Radiation Oncologist	Cancer Registry Representative
Surgeon	Social Services Representative
American College of Surgeons Liaison Physician	Oncology Nurse - RN, OCN

- (c) The committee shall meet quarterly, maintain a record of its activities, and report to the Medical Audit and Review Committee which in turn reports to the Medical Executive Committee.

Section 7.12 Credentials Committee.

- (a) The Credentials Committee shall:
 - (i) review for recommendation to the Medical Executive Committee all applications and reapplications for appointment and privileges of Members of the Medical Staff, Allied Health Professionals, and Mid Level Professionals;
 - (ii) review for recommendation to the Medical Executive Committee all requests for changes in privileges for practitioners or requests for change in Medical Staff category;
 - (iii) recommend to the Medical Executive Committee changes in credentialing policies and procedures, as well as recommendations for Bylaw changes; and
 - (iv) recommend criteria for privileges.
- (b) The Credentials Committee shall consist of the past Chief of Staff, of two representatives from each medical staff department appointed by the Chief of Staff, and of the Chair of the Bylaws Committee. The chair of the committee will be

elected from the committee members. The Credentials Committee shall meet monthly or as necessary to review requests and make recommendation to the Medical Executive Committee.

- (c) All credentialing functions and activities of the Credentials Committee shall be deemed peer review activities, and all the records and communications to the Credentials Committee shall be maintained in a confidential manner and as privileged information under the Indiana Peer Review Act. The Committee will monitor procedural consistency in the application process and fair treatment of each applicant.

Section 7.13 Medical Staff Aid Committee.

- (a) The Medical Staff Aid Committee is formed to assist Members in retaining or regaining optimal professional functioning, consistent with the protection of patients, if issues of physical, psychiatric, or emotional illness arise. The objectives of the Medical Staff Aid Committee are:
 - (i) to provide education about Member health;
 - (ii) to address prevention of physical, psychiatric, or emotional illness;
 - (iii) to facilitate confidential diagnosis, treatment, and rehabilitation of Members who suffer from potentially impairing conditions;
 - (iv) to maintain the confidentiality of the Member seeking referral or who is referred for assistance, except as limited by law, ethical obligation, or when the safety of the patient is threatened;
 - (v) to evaluate the credibility of any complaint, allegation, or concern about a Member's behavior, conduct, or alleged criminal activity which may indicate a physical, psychiatric or emotional illness;
 - (vi) to monitor the Member and the safety of patients until the Members rehabilitation is complete; and
 - (vii) to report to the Medical Executive Committee an instance in which a Member may be providing unsafe treatment.
- (b) The Medical Staff Aid Committee will be appointed on an ad hoc basis and will consist of no less than three (3) Active Staff Members. Term of appointment shall be for the period required to fully address the current issue. Members of this committee shall not be partner, employee or competitor of the Member seeking or requiring assistance.
- (c) The Committee shall meet on an as-needed basis or at the request of the Medical Executive Committee. The committee shall maintain only such record of its proceedings as it deems advisable. If at any time during the diagnosis, treatment

or rehabilitation phase of the process of addressing a Member's health issue, it is determined that the Member is unable to safely perform the clinical privileges he/she has been granted, the matter will be forwarded to the Medical Executive Committee for appropriate action.

Section 7.14 Nominating Committee.

The Nominating Committee shall nominate one or more Members of the Active Staff for each elective office of the Medical Staff, prior to the annual meeting of the Staff in November. The Nominating Committee shall consist of the elected Medical Staff officers, elected Department officers, and the Immediate Past Chief of Staff. The President and Physician Executive shall be non-voting advisory members, and shall not be present when final nomination selections are made. The Chief of Staff shall serve as chairman of the Nominating Committee.

ARTICLE VIII

MEDICAL STAFF DEPARTMENTS

Section 8.1 Departments.

- (a) The Medical Staff shall be divided into two (2) Departments. Each Department shall be organized and shall have a Department Chief who is responsible to the Chief of Staff for carrying out the functions of the Department and the Department Chief's duties and responsibilities. The Department may be further subdivided into Divisions. Members of Divisions shall be directly responsible to the Department in which they function.
- (b) On the date of the annual meeting of the Medical Staff, the Active Staff of each Department shall meet to elect a Department Chief and Vice-Chief. The Department Chief and Vice-Chief shall be responsible for directing the activities of the Department for the ensuing year and shall have general supervision over the clinical work within the Department.
- (c) Each Department Chief shall organize and be responsible for an emergency call list for the Department.
- (d) Meetings of the Departments and attendance requirements are set forth in Article IX of these Bylaws.

Section 8.2 Department of Medicine.

The Department of Medicine consists of the following Divisions:

cardiology	oncology
dermatology	pathology
emergency medicine	pediatrics
family practice	physiatry
gastroenterology	psychiatry

internal medicine	pulmonology
nephrology	radiology
neurology	

Section 8.3 Department of Surgery.

The Department of Surgery consists of the following Divisions:

anesthesia	oral surgery
cardiothoracic	otorhinolaryngology
general surgery	pain management
obstetrics and gynecology	plastic surgery
ophthalmology	urology
orthopedics	vascular surgery

Section 8.4 Assignments To Departments.

The Department Chiefs shall make the departmental assignments subject to, and in concurrence with, the Medical Executive Committee. Each Member shall be assigned Membership in a Department and a Division within such Department, if appropriate, but may also be granted clinical privileges in the other Department consistent with the practice privileges granted.

Section 8.5 Functions of the Department.

Each Department shall:

- (a) conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided the patients within the Department. The number of such reviews to be conducted during the year shall be as determined by the Medical Executive Committee in consultation with other appropriate committees. The Department shall routinely collect information about important aspects of patient care provided in the Department, periodically assess this information and develop objective criteria for use in evaluating patient care. The patient care review shall include all clinical work performed under the jurisdiction of the Department regardless of whether the Member whose work is subject to such a review is a Member of that Department.
- (b) recommend to the Credentials Committee criteria for granting Clinical Privileges in the performance of specified services within a Department.
- (c) evaluate and make appropriate recommendations regarding the qualifications of Applicants seeking appointment or reappointment and Clinical Privileges within that Department.
- (d) orient and identify continuing educational needs pertinent to the Department's clinical practice.

- (e) review and evaluate departmental adherence to the Medical Staff Policies and Procedures and sound principals of clinical practice.
- (f) coordinate patient care provided by the Department's Members with nursing and ancillary care services.
- (g) maintain quality control programs as directed by Medical Audit and Review Committee or the Medical Executive Committee.
- (h) meet at least twice a year for the purpose of considering patient care review findings, the results of the Department's other review and evaluation activities, and reports from the other Department and Staff functions.
- (i) establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including ongoing professional practice evaluation and focused professional practice evaluation.
- (j) take appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.
- (k) account to the Medical Executive Committee for all professional and administrative activities within the Department.
- (l) appoint such committees as may be necessary or appropriate to conduct Department functions.
- (m) formulate recommendations for Departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the Medical Staff.
- (n) assess and recommend to Hospital administration off-site sources for needed patient care, treatment, and services not provided by the Hospital.
- (o) participate in the development and implementation of policies and procedures that guide and support the provision of care, treatment and services.
- (p) recommend a sufficient number of qualified and competent persons to provide care, treatment and services.
- (q) participate in the determination of qualifications and competence of Department personnel who are not Professional Staff members, and who provide patient care, treatment, and services.
- (r) participate in the continuous assessment and improvement of the quality of care, treatment, and services; and
- (s) recommend space and other resources needed by the Department.

Section 8.6 Functions of Divisions.

Subject to approval by the Medical Executive Committee, each Division shall perform the functions assigned to it by the Department Chief.

Section 8.7 Department Chief.

- (a) Each Department shall have a Chief and Vice-Chief who shall be Members of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Department.
- (b) Each Department Chief must be certified by an appropriate specialty board or be Board Eligible for an appropriate specialty board.
- (c) Each Department Chief and Vice-Chief shall serve a two-year term which coincides with the Medical Staff year unless they shall sooner resign, be removed from office, or lose their Medical Staff Membership or clinical privileges in that Department.
- (d) The Department officers shall be eligible to succeed themselves with no term limits.

Section 8.8 Removal of Department Chief.

- (a) Removal of the Chief or Vice-Chief from office may occur for cause after a two-thirds (2/3) vote of the Department Members present and eligible to vote on Departmental matters.
- (b) In the event that 10% of the voting Members of the Medical Staff each sign a petition or otherwise evidence disagreement with any action taken by the Medical Executive Committee, the process for removal shall be initiated. The petition should clearly state the basis of the disagreement and may include any other information by way of additional explanation to the Medical Staff Members. The petitioner must acknowledge that they have read the petition and all attachments, if any, in order for their signature to be considered valid. Once the removal petition threshold has been achieved, the petition and any attachments and a list of the petitioners shall be forwarded to the Medical Executive Committee. Within thirty (30) days of the Medical Executive Committee's receipt of the petition, a meeting of the department shall be set to take a vote.

Section 8.9 Chief Duties.

- (a) Each Chief shall have the following authority, duties and responsibilities and the Vice-Chief in the absence of the Chief shall assume all of those duties and shall otherwise perform such duties as may be assigned to him/her:
 - (i) Act as presiding officer at Departmental meetings;

- (ii) Report to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the Department;
- (iii) Develop, implement, and monitor departmental programs for retrospective patient care review, ongoing monitoring of practice, and professional performance rendered by Members with clinical privileges in the Department, credentials review and privileges delineation, medical education, utilization review and quality assurance through a planned and systematic process; oversee the effective conduct of the patient care, evaluation and monitoring functions delegated to the Department by the Medical Executive Committee;
- (iv) Be a Member of the Medical Executive Committee and give guidance on overall medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding his/her Department;
- (v) Transmit to the Medical Executive Committee the Department's recommendations concerning Applicant or Member and classification, reappointment, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in his/her Department;
- (vi) Endeavor to enforce the Medical Staff Bylaws and Rules, Policies and Regulations within his/her Department;
- (vii) Implement within his/her Department appropriate actions taken by the Medical Executive Committee;
- (viii) Integrate, coordinate, and participate in the primary functions of the hospital, including interdepartmental and intradepartmental services, such as personnel, supplies, special regulations, standing orders and techniques;
- (ix) Recommend delineated clinical privileges for each Member of the Department;
- (x) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee; and
- (xi) Assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.

ARTICLE IX

MEETINGS

Section 9.1 Annual Meeting.

The annual meeting of the Medical Staff shall be held during the month of November. At this meeting the retiring officers and committees shall make such reports as may be desirable and officers for the ensuing year shall be elected.

Section 9.2 Regular Meetings.

Meetings of the Medical Staff shall be held on the second Tuesday during the months of May and November.

- (i) The sole objective of these meetings is improvement in the care and treatment of patients in the Hospital.
- (ii) Business or other executive sessions of the Medical Staff will be conducted by the Medical Staff.
- (iii) Attendance of a quorum of voting Members of the Medical Staff and the Chief of Staff, or his/her designee, is required to conduct business.
- (iv) The Medical Staff delegates to the Medical Executive Committee authority to act on behalf of the full Medical Staff between the regular meetings scheduled in the months of May and November

Section 9.3 Departmental Meetings.

Regular meetings of the Departments shall be held at least semi-annually in the months of May and November. Special meetings of the Department may be called at any time by the Chief of the Department. The date, time, and place shall be selected by each Department. Written records shall be made for each regular Departmental meeting. Attendance at Department meetings is encouraged.

Section 9.4 Committee Meetings.

All committees shall meet sufficiently often to function properly. Each committee shall routinely report to the Medical Audit and Review Committee or directly report to the Medical Executive Committee.

Section 9.5 Special Meetings.

Special meetings of the Medical Staff may be called at any time by the Chief of Staff and shall be called at the request of the Board of Directors, the Medical Executive Committee, or any five (5) Members of the Active Medical Staff. At any special meeting no business shall be

transacted except that stated in the notice calling the meeting. Sufficient notice of the meeting shall be a notice posted at least forty-eight (48) hours before the time set for the meeting.

Section 9.6 Meetings Attendance.

- (a) All Members of the Medical Staff shall be encouraged to attend meetings.
- (b) Notice of regular and special meetings shall be posted in the Hospital and sent to Members of the Staff at least two (2) days prior to the meetings by the medical staff assistant. The minutes from the previous general Staff Meeting and any special meetings shall be posted at least two (2) days prior to the meeting by the medical staff assistant.

Section 9.7 Quorum. The voting members present at a regular or special meeting shall constitute a quorum.

Section 9.8 Agenda.

- (a) Any regular meeting agenda shall indicate:

Call to Order	Medical Staff Committee Reports
Approval of the Minutes	Medical Staff Committee Recommendations
Unfinished Business	for improvement of the professional work of
Communications	the Hospital;
Reports of Departments	Hospital President's Report
New Business	Adjournment
Review and Analysis of the Clinical Work	

- (b) Any special meeting agenda shall include the reading of the notice calling the meeting, transaction of the business for which the meeting was called, and adjournment.

Section 9.9 Conduct of Meetings. Unless otherwise specified, meetings shall be conducted according to Roberts Rules of Order. However, technical or no substantive departures from such rules shall not invalidate actions taken at such a meeting.

Section 9.10 Action in Lieu of Meeting. Any action required or permitted to be taken by the Medical Staff may be taken without a meeting if the majority of the Active Staff shall

individually or collectively agree by written ballot to such action. Such action by written ballot shall have the same force and effect as a vote taken at a meeting of the Medical Staff.

ARTICLE X

RECORDS OF THE MEDICAL STAFF

Section 10.1 Maintenance of Medical Staff Records and Information.

The records and information of the Medical Staff shall be kept in the Medical Staff Services Department of Community Howard Regional Health and shall be confidential. Access to such records shall be restricted to only those Members of the Medical Staff authorized to have access due to an office or committee appointment.

Section 10.2 Confidentiality.

All communications to and from the Hospital or a committee of the Hospital serving its peer review functions (including, but not limited to, the minutes, files, records, letters of reference, evaluation, including information regarding any Member or Applicant to this Medical Staff) shall be confidential to the fullest extent permitted by law. Dissemination of any such information and records shall only be made (1) where expressly required by law as determined by the President after conferring with the Hospital attorney; (2) pursuant to officially adopted Policies of the Medical Staff; or (3) in the absence of officially adopted policies, with the expressed written approval of the Medical Executive Committee or The Board of Directors. The Board of Directors may enter into peer review information sharing agreements with other healthcare entities who carry out peer review activities without waiving the peer review privilege.

Section 10.3 Breach of Confidentiality.

Effective peer review and consideration of the qualifications of Medical Staff Members and Applicants must be based on free and candid discussions. Any breach of confidentiality of these discussions or deliberations is outside of the appropriate standards of conduct for this Medical Staff. Any such breach of confidentiality will be deemed disruptive to the operation of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

Section 10.4 Immunity From Liability.

Each Member of the Medical Staff and the representative, employee, personnel or agent of the Hospital shall be exempt, to the fullest extent permitted by law, from liability for damages for any action taken or statements or recommendations made within the scope of his/her duties to the Medical Staff or Hospital.

Each Member of the Medical Staff and representative, employee, personnel or agent of the Hospital and all third parties shall be exempt to the fullest extent permitted by law from liability to an Applicant or Member for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such a person who is or has been an

Applicant to or Member of the staff, or who did, or does exercise clinical privileges or provide services at this Hospital.

Section 10.5 Activities and Information Covered.

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other healthcare entity's activities concerning, but not limited to:

- (a) application for appointment, re-appointment, or clinical privileges;
- (b) corrective action;
- (c) hearings or appellate reviews;
- (d) utilization reviews;
- (e) other activities related to monitoring, performance improvement, quality patient care and professional conduct;
- (f) peer review organizations and similar reports.

Section 10.6 Releases.

Each Applicant or Member shall, upon request of the Medical Staff or Hospital, execute general and specific release in accordance with the expressed provisions and general intent of this Article. Execution of such release shall not be deemed a prerequisite to the effectiveness of this Article.

Section 10.7 Medical Staff Credentials Files.

- (a) A Member may inspect the information gathered about the Member by the Credentials Committee or MEC by written request and scheduling an appointment with the Medical Staff Office for inspection that is mutually convenient for the Medical Staff Office and the Member.
- (b) The minutes and records of any Medical Staff Committee responsible for the evaluation and improvement of patient care shall be confidential. The Hospital will take measures to protect them from unauthorized disclosure.
- (c) Access to such records shall be limited to duly-appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and shall be subject to the requirement that confidentiality be maintained.
- (d) Information which is disclosed to the Board of Directors or its appointed representatives, in order that the Board of Directors may discharge its lawful obligations and responsibilities, shall be maintained by the Board as confidential.

- (e) Information contained in the credentials files of any Member may be disclosed to another healthcare entity conducting peer review with the Member's written authorization to the Hospital.
- (f) Any disclosure of information in a Member's credentialing file outside of the Medical Staff, except with the Member's consent, shall require the authorization of the Chief of Staff and the Department Chief.

Section 10.8 Organized Health Care Arrangement.

The Medical Staff and Allied Health Professionals are an organized health care arrangement ("OHCA") as defined at 45 CFR § 160.103 of the Privacy Regulations [45 CFR Parts 160 and 164] of the Health Insurance Portability and Accountability Act of 1996 with the Hospital and applicants shall become members of the OHCA upon acceptance of the appointment of Membership or Clinical Privileges.

ARTICLE XI

MISCELLANEOUS PROVISIONS

Section 11.1 Authority To Act.

Any Member who acts in the name of this Medical Staff but without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

Section 11.2 Division of Fees.

Any division of fees by the Members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

Section 11.3 Disclosure of Interest.

All nominees for election or appointment to Medical Staff offices, Department Chiefs, the Medical Executive Committee, Medical Audit & Review Committee, or Credentials Committee shall disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff of the Hospital.

Section 11.4 Advanced Trainees.

The Hospital may participate as a host facility in a post graduate residency and fellowship program of, or host medical school students from various medical schools on behalf of, the Community Health Network, Inc. ("Sponsor Institute"). Any Advanced Trainee (resident, fellow or medical student in the program of Sponsor Institute) shall be supervised by a practitioner with appropriate clinical privileges at Hospital ("Supervising Practitioner"). This process serves as the structure for supervision by Supervising Practitioner of each Advanced Trainee in carrying out his or her patient care responsibilities.

- (a) The Sponsor Institute will provide all the necessary written documentation for the Hospital as host facility to credential the Advanced Trainee.
- (b) The Sponsor Institute will provide the written description of the roles, responsibilities, and patient care activities of the Advanced Trainee to the Credentials Committee or its designee and the Supervising Practitioner.
- (c) The written description will describe the mechanism by which the Supervising Practitioner and the program director of Sponsor Institute will make decisions about each Advanced Trainee.
- (d) The Supervising Practitioner will communicate to the Sponsoring Institute and the Credentials Committee of the Hospital about the patient care, treatment and services provided by, and the related educational and supervisory needs of the Advanced Trainees.
- (e) Advanced Trainees are required to abide by the Medical Staff Bylaws, Rules and Regulations, and Policies of the Hospital as well as any policies of the Sponsor Institute. As non-Members of the Hospital Staff, Advanced Trainees are not entitled to any of the benefits of the hearing and appeal rights afforded to Members of Hospital or other prerogatives and benefits afforded solely to Members.

ARTICLE XII

ADOPTION AND AMENDMENTS OF BYLAWS

Section 12.1 Grass Roots Procedure.

- (a) The Medical Staff shall review the Bylaws at least on a biennial basis to determine whether any amendments shall be considered for adoption. Unless amendments are proposed directly to the Board of Directors, any proposed amendment shall be first submitted to and/or considered by the Bylaws Committee.
- (b) Upon the request of the Chief of Staff, the Medical Executive Committee, the Bylaws Committee, a timely written petition signed by at least ten percent (10%) of the Members of the Medical Staff who are entitled to vote, or upon request at any regular meeting of the Medical Staff, consideration shall be given to the amendment of these Bylaws. This request will be referred to the Bylaws Committee, which shall make a report back to the Medical Executive Committee and Medical Staff for their action.
- (c) The Medical Executive Committee shall make recommendation as to the amendment(s) proposed.
- (d) Thereafter, the proposed amendment shall come before the voting Medical Staff. In the event the Medical Staff does not approve the proposed amendment, the Medical Executive Committee can elect to pursue the conflict management process under Section 12.2.

- (e) Such action shall be taken at a regular or special meeting, provided notice of the meeting includes notice that a Bylaws change will be considered and includes the exact wording of the existing Bylaw (if any), and the wording of the proposed amendment. An amendment to the Bylaws shall require an affirmative vote of two-thirds (2/3) of the eligible to vote Members present.
- (f) Amendments so made shall be effective when approved by the Board of Directors. If in the event that the Board does not approve all amendments recommended by the Medical Staff, the Medical Staff may pursue the conflict management process set forth under the Corporate Bylaws.

Section 12.2 Abbreviated Procedure.

These Bylaws may be amended by an abbreviated procedure. An amendment pursuant to this paragraph shall first be considered and approved by a majority vote of the Bylaws Committee. Thereafter, the proposed amendment shall be considered by the Medical Executive Committee of the Medical Staff. Two-thirds (2/3) of a quorum of the Medical Executive Committee shall be required to adopt the proposed amendment. If the proposed amendment is adopted by the Medical Executive Committee, the Chairman of the Medical Executive Committee shall cause the proposed amendment to be posted in the Medical Staff lounge for not less than twenty (20) days and mailed by first class mail or delivered by Hospital courier to the Active Medical Staff. The notice of the proposed amendment shall provide each Member of the Active Medical Staff with an opportunity to reject the proposed amendment. If the chairman of the Medical Executive Committee has not received a written notification of acceptance of the proposed amendment by a two-thirds (2/3) majority of the returned ballots within twenty (20) days of the date on which the proposed amendment was mailed, then the proposed amendment shall be considered rejected. The amendments approved shall be considered adopted by the Medical Staff and shall be submitted to the Board of Directors. Amendments so made shall be effective when approved by the Board of Directors. If in the event that the Board does not approve any of the amendments recommended by the Medical Staff, the Medical Staff has the option of requesting conflict management process set forth under the Corporate Bylaws be pursued.

Section 12.3 Medical Staff Conflict Management Process.

- (a) Except as provided in Subsection (f), in the event that ten percent (10%) of the voting Members of the Medical Staff each sign a petition or otherwise evidence disagreement with any action taken by the Medical Executive Committee, including, but not limited to, any proposed Bylaw, Rule, Regulation or Policy, these Members can require that the conflict management process under this Article be followed. The petition should clearly state the basis of the disagreement and may include any other information by way of additional explanation to the Medical Staff Members. All petitioners must acknowledge that they have read the petition and all attachments, if any, in order for their signature to be considered valid and counted.
- (b) Once the conflict management threshold has been achieved, the petition and any attachments and a list of the petitioners shall be forwarded to the Medical Executive

Committee. Within thirty (30) days of the Medical Executive Committee's receipt of the petition, a meeting between the representatives of both the Medical Executive Committee, as determined by the Chief of Staff, and the petitioners shall be scheduled. The parties shall act in good faith and shall take reasonable steps to resolve the conflict in question.

- (c) If the Medical Executive Committee and the petitioners are able to resolve the conflict, the resolution shall be submitted to the voting Members. If the voting Members approve the proposed resolution, the proposal will be forwarded to the Board of Directors for its review and consideration.
- (d) Should the parties fail to reach a resolution, or if the voting Members do not approve any proposed solution agreed by the petitioners and the Medical Executive Committee, the petition and any accompanying materials will be forwarded to the Board of Directors for its review and consideration. The decision of the Board of Directors shall be final and shall not serve as a basis for conflict management under the Corporate Bylaws. If, on the other hand, the voting Members accept the conflict resolution as proposed by the petitioners and the Medical Executive Committee, the resolution, the initial petition and all accompanying materials shall be forwarded to the Board of Directors for its review and consideration. If approved by the Board of Directors, the decision shall be final. If not approved, the Medical Executive Committee and/or the petitioning representatives of the Medical Staff shall each have the option of requesting that the conflict management process under the Corporate Bylaws be pursued.
- (e) Nothing under this section precludes direct communication between an individual Member and the Board of Directors on any rule, regulation or policy already adopted by the Medical Staff or the Medical Executive Committee. Such communication shall be forwarded to the Executive Committee of the Board of Directors through the President of the Hospital and to the Medical Executive Committee through the Chief of Staff. The Chair of the Board of Directors shall determine the manner and method of responding to any Member communicating to the Board of Directors under this Article.
- (f) This section does not allow the Medical Staff to challenge the peer review activities of any medical staff committee, including any recommendations or action taken.

ARTICLE XIII

RULES AND REGULATIONS, AND POLICIES

Section 13.1 Rules and Regulations.

The Medical Staff shall adopt rules and regulations as may be necessary for the proper conduct of its work. Such rules and regulations shall become a part of these Bylaws, Rules and Regulations, and Policies of the Medical Staff, as set forth herein. Unless the voting members of

the Medical Staff propose to adopt a rule or regulation or policy or amendment thereto, as set forth under Article XII of these Bylaws, they shall be proposed and considered as follows:

The Medical Executive Committee, Bylaws Committee, or any member of the Active Medical Staff may recommend amendments to the Rules and Regulations at any regular meeting of the Medical Executive Committee. Notice of the proposed rule and regulation shall be given to all Active Members of the Medical Staff prior to the meeting. The proposal shall be voted upon at the meeting or a special meeting or under the provisions of Section 13.6.

Amendments shall be effective when approved by the Board of Directors. Amendments to the Rules and Regulations shall be posted and available to the Medical Staff. In the event that the Board of Directors does not approve an amendment recommended by the Medical Staff, the Medical Staff has the option of requesting the conflict management process set forth under the Corporate Bylaws.

Section 13.2 Policies of the Medical Staff.

The Medical Staff shall adopt policies as may be necessary for the proper conduct of its work. Such policies shall become a part of these Bylaws, Rules and Regulations, and Policies of the Medical Staff; as set forth herein. Unless the voting members of the Medical Staff propose to adopt a policy or amendment thereto, as set forth under Article XII of these Bylaws, they shall be proposed and considered as follows:

The Medical Executive Committee may recommend policies and/or amendments to policies for administrative procedures associated with processes described in these Bylaws to the Board. These policies include, among others, Appointment, Reappointment and Credentialing Policy, Fair Hearing Policy and Temporary Privilege Policy. In order that such policies may be enacted expeditiously to provide protection to all Members of the Medical Staff and Hospital, the Medical Executive Committee shall post in the medical staff lounge, the proposed policy or amendment and allow a fourteen (14) day period for written comment. Written comments must be received by the medical staff office before the comment period expires. Any Member may request an audience with the Medical Executive Committee to discuss a proposed policy or amendment at the next regularly scheduled Medical Executive Committee meeting. If after the comment period, the Medical Executive Committee's recommended policy and/or amendment remain unchanged or materially unchanged then it will be forwarded to the Board for action. If after the comment period, the Medical Executive Committee makes a material change, it shall be submitted for another comment period.

Amendments shall be effective when approved by the Board of Directors. Amendments to the Policies shall be posted and available to the Medical Staff. In the event that the Board of Directors does not approve an amendment recommended by the Medical Staff, the Medical Staff has the option of requesting the conflict management process set forth under the Corporate Bylaws.

Section 13.3 Conflicting Rules.

Medical Staff Department rules and regulations shall not conflict with, alter, or supersede the Bylaws, Rules and Regulations or Policies of the Medical Staff of Community Howard

Regional Health. If a conflict is judged to be present by the Medical Executive Committee, such Department rule or regulation shall be rescinded or modified so as not to be inconsistent.

Section 13.4 Interpretation.

Questions related to whether a certain Bylaw provision, Rule or Regulation or Policy applies to a Member of the Medical Staff or the Professional Staff shall be posed in writing to the Medical Executive Committee, the Medical Executive Committee may seek input from the Bylaws Committee and shall make a recommendation as to the answer and shall forward such questions and its recommendation to the Board of Directors for final interpretation.

Section 13.5 Placement of Bylaw, Rule and Regulation and Policy.

In matters of interpretation with respect as to which category a proposed Bylaws, Rules or Regulations or Policies belongs the final decision will rest with the Bylaws Committee.

Section 13.6 Urgent Amendment to Rules and Regulations or Policy.

- (a) **Rule and Regulation.** In the event that the Hospital receives a written notice, demand or similar communication from a governmental or similar entity, or if the Hospital is put on notice that it needs to amend a rule or regulation of the Medical Staff in order to comply with any law or regulation governing the Hospital, the Medical Staff Executive Committee shall be delegated with the authority to provisionally adopt, and the Board of Directors may provisionally approve, an amendment to a rule or regulation, as may be required to comply with the law, without any prior approval of the Medical Staff. In such cases, the entire Medical Staff will be immediately notified by the Medical Executive Committee. Copies of any notice or materials requiring urgent amendment, if not otherwise confidential, will be submitted along with the written notice. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendment will remain in effect. If there is a conflict over the provisional amendment, the process will result in the conflict resolution process as set forth in Section 12.3 between the Medical Staff and the Medical Executive Committee will be implemented. If necessary, a revised amendment will be submitted to the Board for its review and consideration.
- (b) **Policy.** Where the urgent change only involves a change to a policy of the organized Medical Staff, the approved process referenced above does not apply, but a copy of the policy amendment will be sent to all members of the Medical Staff.

ARTICLE XIV

MEDICAL STAFF ADMINISTRATIVE LIAISON

Section 14.1 Physician Executive.

The Physician Executive shall serve as the liaison between the Medical Staff and Hospital. The Physician Executive shall assist with coordination of the Medical Staff's quality assessment and improvement program activities and the clinical organization of the Medical Staff. The Physician Executive shall assist the Chief of Staff in fulfilling his/her duties, at the request of the Chief of Staff. He/she shall be a non-voting member of all Medical Staff committees.

[Signature Page Follows]

BYLAWS OF THE MEDICAL STAFF OF
COMMUNITY HOWARD REGIONAL HEALTH, INC.

Reviewed, revised, and adopted by two-thirds majority vote of the Active Medical Staff on November 14, 2017. Approved by Board of Directors on November 24, 2017.

Carol Sheridan, MD
Chief of the Medical Staff of
Community Howard Regional Health, Inc.

Lynette Hazelbaker, MD
Chair, Board of Directors
Community Howard Regional Health, Inc.