

**MEDICAL STAFF BYLAWS
OF
BROADLAWNS MEDICAL CENTER**

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PART ONE:

GENERAL PROVISIONS

ARTICLE 1

GENERAL

1.A: DEFINITIONS

The following definitions shall apply to terms used in these Bylaws:

- (1) “ALLIED HEALTH PROFESSIONALS” (“AHPs”) means individuals other than Medical Staff members who are authorized by law and by the Medical Center to provide patient care services within the Medical Center. All AHPs are described as Category I, Category II, or Category III practitioners in the Medical Staff Bylaws documents:
 - “CATEGORY I PRACTITIONER” means a Licensed Independent Practitioner, a type of Allied Health Professional who is permitted by law and by the Medical Center to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted. Category I practitioners also include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the Medical Center under the conditions set forth in these Bylaws (i.e., moonlighting residents). See Appendix A.
 - “CATEGORY II PRACTITIONER” means an Advanced Dependent Practitioner, a type of Allied Health Professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by state law and/or the Medical Center to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician/Provider pursuant to a written supervision or collaborative agreement. See Appendix B.
 - “CATEGORY III PRACTITIONER” means a Dependent Practitioner, a type of Allied Health Professional who is permitted by law or the Medical Center to function only under the direction of a Supervising Physician/Provider, pursuant to a written supervision agreement and consistent with the scope of practice granted. See Appendix C.
- (2) “BOARD” means the Board of Trustees of the Medical Center, which has the overall responsibility for the Medical Center.
- (3) “CHIEF EXECUTIVE OFFICER” (or “CEO”) means the individual appointed by the Board to act on its behalf in the overall management of the Medical Center.

- (4) “CHIEF MEDICAL OFFICER” (or “CMO”) means the individual appointed by the CEO and the Board to act on behalf of the Medical Center in Medical Staff affairs, in cooperation with the President of the Medical Staff.
- (5) “CLINICAL PRIVILEGES” means the authorization granted by the Board to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.
- (6) “CORE PRIVILEGES” means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.
- (7) “DAYS” shall refer to calendar days (not working days).
- (8) “DENTIST” means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).
- (9) “EXECUTIVE COMMITTEE” means the Executive Committee of the Medical Staff.
- (10) “MEDICAL CENTER” means Broadlawns Medical Center.
- (11) “MEDICAL STAFF” means all physicians and dentists who have been appointed to the Medical Staff by the Board.
- (12) “MEDICAL STAFF LEADER” means any Medical Staff officer, Department Chair, Section Chief, and Committee Chair.
- (13) “MEMBER” (or “APPOINTEE”) means a physician or dentist who has been appointed to the Medical Staff by the Board.
- (14) “NOTICE” means written communication by regular U.S. mail, e-mail, facsimile, hospital mail, or hand delivery.
- (15) “ORGANIZED HEALTH CARE ARRANGEMENT” means the term used by the HIPAA Privacy Rule to describe a clinically-integrated care setting in which patients typically receive health care from more than one provider (such as a hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.
- (16) “PATIENT CONTACTS” includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in the

Medical Center or in any facility operated by the Medical Center, including outpatient facilities.

- (17) “PERMISSION TO PRACTICE” means the authorization granted to Allied Health Professionals to exercise clinical privileges or a scope of practice.
- (18) “PHYSICIAN” includes doctors of medicine (“M.D.s”), doctors of osteopathic medicine (“D.O.s”), and doctors of podiatric medicine (“D.P.M.s”).
- (19) “PRIMARY CARE” means the primary care specialties of Family Practice, Pediatrics, and Internal Medicine.
- (20) “PRIMARY CARE SERVICES” refers to those services expected of a Generalist in the area of Family Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, Psychiatry, Podiatry, Surgery, and Emergency Medicine.
- (21) “SCOPE OF PRACTICE” means the authorization granted to a Category III practitioner to perform certain clinical activities and functions under the supervision of, or in collaboration with, a Supervising Physician/Provider.
- (22) “SPECIAL PRIVILEGES” means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.
- (23) “SPECIAL NOTICE” means hand delivery, certified mail/return receipt requested, or overnight delivery service providing receipt.
- (24) “SUPERVISING PHYSICIAN/PROVIDER” means an individual with clinical privileges, who has agreed in writing to supervise or collaborate with a Category II or Category III practitioner and to accept full responsibility for the actions of the Category II or Category III practitioner while he or she is practicing in the Medical Center.
- (25) “SUPERVISION” means the supervision of (or collaboration with) a Category II or Category III practitioner by a Supervising Physician/Provider, that may or may not require the actual presence of the Supervising Physician/Provider, but that does require, at a minimum, that the Supervising Physician/Provider be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each Category II or Category III practitioner is credentialed and shall be consistent with any applicable written supervision agreement that may exist. (“General” supervision means that the physician is immediately available by phone, “direct” supervision means that the physician is on the Medical Center’s campus, and “personal” supervision means that the physician is in the same room.)

- (26) “TELEMEDICINE” means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.

1.B: CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.B.1. Confidentiality:

Actions taken and recommendations made pursuant to these Bylaws shall be strictly confidential. Individuals participating in, or subject to, credentialing and peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

- (a) when the disclosures are to another authorized member of the Medical Staff or authorized Medical Center employee and are for the purpose of conducting legitimate credentialing and peer review activities;
- (b) when the disclosures are authorized by a Medical Staff or Medical Center policy; or
- (c) when the disclosures are authorized, in writing, by the CEO or by legal counsel to the Medical Center.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any member of the Medical Staff who becomes aware of a breach of confidentiality must immediately inform the CEO or the President of the Medical Staff (or the President-Elect if the President of the Medical Staff is the person committing the claimed breach).

1.B.2. Peer Review Protections:

- (a) All credentialing and peer review activities pursuant to these Bylaws and related Medical Staff documents shall be performed by “Peer Review Committees” in accordance with Iowa state law. Peer review committees include, but are not limited to:
 - (1) all standing and ad hoc Medical Staff and Medical Center committees;
 - (2) hearing panels;
 - (3) the Board and its committees;
 - (4) any individual acting for or on behalf of any such entity, including but not limited to Section Chiefs, Department Chairs, Committee Chairs and members, officers of the Medical Staff, the CMO, and experts or consultants retained to assist in peer review activities; and

- (5) all departments and sections.

All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of Iowa Code Ann. §§147.1 and 147.135, and/or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

- (b) All peer review committees shall also be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq.*

1.C: CONFLICTS OF INTEREST

- (1) When performing a function outlined in these Bylaws or the Rules and Regulations, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before leaving.
- (2) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of President of the Medical Staff (or to the President-Elect if the President of the Medical Staff is the person with the potential conflict), or the applicable Department or Committee Chair. The President of the Medical Staff or the applicable Department or Committee Chair shall make a final determination as to whether the provisions in this Section should be triggered.
- (3) The fact that a Section Chief, Department Chair, or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel disqualification of another staff member based on an allegation of conflict of interest.
- (4) The fact that a committee member or Medical Staff Leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

1.D: INDEMNIFICATION

The Medical Center shall provide a legal defense for, and shall indemnify, all Medical Staff officers, Department Chairs, Section Chiefs, Committee Chairs, committee members, and

authorized representatives when acting in those capacities, to the fullest extent permitted by law, in accordance with the Medical Center's bylaws.

1.E: DELEGATION OF FUNCTIONS

- (1) When a function under these Bylaws is to be carried out by a member of Medical Center management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Medical Center employee (or a committee of such individuals). Any such designee is bound by all the terms, conditions and requirements of these Bylaws. However, the delegating individual or committee is responsible for ensuring the designee performs the function as required by these Bylaws.
- (2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.F: MEDICAL STAFF DUES

- (1) Annual Medical Staff dues may be as recommended by the Executive Committee and may vary by staff category.
- (2) Dues shall be payable annually upon request. Failure to pay dues shall result in ineligibility to apply for reappointment.

PART TWO:

GOVERNANCE AND STRUCTURE

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in Article 8 of these Bylaws are eligible to apply for appointment to one of the following categories:

2.A: ACTIVE ATTENDING STAFF

2.A.1. Qualifications:

The Active Attending Staff shall consist of those physicians and dentists who:

- (a) are involved in at least 24 Broadlawns Medical Center patient contacts per two-year appointment term; and
- (b) have expressed a willingness to contribute to Medical Staff functions and/or demonstrated a commitment to the Medical Staff and Medical Center through service on committees and/or active participation in performance improvement or professional practice evaluation functions.

Guidelines:

Unless an Active Attending Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

- * Any member who has fewer than 24 patient contacts during his/her two-year appointment term shall not be eligible to request Active Attending Staff status at the time of his/her reappointment.
- ** The member will be transferred to another staff category that best reflects his/her relationship to the Medical Staff and the Medical Center (options – Courtesy, Consulting, or Ambulatory Care).

2.A.2. Prerogatives:

Active Attending Staff members may:

- (a) vote in all general and special meetings of the Medical Staff and applicable departments and committees, except during Provisional Status following initial appointment;

- (b) hold office, serve as Department Chairs, serve on Medical Staff committees, and serve as chairs of such committees, except during Provisional Status following initial appointment; and
- (c) be entitled to attend meetings of the Executive Committee, without vote, so long as two weeks' notice is given to the President of the Medical Staff. Participation in such meetings may be limited by the President of the Medical Staff. The Active Attending Staff member will leave for any discussion of confidential peer review issues.

2.A.3. Responsibilities:

Active Attending Staff members must:

- (a) assume all the functions and responsibilities of membership on the Active Attending Staff, including committee service, emergency call, care for unassigned patients, and evaluation of members during the provisional period;
- (b) actively participate in the peer review and performance improvement process;
- (c) accept consultations and teaching assignments where applicable;
- (d) attend applicable meetings;
- (e) faithfully perform the duties of any office or position to which elected or appointed; and
- (f) pay application fees, dues, and assessments, when applicable.

2.B: COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of those physicians and dentists who:

- (a) are involved in at least four, but fewer than 24, patient contacts per two-year appointment term;
- (b) meet all the same threshold eligibility criteria as other Medical Staff members, including specifically those relating to availability and response times with respect to the care of their patients; and
- (c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's

office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

- * Any member who has fewer than four patient contacts during his/her two-year appointment term will be transferred to another staff category that accurately reflects his/her relationship to the Medical Staff and the Medical Center (options – Consulting, Affiliate, or Coverage).
- ** Any member who has 24 or more patient contacts during his/her two-year appointment term shall be automatically transferred to Active Attending Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

- (a) may attend and participate in Medical Staff and department meetings (without vote);
- (b) may not hold office or serve as Department Chairs or committee chairs;
- (c) may be invited to serve on committees (with vote);
- (d) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but:
 - (1) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician;
 - (2) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department; and
 - (3) will be required to provide specialty coverage if the Executive Committee finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;
- (e) shall cooperate in the professional practice evaluation and performance improvement processes;

- (f) shall exercise such clinical privileges as are granted to them; and
- (g) shall pay any required application fees, dues, and assessments.

2.C: CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff shall consist of individuals who:

- (a) are of demonstrated professional ability and expertise who provide a service not otherwise available or in very limited supply on the Active Staff (should the service become readily available on the Active Staff, the Consulting Staff members would not be eligible to request continued Consulting Staff status at the time of their next reappointments and, instead, would have to move to a different staff category that more accurately describes their relationship to the Medical Center) or who provide services related to medical education activities;
- (b) are members in good standing of the Active Attending Staff at another hospital where they are currently practicing; and
- (c) at each reappointment time, provide evidence of clinical performance at their primary hospital where they have Active Attending Staff appointment in such form as may be required in order to allow for an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges.

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

- (a) may treat (but not admit) patients in conjunction with another physician on the Active Attending Staff;
- (b) may attend meetings of the Medical Staff (without vote) and applicable department meetings (without vote) and may be invited to serve on ad hoc committees (with vote);
- (c) are excused from emergency service on-call responsibilities; and
- (d) shall pay application fees, dues, and assessments.

2.D: AMBULATORY CARE STAFF

2.D.1. Qualifications:

The Ambulatory Care Staff consists of those physicians and dentists who:

- (a) desire to be associated with, but who do not intend to establish a clinical practice at, this Medical Center. The Ambulatory Care Staff is a membership-only category, with no clinical privileges being granted. The primary purpose of the Ambulatory Care Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Medical Center services for their patients by referral of patients to Active Staff members for admission and care; and
- (b) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Ambulatory Care Staff as outlined in Section 2.D.2.

2.D.2. Prerogatives and Responsibilities:

Ambulatory Care Staff members:

- (a) may attend meetings of the Medical Staff and applicable departments (without vote);
- (b) may not hold office or serve as Department Chairs or committee chairs unless waived by the Executive Committee and Board (the Executive Committee may only consider waivers of this provision for members of the Ambulatory Care Staff who had previously been appointed to the Active Attending Staff for a period of at least four years and who only transitioned to the Ambulatory Care Staff in response to changes in that individual's clinical practice patterns);
- (c) shall generally have no staff committee responsibilities, but may be asked to serve on committees (with vote);
- (d) may attend educational activities sponsored by the Medical Staff and the Medical Center;
- (e) may refer patients to members of the Active Attending Staff for admission and/or care;
- (f) are encouraged to submit their outpatient records for inclusion in the Medical Center's medical records for any patients who are referred;
- (g) are also encouraged to communicate directly with Active Attending Staff members about the care of any patients referred, as well as to visit any such patients and

record a courtesy progress note in the medical record containing relevant information from the patients' outpatient care;

- (h) may review the medical records and test results (via paper or electronic access) for any patients who are referred;
- (i) may perform preoperative history and physical examinations in the office and have those reports entered into the Medical Center's medical records;
- (j) may not: admit patients, attend patients, exercise inpatient or outpatient clinical privileges, write inpatient or outpatient orders, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Medical Center;
- (k) may actively participate in the professional practice evaluation and performance improvement processes;
- (l) may refer patients to the Medical Center's diagnostic facilities and order such tests;
- (m) must accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and
- (n) must pay application fees, dues, and assessments.

2.E: EMERITUS STAFF

2.E.1. Qualifications:

Medical Staff members who have retired may advance at that time to the Emeritus Staff.

2.E.2. Prerogatives and Responsibilities:

Members of the Emeritus Staff:

- (a) are not eligible to admit patients to or exercise clinical privileges at the Medical Center;
- (b) may attend meetings of the Medical Staff and applicable department meetings (without vote);
- (c) may be invited to serve on committees (with vote);
- (d) are entitled to attend educational programs of the Medical Staff and Medical Center; and
- (e) are not required to pay any application fees, dues, or assessments.

2.F: PHYSICIANS IN TRAINING

2.F.1. Qualifications:

- (a) Physicians in training at the Medical Center (such as residents) shall **not** hold appointments to the Medical Staff and as such, shall not be granted specific clinical privileges. The program director, clinical faculty, and/or a Medical Staff member shall be responsible for the direction and supervision of the day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Director of Medical Education and the Graduate Medical Education Committee. The applicable program director is responsible for verifying and evaluating the qualifications of each physician in training.
- (b) A member of the Medical Staff shall serve as faculty back-up for each resident on call.
- (c) Residents may: order tests, perform histories and physicals, complete discharge summaries, prescribe medications, and write orders and progress notes. Histories and physicals, progress notes, and discharge summaries require countersignature by a member of the Active Attending Staff or Consulting Staff.

2.F.2. Prerogatives and Responsibilities:

The President of the Medical Staff, in collaboration with the CMO, may appoint residents to be observing, non-voting members of any committee of the Medical Staff. Residents may not hold office or vote. The Graduate Medical Education Committee is responsible for peer review and disciplinary activities for resident members.

2.G: REFERRING PHYSICIANS

Physicians who wish to have an association with the Medical Center for the purpose of referring patients for outpatient ancillary services, but who do not desire Medical Staff appointment and/or clinical privileges, may be designated as Referring Physicians. Orders from Referring Physicians shall be accepted by the Medical Center based upon current Iowa license, NPI billing number, and medical necessity.

ARTICLE 3

ELECTED OFFICERS

3.A: DESIGNATION

The elected officers of the Medical Staff shall be: President, President-Elect, and Secretary-Treasurer.

3.B: ELIGIBILITY CRITERIA

Only those members of the Active Attending Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an elected officer of the Medical Staff, unless an exception is recommended by the Executive Committee and approved by the Board. They must:

- (1) be appointed in good standing to the Active Attending Staff and have served on the Active Attending Staff for at least one year;
- (2) have no past or pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
- (3) not presently be serving as a medical staff officer, board member, or Department Chair at any other hospital and shall not so serve during their term of office;
- (4) be willing to faithfully discharge the duties and responsibilities of the position;
- (5) have experience in a leadership position, or other involvement in performance improvement functions for at least two years;
- (6) have attended continuing education relating to Medical Staff leadership and/or credentialing functions prior to, or be willing to attend during, the term of the office;
- (7) have demonstrated an ability to work well with others; and
- (8) disclose any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Medical Center or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner. The Executive Committee shall review any such relationships to determine whether they are significant enough to render an individual ineligible for the position in question.

All such individuals are encouraged to obtain education relating to Medical Staff leadership, credentialing, and/or professional practice evaluation functions prior to or during the term of the office.

3.C: DUTIES

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

The President of the Medical Staff shall:

- (a) act in coordination and cooperation with the CMO and Medical Center management in matters of mutual concern involving the care of patients in the Medical Center;
- (b) represent and communicate the views, policies, and needs of the Medical Staff and report at least annually on the activities of the Medical Staff to the Board and the CEO;
- (c) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the Executive Committee;
- (d) appoint all Committee Chairs and committee members, in consultation with the CMO;
- (e) chair the Executive Committee (with vote, as necessary) and be invited to all other Medical Staff committee meetings (with voting privileges when in attendance);
- (f) promote adherence to the bylaws, policies, rules and regulations of the Medical Staff and to the policies and procedures of the Medical Center;
- (g) recommend Medical Staff representatives to Medical Center committees;
- (h) perform all functions authorized in all applicable policies of the Medical Staff, including the collegial intervention steps outlined in these Bylaws; and
- (i) be the spokesperson for the Medical Staff in external professional and public relations.

3.C.2. President-Elect:

The President-Elect shall:

- (a) assume all duties of the President and act with full authority as President in his or her absence;
- (b) serve on the Executive Committee;

- (c) assume all such additional duties as are assigned to him or her by the President or the Executive Committee; and
- (d) assume the office of President at the end of the current President's term.

3.C.3. Secretary-Treasurer:

The Secretary-Treasurer shall:

- (a) serve on the Executive Committee;
- (b) cause to be kept accurate and complete minutes of all Executive Committee and Medical Staff meetings;
- (c) call Medical Staff meetings on order of the President of the Medical Staff, attend to all correspondence, and perform such other duties as ordinarily pertain to the office of Secretary-Treasurer;
- (d) collect staff dues and assessments and coordinate disbursements authorized by the Executive Committee or its designees; and
- (e) perform such additional duties as are assigned by the President of the Medical Staff or the Executive Committee.

3.C.4. Immediate Past President:

The Immediate Past President shall:

- (a) serve on the Executive Committee; and
- (b) assume all such duties as are assigned to him or her by the President of the Medical Staff or the Executive Committee.

3.D: NOMINATIONS

The President of the Medical Staff shall appoint a Nominating Committee for all general and special elections consisting of three members of the Active Attending Staff. The Nominating Committee shall convene at least 60 days prior to the election and shall submit to the President of the Medical Staff the names of one or more qualified nominees for the offices of President-Elect and Secretary-Treasurer and for the six at-large members of the Executive Committee. The Nominating Committee is also charged with seeking nominees who have sectional diversity. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election. Nominations may also be submitted in writing by petition signed by at least five Active Attending Staff members at least 10 days prior to the election. In order for a nomination to be placed on the ballot, the candidate must meet

the qualifications in Section 3.B, in the judgment of the Nominating Committee, and be willing to serve. Nominations from the floor shall not be accepted.

3.E: ELECTION

- (1) Candidates receiving a majority of written votes cast shall be elected. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes of those present.
- (2) In the alternative, in the discretion of the Executive Committee, the election may be held solely by written ballot returned to the Medical Staff Office. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected.

3.F: TERM OF OFFICE

Officers shall serve for a term of one year or until a successor has taken office.

3.G: REMOVAL

- (1) Removal of an elected officer or a member of the Executive Committee may be effectuated by a two-thirds vote of the Executive Committee or by a two-thirds vote of all members of the Active Attending Staff. Grounds for removal shall be:
 - (a) failure to comply with applicable policies, bylaws, or rules and regulations;
 - (b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;
 - (c) failure to perform the duties of the position held;
 - (d) conduct detrimental to the interests of the Medical Center and/or its Medical Staff; or
 - (e) an infirmity that renders the individual incapable of fulfilling the duties of that office.
- (2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Executive Committee or Active Staff, as applicable, prior to a vote on removal.

3.H: VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the President-Elect, who shall serve until the end of the President's unexpired term, provided the unexpired term is less than six months. In the event there is a vacancy in another office, the Executive Committee shall appoint an individual to fill that office for the remainder of the term or until a special election can be held, at the discretion of the Executive Committee.

If the President of the Medical Staff's unexpired term is greater than six months or the President-Elect is unwilling or unable to assume the office of President, then the Executive Committee shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the Executive Committee.

ARTICLE 4

APPOINTED OFFICERS

4.A: APPOINTED OFFICERS

The appointed officers of the Medical Staff shall be: Chief Medical Officer, Director of Medical Education, and Section Chiefs.

4.B: CHIEF MEDICAL OFFICER

4.B.1. Appointment:

The Chief Medical Officer shall be appointed by the CEO and the Board to act on behalf of the Medical Center in Medical Staff affairs.

4.B.2. Duties:

The Chief Medical Officer shall:

- (a) act in coordination and cooperation with the CEO and the President of the Medical Staff in matters of mutual concern involving the care of patients in the Medical Center;
- (b) develop, coordinate, and oversee the provision of quality medical and clinical services and the implementation of all aspects of educational and research activities of the Medical Staff;
- (c) assist and oversee the credentialing and performance improvement processes involving the Medical Staff and allied professionals;
- (d) serve as an *ex officio* member of all Medical Staff committees, with vote;
- (e) assume and fulfill the duties and responsibilities of the President of the Medical Staff in the absence or unavailability of the President and the President-Elect;
- (f) assist the Medical Staff officers, Department Chairs, and Section Chiefs in the implementation and enforcement of the bylaws, policies, rules and regulations of the Medical Staff and the Medical Center;
- (g) provide leadership in the coordination of medical and administrative policies of the Medical Center and Medical Staff and act as an advisor to the CEO, the Board, and the Executive Committee in all professional matters of the Medical Center; and

- (h) perform such additional duties as are specified in these Bylaws and related Medical Staff documents and in the position description established by the CEO.

4.C: DIRECTOR OF MEDICAL EDUCATION

4.C.1. Appointment:

The Director of Medical Education shall be appointed by the CMO and CEO to act on behalf of the Medical Center in all medical education activities at the Medical Center.

4.C.2. Duties:

The Director of Medical Education shall:

- (a) act in coordination and cooperation with the CEO, CMO, and the President of the Medical Staff in matters involving medical education at the Medical Center;
- (b) coordinate, oversee, and implement all medical education programs in the Medical Center, including those for all residents, medical students, allied health professional students, allied health professionals, and Medical Staff members;
- (c) ensure that the educational programs are in accordance with the requirements of the Accreditation Council for Graduate Medical Education, the American Board of Family Practice, and other pertinent regulatory bodies;
- (d) make periodic reports to the Medical Executive Committee on the activities of the Graduate Medical Education Committee, including any adverse actions regarding physicians in training;
- (e) work actively with the Des Moines University, the University of Iowa and the Des Moines Area Medical Education Consortium in the coordination of regional medical education activities; and
- (f) assume the duties and functions of the CMO in his or her absence.

4.D: SECTION CHIEFS

4.D.1. Appointment and Qualifications:

The CEO, upon recommendation of the CMO, may appoint a Section Chief for each of the clinical sections within the departments of the Medical Staff. These individuals must be members of the Active Attending Staff and must possess all of the qualifications set forth in Section 3.B of these Bylaws. Section Chiefs may be removed and replaced by the CEO, upon recommendation of the CMO.

4.D.2. Duties:

Each Section Chief shall:

- (a) act in coordination and cooperation with the chair of the department in performing all of the applicable duties set forth in these Bylaws and in the related Medical Staff documents;
- (b) review and report on applications for initial appointment and clinical privileges, including interviewing applicants;
- (c) review and report on applications for reappointment and renewal of clinical privileges;
- (d) participate in the development of criteria for clinical privileges relevant to the care provided within the section;
- (e) review and report regarding the professional performance of individuals exercising clinical privileges within the section, including conducting ongoing and focused professional practice evaluations in accordance with the Performance Improvement and Peer Review Plan;
- (f) assist in the development of an appropriate on-call policy and schedule;
- (g) assess and recommend off-site sources for needed patient care services not provided by the section, department, or Medical Center;
- (h) develop and implement policies and procedures that guide and support the provision of services;
- (i) make recommendations for a sufficient number of qualified and competent persons to provide care or service;
- (j) continuously assess and improve the quality of care and services provided within the section;
- (k) maintain quality monitoring programs, as appropriate;
- (l) make recommendations for space and other resources needed by the section;
- (m) assist with the coordination of all clinically- and administratively-related activities of the section;
- (n) assist with the coordination of services provided within the section as well as the integration of those services into the primary functions of the Medical Center;

- (o) provide input into the qualifications and competence necessary for personnel within the section who provide patient care, treatment, and services who are not licensed independent practitioners;
- (p) perform all credentialing and peer review functions authorized in these Bylaws including collegial intervention; and
- (q) perform such additional duties as may be assigned by the CMO or CEO.

ARTICLE 5

DEPARTMENTS

5.A: ORGANIZATION

The Medical Staff shall be organized into three clinical departments:

- (1) Department of Medicine (including Emergency Medicine/Urgent Care, Family Practice, Geriatrics, Internal Medicine and Subspecialties, Neurology, Oncology, Pain Management, Pediatrics, and Sleep Medicine)
- (2) Department of Surgery (including Anesthesia, General Surgery and Subspecialties, Obstetrics & Gynecology, Ophthalmology, Oral Medicine, Orthopedics, Pathology, Podiatry, Radiology, and Urology)
- (3) Department of Psychiatry

5.B: ASSIGNMENT TO DEPARTMENTS

- (1) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical department.
- (2) An individual may request a change in his or her department assignment to reflect a change in the individual's clinical practice.

5.C: FUNCTIONS OF DEPARTMENTS

- (1) The departments shall be organized to deliver primary healthcare services and for the purpose of implementing processes (a) to monitor and evaluate the quality and appropriateness of care of patients served by the departments, and (b) to monitor the practice of all those with clinical privileges in a given department.
- (2) Each department shall assure appropriate emergency call coverage for all patients requiring the primary care services available in that department.

5.D: FUNCTIONS OF SECTIONS

- (1) Sections may perform any of the following activities:
 - (a) continuing education;
 - (b) discussion of policy;
 - (c) discussion of equipment needs;

- (d) development of recommendations to the Department Chair or the Executive Committee;
 - (e) participation in the development of criteria for clinical privileges (when requested by the Department Chair); and
 - (f) discussion of a specific issue at the special request of a Department Chair or the Executive Committee.
- (2) No minutes or reports will be required reflecting the activities of sections, except when the sections are making formal recommendations to a department, Department Chair, Credentials Committee, or Executive Committee.
 - (3) Sections shall not be required to hold any number of regularly scheduled meetings.

5.E: SELECTION AND REMOVAL OF DEPARTMENT CHAIRS

5.E.1. Qualifications of Department Chairs:

Each Department Chair shall:

- (a) be an Active Attending Staff member;
- (b) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and
- (c) satisfy the eligibility criteria set forth in Section 3.B.

5.E.2. Election and Removal of Department Chairs:

- (a) Each department shall elect a chair at the last meeting of the department prior to the end of the Medical Staff year, as stated in Article 7.A of these Bylaws.
- (b) The Department Chair shall serve for a term of one year. There is no limitation on the number of times that an individual may be elected to serve as chair of a department.
- (c) A Department Chair may be removed by a two-thirds vote of the department members or the Executive Committee members. Grounds for removal shall include:
 - (1) failure to comply with applicable policies, bylaws, or rules and regulations;
 - (2) failure to perform the duties of the position held;

- (3) conduct detrimental to the interests of the Medical Center and/or its Medical Staff; or
 - (4) an infirmity that renders the individual incapable of fulfilling the duties of that office.
- (d) At least 10 days prior to the initiation of any removal action, the CMO shall give written notice to the individual regarding the date of the meeting at which such action shall be considered. The individual shall be afforded an opportunity to speak to the department or Executive Committee, as applicable, prior to a vote on removal.

5.F: DUTIES OF DEPARTMENT CHAIRS

Each Department Chair is responsible for the following:

- (1) acting in cooperation with the Section Chiefs to carry out their duties as outlined in Section 4.D.2 of these Bylaws;
- (2) representing the department at the Medical Executive Committee meetings;
- (3) presiding over department meetings; and
- (4) performing any such additional duties as may be assigned by the President of the Medical Staff.

ARTICLE 6

MEDICAL STAFF COMMITTEES AND FUNCTIONS

6.A: MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT ACTIVITIES

- (1) This Article outlines the Medical Staff committees that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.
- (2) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:
 - (a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;
 - (b) the Medical Center's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;
 - (c) medical assessment and treatment of patients;
 - (d) medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;
 - (e) the utilization of blood and blood components, including review of significant transfusion reactions;
 - (f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;
 - (g) appropriateness of clinical practice patterns;
 - (h) significant departures from established patterns of clinical practice;
 - (i) use of information about adverse privileging determinations regarding any practitioner;
 - (j) the use of developed criteria for autopsies;
 - (k) sentinel events, including root cause analyses and responses to unanticipated adverse events;
 - (l) nosocomial infections and the potential for infection;

- (m) unnecessary procedures or treatment;
- (n) appropriate resource utilization;
- (o) education of patients and families;
- (p) coordination of care, treatment, and services with other practitioners and Medical Center personnel;
- (q) accurate, timely, and legible completion of medical records;
- (r) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix D of these Bylaws;
- (s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and
- (t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board.

6.B: APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

- (1) All Committee Chairs and members shall be appointed by the President of the Medical Staff, in consultation with the CMO. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws; however, Allied Health Professionals may also be appointed to serve on committees (voting rights of such appointees shall be addressed in any specific committee composition).
- (2) Committee chairs and members shall be appointed for initial terms of two or three years, but may be reappointed for additional terms unless otherwise specified.
- (3) The CMO and CEO (or other respective designees) shall serve as *ex officio* members on all Medical Staff Committees.
- (4) The President of the Medical Staff shall be invited to all committee meetings, with voting privileges when in attendance.
- (5) All Medical Center and administrative representatives on the committees shall be appointed by the CEO or designee.
- (6) Unless otherwise indicated, only Medical Staff members shall vote on the committees outlined in these Bylaws. All other individuals shall be *ex officio*, non-voting members.

6.C: MEETINGS, REPORTS, AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws shall meet at least quarterly, or at the discretion of the chair, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report (including suggested policy or practice changes) after each meeting to the Executive Committee and to other committees and individuals as may be indicated.

6.D: CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in these Bylaws, the Executive Committee may recommend the establishment of additional committees to perform one or more staff functions. The Executive Committee may also recommend the dissolution or rearrangement of committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special committee shall be performed by the Executive Committee.

6.E: ALLIED HEALTH PROFESSIONALS REVIEW COMMITTEE

6.E.1. Composition:

The Allied Health Professionals Review Committee (“AHP Committee”) shall consist of one Credentials Committee member, the CMO, one Medical Staff member appointed by the CMO, at least one Licensed Independent Practitioner, one Advanced Dependent Practitioner. A Licensed Independent Practitioner or Advanced Dependent Practitioner will serve as chair of the AHP Committee. Depending on the issue under consideration, the AHP Committee may also obtain assistance, on an ad hoc basis, from the relevant Department Chair(s) or designee(s), and/or relevant hospital Section Chiefs or nurse manager(s).

6.E.2. Duties:

The AHP Committee shall perform the following duties:

- (a) evaluate and make recommendations to the Executive Committee regarding the need for the services that could be provided by classes of Allied Health Professionals that are not currently permitted to practice in the Medical Center;
- (b) evaluate and make recommendations to the Executive Committee regarding the need for the services that could be provided by classes of Allied Health Professionals that are currently permitted to practice in the Medical Center;
- (c) develop and recommend policies for each class of Allied Health Professional permitted by the Board to practice in the Medical Center as outlined in Section 14.C of these Bylaws;

- (d) review the qualifications of all Allied Health Professionals who apply for permission to practice in the Medical Center, interview such applicants as may be necessary, and make a written report of its findings and recommendations to the Credentials Committee;
- (e) at the request of the Credentials Committee, review information regarding the clinical competence and/or behavior of Allied Health Professionals currently permitted to practice in the Medical Center and, as a result of such a peer review, report its findings and recommendations to the Credentials Committee; and
- (f) appoint three Allied Health Professionals who may attend Medical Staff meetings as non-voting liaisons to the Medical Staff.

6.F: CREDENTIALS COMMITTEE

6.F.1. Composition:

- (a) The Credentials Committee shall consist of Active Attending Staff members who possess the qualifications set forth in Section 3.B of these Bylaws. Particular consideration is to be given to Past Presidents of the Medical Staff and to other physicians knowledgeable in the credentialing and quality improvement processes. Each year, two new members shall be appointed to serve three-year terms to preserve the continuity of the committee. At the time of yearly appointments, one member of the committee shall be designated to serve as Chair for the ensuing year.
- (b) To the fullest extent possible, service on this committee shall be considered as the primary Medical Staff obligation of each member of the committee and the member shall not be required to serve on any other Medical Staff committee (unless he/she agrees to do so).

6.F.2. Duties:

The Credentials Committee shall:

- (a) in accordance with these Bylaws, review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations, including, as applicable, the duration of any provisional periods and extent of focused professional practice evaluations;
- (b) review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff and, as a result of such review, make a written report of its findings and recommendations; and

- (c) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Medical Center, including specifically as set forth in Section 10.A.4 (“Clinical Privileges for New Procedures”) and Section 10.A.5 (“Clinical Privileges That Cross Specialty Lines”) of these Bylaws.

6.G: CRITICAL CARE COMMITTEE

6.G.1. Composition:

The Critical Care Committee shall consist of representatives from Emergency Medicine, Surgery, Pediatrics, Anesthesiology, Radiology, Internal Medicine, Family Practice, and Psychiatry as well as appropriate representatives from administration.

6.G.2. Duties:

The Critical Care Committee shall perform the following functions:

- (a) monitor and evaluate the quality and appropriateness of patient care provided in the critical care units of the Medical Center;
- (b) be responsible for the formulation, review, and implementation of the policies for the critical care units of the Medical Center, including the procedures to follow during cardiac arrest and critical care situations;
- (c) review and make recommendations regarding adequate staffing, equipment, and medications in the critical care units;
- (d) formulate rules regulating admission to, and discharge from, the critical care units to ensure optimal utilization of this specialized area and monitor and adjudicate questions regarding the utilization of critical care beds;
- (e) appoint one physician member of the committee to serve as a Medical Advisor to the appropriate Nursing Supervisors for these units;
- (f) assist in the training and equipping of the cardiac resuscitation team and periodically review records of specific resuscitation efforts and consider problems involved in specific resuscitation efforts;
- (g) review and make recommendations regarding transfers to a higher level of care within the Medical Center; and
- (h) receive reports from the Medical Center’s Trauma Performance Committee which is formed based upon Iowa Department of Public Health, Bureau of Emergency Medical Services, guidelines for a Level III Trauma Center.

6.G.3. Reports:

In addition to the Executive Committee, the Critical Care Committee shall forward department-specific findings to each Department Chair and/or Section Chief for review and follow-up.

6.H: EXECUTIVE COMMITTEE

6.H.1. Composition:

- (a) The Executive Committee shall include the following voting members:
- the elected officers of the Medical Staff;
 - the Immediate Past President;
 - the Department Chairs;
 - the Chair of the Credentials Committee;
 - six at-large members elected by the Medical Staff; and
 - one Allied Health Professional to be appointed by the Executive Committee, and who shall serve a one-year term.
- (b) The President of the Medical Staff will chair the Executive Committee.
- (c) The CEO, the CMO, and the Director of Medical Education shall be *ex officio* members of the Executive Committee, without vote.
- (d) Other Medical Staff members or Medical Center personnel may be invited to attend a particular Executive Committee meeting (as guests, without vote) in order to assist the Executive Committee in its discussions and deliberations regarding an issue(s) on its agenda. These individuals shall be present only for the relevant agenda item(s) and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the Executive Committee.

6.H.2. Duties:

The Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and over performance improvement activities regarding the professional services provided by individuals with clinical privileges. This authority may be removed by amending these Bylaws and related policies. The Committee is responsible for the following:

- (a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Executive Committee meetings);
- (b) recommending directly to the Board on at least the following:
 - (1) the Medical Staff's structure;
 - (2) the mechanism used to review credentials and to delineate individual clinical privileges;
 - (3) applicants for Medical Staff appointment and reappointment;
 - (4) delineation of clinical privileges for each eligible individual;
 - (5) participation of the Medical Staff in Medical Center performance improvement activities and the quality of professional services being provided by the Medical Staff;
 - (6) the mechanism by which Medical Staff appointment may be terminated;
 - (7) hearing procedures; and
 - (8) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;
- (c) consulting with administration on quality-related aspects of contracts for patient care services;
- (d) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;
- (e) providing leadership in activities related to patient safety;
- (f) providing oversight in the process of analyzing and improving patient satisfaction;
- (g) ensuring that, at least every three years, the Bylaws, policies, and associated documents of the Medical Staff are reviewed and updated; and
- (h) performing such other functions as are assigned to it by these Bylaws or other applicable policies.

6.H.3. Meetings:

The Executive Committee shall meet as often as necessary to fulfill its responsibilities and shall maintain a permanent record of its proceedings and actions. Copies of Executive

Committee agendas will be available to any member of the Medical Staff in advance of the meeting. Any member of the Medical Staff may request permission to attend a meeting for participation in discussion of a particular agenda item without vote.

6.I: INFECTION CONTROL COMMITTEE

6.I.1. Composition:

The Infection Control Committee shall consist of representatives from each of the departments of the Medical Staff and the Medical Center's Pathologist, who shall serve as chair, as well as appropriate representatives from administration.

6.I.2. Duties:

Infection Control Functions:

The Infection Control Committee shall:

- (a) have oversight responsibilities for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the oversight of infection control in all phases of the Medical Center's activities;
- (b) establish a system for documenting all Medical Center infections, including infections among patients and hospital personnel, to provide a basis for studying infection sources;
- (c) monitor the standards and the bacteriological services available to the Medical Center;
- (d) recommend specific immunization programs;
- (e) review and recommend proper isolation techniques;
- (f) monitor and evaluate findings from any patient care performance improvement activity that relates to infection control; and
- (g) recommend an infection control prevention program and a continuing education program for Medical Staff and hospital personnel on infectious disease control.

Blood Usage Review Functions:

The Infection Control Committee shall:

- (a) develop policies and procedures for distribution, handling, use, and administration of whole blood and blood components;
- (b) review adequacy of transfusion services for patient needs;
- (c) review actual or suspected transfusion reactions; and
- (d) evaluate blood usage, including the review of the amount of blood requested, the amount of blood used, and the amount of blood wasted.

6.I.3. Reports:

In addition to the Executive Committee, the Infection Control Committee shall report its activities and findings to the PI Coordinator. Department-specific findings are also referred to each Department Chair and/or Section Chief for review and follow-up. Information related to antibiotic review results is forwarded to the Pharmacy/Drug Utilization Committee.

6.J: MEDICAL RECORDS/UTILIZATION REVIEW COMMITTEE

6.J.1. Composition:

The Medical Records/Utilization Review Committee shall consist of at least one representative from each of the departments of the Medical Staff as well as appropriate representatives from administration.

6.J.2. Duties:

Medical Records Review Functions:

The Medical Records/Utilization Review Committee shall:

- (a) review and determine that each medical record, or a representative sample of records, is complete and legible in accordance with Medical Staff Rules and Regulations;
- (b) conduct periodic reviews of summary information regarding the timely completion of all medical records and make recommendations concerning the same as appropriate;
- (c) review Medical Staff and departmental policies and/or rules pertaining to medical records, including medical record completion, filing, indexing, storage, destruction and availability, and recommend changes as appropriate and/or necessary;

- (d) review and recommend all forms proposed for inclusion in the permanent medical record;
- (e) review triennially the policies and procedures of the medical records department and make recommendations as appropriate and/or necessary; and
- (f) recommend a medical record abbreviation list.

Utilization Review Functions:

The Medical Records/Utilization Review Committee shall:

- (a) monitor utilization to evaluate the appropriateness of hospital admissions, lengths of stay, discharge practices, use of medical and hospital services and resources, and other factors related to utilization of hospital and physician services;
- (b) review and periodically update the utilization review plan for the Medical Center, to be approved by the Executive Committee, the CEO, and the Board, in accordance with all applicable accreditation, third-party payor, PRO, and regulatory requirements which shall be in effect at all times;
- (c) evaluate the medical necessity for initiation of and continued hospital services or level of care for particular patients, and make recommendations on the same to the attending physician, the Executive Committee, and the CEO. No physician shall have review responsibility for any extended stay cases in which that physician has been professionally involved;
- (d) implement concurrent review for those diagnoses, procedures, and/or practitioners with identified or suspected utilization-related problems; and
- (e) evaluate the appropriateness, timeliness, and adequacy of discharge planning and discharge placement.

6.J.3. Reports:

In addition to the Executive Committee, this committee may forward information to each clinical department and/or section, as appropriate, for review and follow-up.

6.K: PHARMACY AND THERAPEUTICS COMMITTEE

6.K.1. Composition:

The Pharmacy and Therapeutics Committee shall consist of at least one representative from each of the departments of the Medical Staff as well as appropriate representatives from administration and Pharmacy. Pharmacy representatives shall be non-voting members.

6.K.2. Duties:

The Pharmacy and Therapeutics Committee shall:

- (a) review the appropriateness of the prophylactic, empiric, and therapeutic use of drugs through the review and analysis of individual or aggregate patterns or variations of drug practice;
- (b) develop and recommend to the Executive Committee policies relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials;
- (c) define and review all significant untoward drug reactions;
- (d) maintain and periodically review the Medical Center formulary or drug list;
- (e) recommend drugs to be stocked on the nursing unit floors and by other services;
- (f) evaluate clinical data concerning new drugs or preparations requested for use in the Medical Center and report decisions and/or concerns to the Executive Committee for action;
- (g) recommend standards and develop protocols concerning the safe use and control of investigational drugs and of research involving use of any drugs in the Medical Center, in conjunction with the Medical Center's delegated Institutional Review Board(s);
- (h) monitor guidelines for automatic stop orders for drugs as specified in the rules and regulations or other Medical Center policy;
- (i) serve as an advisory group to the Medical Staff and pharmacist on matters pertaining to choice of available drugs; and
- (j) prevent unnecessary duplication in stocking drugs within the Medical Center.

6.K.3. Reports:

In addition to the Executive Committee, this committee may forward information to each clinical department and/or section, as appropriate, for review and follow-up.

6.L: SPECIAL COMMITTEES

Special committees shall be created and their members and chairs shall be appointed by the President of the Medical Staff, after consulting with the CMO. Such task forces shall confine their activities to the purpose for which they were appointed and shall report to the Executive Committee.

ARTICLE 7

MEETINGS

7.A: MEDICAL STAFF YEAR

The Medical Staff year is February 1 to January 31.

7.B: MEDICAL STAFF MEETINGS

7.B.1. Regular Meetings:

The Medical Staff shall meet at least quarterly for review of reports on quality of care and performance improvement initiatives as well as the annual election.

7.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the CMO, the Executive Committee, the CEO, the Board, or by a petition signed by not less than 20% of the Active Attending Staff.

7.C: DEPARTMENT, SECTION, AND COMMITTEE MEETINGS

7.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws, each department shall meet at least annually and each committee shall meet at least quarterly, at times set by the presiding officer. Sections shall meet as often as necessary to accomplish their functions.

7.C.2. Special Meetings:

A special meeting of any department, section, or committee may be called by or at the request of the presiding officer, the President of the Medical Staff, the CMO, or by a petition signed by not less than 25% of the Active Attending Staff members of the department, section, or committee, but not by fewer than two members.

7.D: PROVISIONS COMMON TO ALL MEETINGS

7.D.1. Notice of Meetings:

- (a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments, sections, and committees at least 14 days in advance of the meetings. Notice may also be provided by posting in a designated location at least two weeks prior to the meetings. All notices shall state the date, time, and place of the meetings.

- (b) When special meetings of the Medical Staff, departments, sections, and/or committees are called, the required notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). In addition, posting in a designated location may not be the sole mechanism used for providing notice of special meetings.
- (c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

7.D.2. Quorum and Voting:

- (a) For any regular or special meeting of the Medical Staff, department, section, or committee, those voting members present shall constitute a quorum.
- (b) Recommendations and actions of the Medical Staff, departments, sections, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present.
- (c) As an alternative to a formal meeting, the voting members of the Medical Staff, a department, a section, or a committee may also be presented with a question by mail, facsimile, e-mail or other approved electronic method, hand-delivery, or telephone, and their votes returned to the Presiding Officer by the method designated in the notice. A quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned have so indicated.
- (d) Meetings may also be conducted by telephone conference or videoconference.
- (e) For the annual Medical Staff election, an absentee ballot may be requested no more than nine days before the election date and must be returned no later than one day before that date. If a Medical Staff member votes by absentee ballot, that individual may not vote on the actual election date.

7.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, section, or committee.

7.D.4. Rules of Order:

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

prevail at all meetings. The Presiding Officer shall have the authority to rule definitively on all matters of procedure.

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

- (a) Minutes of all meetings of the Medical Staff, departments, and committees (and applicable section meetings) shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the Presiding Officer.
- (b) A summary of all recommendations and actions of the Medical Staff, departments, sections, and committees shall be transmitted to the Executive Committee and the CEO. The Board shall be kept apprised of the recommendations of the Medical Staff and its departments, sections, and committees.
- (c) A permanent file of the minutes of all meetings shall be maintained by the Medical Center.

7.D.6. Confidentiality:

All Medical Staff business conducted by committees, departments, and sections is considered confidential and proprietary and should be treated as such. However, members of the Medical Staff who have access to, or are the subject of, credentialing and/or peer review information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by these Bylaws or other applicable Medical Staff or Medical Center policy. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

7.D.7. Attendance:

Each Active Attending Staff member is expected to attend and participate in Medical Staff meetings and applicable department, section, and committee meetings.

PART THREE:

**APPOINTMENT,
REAPPOINTMENT, AND
CLINICAL PRIVILEGES**

ARTICLE 8

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

8.A: QUALIFICATIONS

8.A.1. Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians and dentists must:

- (a) have a current, unrestricted Iowa license and have never had a license to practice revoked or suspended by any state licensing agency;
- (b) maintain adequate continuing education hours for purposes of licensure, with educational activities relevant to their primary discipline;
- (c) where applicable to their practice, have a current, unrestricted DEA registration and state controlled substance license;
- (d) be available on a continuous basis, either personally or by arranging appropriate coverage, to (i) respond to the needs of any of their patients who have been admitted to the Medical Center and (ii) respond to Emergency Department patients during those times when they are on call in a prompt, efficient, and conscientious manner. (“Appropriate coverage” means coverage by another member of the Medical Staff with appropriate specialty-specific privileges as determined by the Credentials Committee.) Compliance with this eligibility requirement means that the practitioner must document that he or she is willing and able to:
 - (1) respond within 15 minutes, via phone, to an initial contact from the Medical Center; and
 - (2) appear in person (or via technology-enabled direct communication and evaluation, i.e., telemedicine) to attend to a patient within 60 minutes of being requested to do so (or more quickly as required for a particular specialty as recommended by the Executive Committee and approved by the Board);
- (e) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Medical Center;
- (f) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

- (g) have never been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (h) have never had Medical Staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (i) have never resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;
- (j) have never been convicted of, or entered a plea of guilty or no contest to, any felony, or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;
- (k) agree to personally fulfill all responsibilities regarding emergency call coverage for their specialty or obtain appropriate coverage (as determined by the Credentials Committee) from another member of the Medical Staff;
- (l) have or agree to make appropriate coverage arrangements (as determined by the Credentials Committee) with other members of the Medical Staff for those times when the individual shall be unavailable;
- (m) demonstrate recent clinical activity in their primary area of practice during the last two years;
- (n) if applying for privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract;
- (o) document compliance with all applicable training and/or educational protocols, as well as orientation requirements that may be adopted by the Executive Committee, including, but not limited to, those involving electronic medical records, computerized physician order entry (“CPOE”), patient safety, and infection control;
- (p) have successfully completed:*
 - (1) a residency training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in a specialty in which the applicant seeks clinical privileges;
 - (2) a dental surgery training program accredited by the Commission on Dental Education of the American Dental Association; or

- (3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;
- (q) are board certified in their primary area of practice at the Medical Center by the appropriate specialty/subspecialty board of the American Board of Medical Specialties (“ABMS”), the American Osteopathic Association (“AOA”), the American Board of Podiatric Surgery (“ABPS”), the American Board of Lower Extremity Surgery (“ABLES”), or the American Board of Oral and Maxillofacial Surgery, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training;* and
- (r) maintain board certification in their primary area of practice at the Medical Center on a continuous basis, and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so (board certification status will be assessed at reappointment).*

* These requirements are applicable only to those individuals who apply for initial staff appointment after February 12, 2002. All individuals appointed previously shall be governed by the residency and board certification requirements in effect at the time of their appointments.

Further, in exceptional circumstances, the five-year time frame for initial applicants and the time frame for recertification/maintenance of certification by existing members may be extended for one additional period, not to exceed two years, in order to permit an individual an additional opportunity to obtain certification. In order to be eligible to request an extension in these situations, an individual must, at a minimum, satisfy the following criteria:

- (1) the individual has been on the Medical Center’s Medical Staff for at least three consecutive years;
- (2) there have been no significant documented peer review concerns related to the individual’s competence or behavior at the Medical Center during the individual’s tenure;
- (3) the individual provides a letter from the appropriate certifying board confirming that the individual remains eligible to take the certification examination within the next two years; and
- (4) the appropriate section chief at the Medical Center provides a favorable report concerning the individual’s qualifications.

8.A.2. Waiver of Criteria:

- (a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating (i) that he/she is otherwise qualified, and (ii) exceptional circumstances exist (e.g., when there is a demonstrated Medical Center or Medical Staff need for the services in question). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of an applicant (e.g., applicants who wish to defer taking Board examinations).
- (b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant Department Chair and/or Section Chief, and the best interests of the Medical Center and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation shall be forwarded to the Executive Committee. Any recommendation to grant a waiver must include the basis for such.
- (c) The Executive Committee shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis for such.
- (d) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the State of Iowa or the National Practitioner Data Bank.
- (e) Except for a waiver that may be granted for a time-limited period, a waiver is considered to be permanent and the individual does not have to request a waiver at each subsequent reappointment cycle. The waiver remains in effect for the entirety of the individual's tenure at the Medical Center, so long as the individual continuously remains a member of the Medical Staff.
- (f) The granting of a waiver in a particular case does not set a precedent for any other individual or group of individuals.
- (g) An application for appointment that does not satisfy an eligibility criterion shall not be processed until the Board has determined that a waiver should be granted.

8.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the appointment and reappointment processes, as reflected in the following factors:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;
- (c) good reputation and character;
- (d) ability to safely and competently perform the clinical privileges requested;
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, the Medical Center's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

8.A.4. No Entitlement to Appointment:

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

- (a) is employed by the Medical Center or its subsidiaries or has a contract with the Medical Center;
- (b) is or is not a member or employee of any particular physician group;
- (c) is licensed to practice a profession in this or any other state;
- (d) is a member of any particular professional organization;
- (e) has had in the past, or currently has, medical staff appointment or privileges at any hospital or health care facility;
- (f) resides in the geographic service area of the Medical Center; or

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

8.A.5. Nondiscrimination:

No individual shall be denied appointment on the basis of sex, race, creed, national origin, color, or age or any other criterion unrelated to the delivery of quality patient care, professional qualifications, the purposes, needs and capabilities of the Medical Center or community needs.

8.B: GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

8.B.1. Basic Responsibilities and Requirements for Applicants and Members:

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

- (a) to provide continuous and timely care to all patients for whom the individual has responsibility;
- (b) to abide by all Bylaws, policies, and Rules and Regulations of the Medical Center and Medical Staff in force during the time the individual is appointed;
- (c) to accept committee assignments, emergency service call obligations, care of unassigned patients, consultation requests, participation in quality improvement and peer review activities, and such other reasonable duties and responsibilities as assigned;
- (d) to comply with clinical practice or evidence-based protocols and pathways that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance and then meet with the Medical Staff Leaders or committees to discuss the variance, as requested;
- (e) to comply with clinical practice or evidence-based medicine pathways or protocols pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or to clearly document the clinical reasons for variance and then meet with the Medical Staff Leaders or committees to discuss the variance, as requested;
- (f) to notify the CMO of any change in the practitioner's status or any change in the information provided on the individual's application form for initial appointment or reappointment. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to:

- any and all complaints regarding, or changes in, licensure status or DEA controlled substance authorization,
 - changes in professional liability insurance coverage,
 - changes in the practitioner’s Medical Staff status (appointment and/or privileges) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities,
 - knowledge of a criminal investigation involving the member, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter (other than a misdemeanor traffic citation),
 - exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed,
 - any referral to a state board health-related program,
 - any changes in the practitioner’s ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the physician health policy), and
 - any charge of, or arrest for, driving under the influence (“DUI”) (Any DUI incident will be reviewed by the President of the Medical Staff and the CMO so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under the physician health policy or these Bylaws);
- (g) to submit to an appropriate evaluation, which may include diagnostic testing (such as a blood and/or urine test), or to a complete physical, mental, or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the administrative team) are concerned with the individual’s ability to safely and competently care for patients within the time frame required by the individuals requiring the evaluation. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leadership and the Medical Staff member must execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;
- (h) to acknowledge that the individual has had an opportunity to read a copy of these Bylaws and the Medical Staff Rules and Regulations, and agrees to be bound by them;

- (i) within the scope of his or her privileges, and consistent with the relevant staff category, to provide emergency service call coverage, consultations, and care for unassigned patients;
- (j) to comply with all applicable training and/or educational protocols, as well as orientation requirements that may be adopted by the Executive Committee, including, but not limited to, those involving electronic medical records, computerized physician order entry (“CPOE”), patient safety, and infection control;
- (k) to appear for personal interviews in regard to an application for initial appointment or reappointment;
- (l) to use the Medical Center sufficiently to allow continuing assessment of current competence;
- (m) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (n) to refrain from delegating responsibility for patients to any individual who is not qualified or adequately supervised;
- (o) to refrain from deceiving patients as to the identity of any individual providing treatment or services;
- (p) to seek consultation whenever necessary;
- (q) to complete in a timely manner all medical and other required records, containing all information required by the Medical Center and to utilize the electronic medical record as required;
- (r) to participate in an Organized Health Care Arrangement with the Medical Center, to abide by the terms of the Medical Center’s Notice of Privacy Practices with respect to health care delivered in the Medical Center, and to provide patients with a Notice of Organized Health Care Arrangement as a supplement to their own Notice of Privacy Practices;
- (s) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- (t) to promptly pay any applicable dues, fines, and assessments;
- (u) to maintain a current e-mail address with Medical Staff Services, which will be the official mechanism used to communicate all Medical Staff information to the member other than peer review information pertaining to the member and/or protected health information of patients;

- (v) to cooperate with all utilization oversight activities;
- (w) to satisfy continuing medical education requirements; and
- (x) that, if there is any misstatement in, or omission from, the application, the Medical Center may stop processing the application, with no entitlement to any hearing or appeal rights contained in these Bylaws. If appointment has been granted prior to the discovery of a misstatement or omission, an individual's appointment and privileges may be deemed to be automatically relinquished by the Executive Committee. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration. If the determination is made to not process an application or that appointment and privileges should be automatically relinquished pursuant to this provision, the individual may not reapply to the Medical Staff for a period of at least two years.

8.B.2. Burden of Providing Information:

- (a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Medical Center for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.
- (b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.
- (c) Complete Application: An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (d) It is the responsibility of the individual seeking appointment or reappointment to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

8.C: APPLICATION

8.C.1. Information:

- (a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of these Bylaws.
- (b) In addition to other information, the applications shall seek the following:
 - (1) information as to whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged;
 - (2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;
 - (3) information as to whether the individual has opted out of any federal health care program, as well as the results of a query to the System for Award Management;
 - (4) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the Executive Committee, or the Board may request;
 - (5) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and
 - (6) a copy of government-issued photo identification.
- (c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

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

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Medical Center, any member of the Medical Staff, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Medical Center, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Medical Center, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Medical Center and its authorized representatives upon request, and, if applicable, agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Medical Center.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Medical Center representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in these Bylaws shall be the sole and exclusive remedy with respect to any professional review action taken by the Medical Center.

(e) Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action and does not prevail, he or she shall reimburse the Medical Center and any members of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(f) Scope of Section:

All of the provisions in this Section 8.C.2 are applicable in the following situations:

- (i) whether or not appointment or clinical privileges are granted;
- (ii) throughout the term of any appointment or reappointment period and thereafter;
- (iii) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Medical Center's professional review activities; and
- (iv) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure as a member of the Medical Staff.

8.D: ACCESS TO INFORMATION BY INDIVIDUALS

- (1) Upon request, applicants will be informed of the status of their applications for appointment, clinical privileges, or scope of practice.
- (2) Except during the hearing and appeal processes, which are governed by Articles 13 and 18 of these Bylaws, an individual may review information obtained or maintained by the Medical Center only upon request and only if the identity of the individual who provided the information will not be revealed.
- (3) If an individual disputes any information obtained or maintained by the Medical Center, the individual may submit, in writing, a correction or clarification of the relevant information which will be maintained in the individual's file.

ARTICLE 9

PROCEDURE FOR INITIAL APPOINTMENT TO THE MEDICAL STAFF

9.A: PROCEDURE FOR INITIAL APPOINTMENT

9.A.1. Request for Application:

- (a) Applications for appointment shall be in writing and shall be on forms approved by the Credentials Committee.
- (b) An individual seeking initial appointment shall be sent a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form.
- (c) Applications may be provided to residents who are in the final six months of their training. Such applications may be processed, but final action will not be taken until all applicable threshold eligibility criteria are satisfied.

9.A.2. Initial Review of Application:

- (a) A completed application form with copies of all required documents must be returned to the Medical Staff Services Office within 30 days after receipt of same if the individual desires further consideration. The application must be accompanied by the application processing fee.
- (b) As a preliminary step, the application will be reviewed by the CMO to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights within in these Bylaws.
- (c) The CMO shall oversee the process of gathering and verifying relevant information. The CMO shall also be responsible for confirming that all references and other information or materials deemed pertinent have been received.
- (d) The names of applicants shall be communicated so that members of the Medical Staff may submit, in writing, information bearing on the applicant's qualifications for appointment or clinical privileges.

9.A.3. Steps to Be Followed for All Initial Applicants:

- (a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chiefs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.
- (b) An interview with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the Department Chair, the Section Chief, a Credentials Committee representative, the full Credentials Committee, the President of the Medical Staff, the full Executive Committee, the CMO, and/or the CEO.

9.A.4. Department Chair and Section Chief Procedure:

- (a) The primary duty to evaluate applications is delegated to the Section Chief. Applications of Section Chiefs will be reviewed by the respective Department Chairs.
- (b) The CMO shall transmit the complete application and all supporting materials to the Section Chief or Department Chair in which the applicant seeks clinical privileges. Each Section Chief or Department Chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.
- (c) The Section Chief or Department Chair shall be available to answer any questions that may be raised with respect to his or her reports and findings.

9.A.5. Credentials Committee Procedure:

- (a) The Credentials Committee shall review and consider the report prepared by the relevant Section Chief or Department Chair and shall make a recommendation.
- (b) The Credentials Committee may use the expertise of the Section Chief or Department Chair, any other member of the Medical Staff, or an outside consultant if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. The results of this

examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

- (d) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 13.A.1(a) of these Bylaws, such conditions do not entitle an individual to request the procedural rights set forth in Article 13 of these Bylaws.
- (e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the Chair of the Credentials Committee shall send a letter to the applicant, with a copy to the Executive Committee and the CEO, explaining the reasons for the delay.

9.A.6. Executive Committee Procedure:

- (a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Executive Committee shall:
 - (1) adopt the findings and recommendation of the Credentials Committee as its own; or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Executive Committee prior to its final recommendation; or
 - (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.
- (b) If the recommendation of the Executive Committee is to appoint, the recommendation shall be forwarded to the Board through the CMO.
- (c) If the recommendation of the Executive Committee is unfavorable and would entitle the applicant to request a hearing in accordance with Section 13.A.1 of these Bylaws, the Committee shall forward its recommendation to the CEO, who shall promptly send Special Notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

9.A.7. Board Action:

- (a) Expedited Review. The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Executive Committee and there is no evidence of any of the following:
- (1) a current or previously successful challenge to any license or registration;
 - (2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or
 - (3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

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

- (b) Full Board Review. When there has been no delegation to the Board committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:
- (1) appoint the applicant and grant clinical privileges as recommended; or
 - (2) refer the matter back to the Credentials Committee or Executive Committee, or to another source inside or outside the Medical Center, for additional research or information; or
 - (3) reject or modify the recommendation.
- (c) If the Board determines to reject the favorable recommendation, it should first discuss the matter with the Chairs of the Credentials and Executive Committees. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send Special Notice to the applicant that the applicant is entitled to request a hearing.
- (d) Any final decision by the Board to grant, deny, revise, or revoke appointment and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

9.A.8. Time Periods for Processing:

All applications for initial appointment shall be processed in a timely manner. Absent a concern with the application, each complete application that proceeds through the full Credentials Committee procedure shall be processed within 120 days from the date it is deemed complete. (It is expected that applications proceeding through the expedited

processing route will be processed more quickly than these time periods.) These time periods are intended to be guidelines designed to assist the individuals/bodies in accomplishing their tasks. They shall not be deemed to create any right for the applicant to have an application processed within these precise time periods.

9.B. FPPE TO CONFIRM COMPETENCE

All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation (“FPPE”) in order to confirm competence. The FPPE process for these situations is outlined in the Medical Center’s Peer Review Plan.

ARTICLE 10

CLINICAL PRIVILEGES

10.A: CLINICAL PRIVILEGES

10.A.1. General:

- (a) Appointment or reappointment shall not confer any clinical privileges or right to admit or treat patients at the Medical Center.
- (b) Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.
- (c) The granting of clinical privileges includes responsibility for emergency service call established to fulfill the Medical Center's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.
- (d) In order for a request for privileges to be processed, the applicant must satisfy any applicable eligibility criteria.
- (e) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with applicable contracts.
- (f) Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria (or has obtained a waiver in accordance with Section 10.A.2).
- (g) The clinical privileges recommended to the Board shall be based upon consideration of the following factors:
 - (1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to the same;
 - (2) appropriateness of utilization patterns;
 - (3) ability to perform the privileges requested competently and safely;

- (4) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;
 - (5) availability of qualified staff members with appropriate privileges (as determined by the Credentials Committee) to provide coverage in case of the applicant's illness or unavailability;
 - (6) adequate professional liability insurance coverage for the clinical privileges requested;
 - (7) the Medical Center's available resources and personnel;
 - (8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - (9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
 - (10) practitioner-specific data as compared to aggregate data, when available;
 - (11) morbidity and mortality data, when available; and
 - (12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.
- (h) Core privileges, special privileges, privilege delineations, and/or the criteria for the same shall be developed by the relevant Department Chair and/or Section Chief and shall be forwarded to the Credentials Committee for review and recommendation. The Credentials Committee will forward its recommendations to the Executive Committee, which will review the matter and forward its recommendations to the Board for final approval.
- (i) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.
- (j) The report of the Chair of the clinical department and/or Section Chief in which privileges are sought shall be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

10.A.2. Privilege Modifications and Waivers:

- (a) Scope. This Section applies to all requests for modification of clinical privileges during the term of appointment (increases and relinquishments), resignation from the Medical Staff, and waivers related to eligibility criteria for privileges.
- (b) Submitting a Request. Requests for privilege modifications and waivers must be submitted in writing to Medical Staff Services.
- (c) Increased Privileges.
 - (1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.
 - (2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.
- (d) Waivers.
 - (1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
 - (2) If the individual is requesting a waiver of the requirement that each member apply for the full core of privileges in his or her specialty, the process set forth in this paragraph shall apply.
 - (i) Formal Request: The individual must forward a written or electronic request to Medical Staff Services, which must indicate the specific patient care services within the core that the member does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.
 - (ii) Review Process: A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee shall specifically consider the factors outlined in Paragraph (f) below and may obtain input from the relevant Department Chair. The Credentials Committee's recommendation will be forwarded to the Executive Committee, which shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding

whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(e) Relinquishment and Resignation of Privileges.

- (1) Relinquishment of Individual Privileges. A request to relinquish any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of privileges. All such requests will be processed in the same manner as a request for waiver, as described above.
- (2) Resignation of Appointment and Privileges. A request to resign Medical Staff appointment and relinquish all clinical privileges must specify the desired date of resignation, which must be at least 30 days from the date of the request, and be accompanied by evidence that the individual:
 - (i) has completed all medical records;
 - (ii) will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation; and
 - (iii) has completed all scheduled emergency service call or has arranged for appropriate coverage to satisfy this responsibility.

After consulting with the President of the Medical Staff, the CMO will act on the resignation request and report the matter to the Executive Committee.

(f) Factors for Consideration. The Credentials Committee, the Executive Committee, and the Board may consider the following factors, among others, when deciding whether to recommend or grant a modification (increases and/or relinquishments) or waiver related to privileges:

- (1) the Medical Center's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities, including its teaching functions;
- (2) whether sufficient notice has been given to provide a smooth transition of patient care services;
- (3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed upon the individual;
- (4) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them;

- (5) any perceived inequities in modifications or waivers being provided to some, but not others;
 - (6) any gaps in call coverage that might/would result from an individual's removal from the call roster for the relevant privilege and the feasibility and safety of transferring patients to other facilities in that situation; and
 - (7) how the request may affect the Medical Center's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.
- (g) Effective Date. If the Board grants a modification or waiver related to privileges, it shall specify the date that the modification or waiver will be effective. Failure of a member to request privilege modifications or waivers in accordance with this section shall, as applicable, result in the member retaining Medical Staff appointment and clinical privileges and all associated responsibilities.
- (h) Procedural Rights. No individual is entitled to a modification or waiver related to privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of privileges is not granted.

10.A.3. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

- (a) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform in the Medical Center shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Surgical procedures performed by dentists or oral and maxillofacial surgeons shall be under the overall supervision of the Chairman, Department of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician (M.D./D.O.) who is a member of the Medical Staff before dental surgery shall be performed (with the exception of (c) below), and a designated physician (M.D./D.O.) shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) Oral and maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials and Executive Committees.
- (d) The dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their license and

consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Center and Medical Staff Bylaws.

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

- (a) Requests for clinical privileges to perform either a significant procedure not currently being performed at the Medical Center or a significant new technique to perform an existing procedure (“new procedure”) shall not be processed until (1) a determination has been made by Medical Center Administration that the procedure shall be offered by the Medical Center and (2) criteria to be eligible to request those clinical privileges have been established as set forth in this Section.
- (b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the CMO addressing the following:
 - (1) minimum education, training, and experience necessary to perform the new procedure safely and competently;
 - (2) clinical indications for when the new procedure is appropriate;
 - (3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;
 - (4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;
 - (5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and/or
 - (6) whether the Medical Center currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The CMO and Medical Center Administration shall review this report and consult with the Department Chair and/or Section Chief and the Credentials Committee (any of which may conduct additional research as necessary), and shall make a preliminary determination as to whether the new procedure should be offered to the community.

- (c) If the preliminary determination of the Medical Center is favorable, the Credentials Committee will determine whether the request constitutes a “new procedure” as defined by this Section or if it is an extension of an existing privilege. If it is determined that it does constitute a “new procedure,” the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the Medical Center. In

developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

- (1) the appropriate education, training, and experience necessary to perform the procedure or service;
 - (2) the clinical indications for when the procedure or service is appropriate;
 - (3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence; and
 - (4) the manner in which the procedure would be reviewed as part of the Medical Center's ongoing and focused professional practice evaluation activities.
- (d) The Credentials Committee will forward its recommendations to the Executive Committee, which will review the matter and forward its recommendations to the Board for final action.
- (e) The Board will make a reasonable effort to render the final decision within 60 days of receipt of the Executive Committee's recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.
- (f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to perform the procedure or service may be processed.

10.A.5. Clinical Privileges That Cross Specialty Lines:

- (a) Requests for clinical privileges that previously at the Medical Center have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.
- (b) As an initial step in the process, the individual seeking the privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.
- (c) The Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., Department Chairs, Section Chiefs, individuals on the Medical Staff with special interest and/or

expertise) and those outside the Medical Center (e.g., other hospitals, residency training programs, specialty societies).

- (d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:
 - (1) the appropriate education, training, and experience necessary to perform the clinical privileges in question;
 - (2) the clinical indications for when the procedure is appropriate;
 - (3) the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;
 - (4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;
 - (5) the manner in which the procedure would be reviewed as part of the Medical Center's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and
 - (6) the impact, if any, on emergency call responsibilities.
- (e) The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the Executive Committee's recommendation.
- (f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed.

10.A.6. Telemedicine Privileges:

- (a) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.
- (b) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the CMO in consultation with the President of the Medical Staff:
 - (1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in these Bylaws. In such

case, the individual must satisfy all qualifications and requirements set forth in these Bylaws, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

- (2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Medical Center must ensure, through a written agreement, that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:
 - (i) confirmation that the practitioner is licensed in Iowa;
 - (ii) a current list of privileges granted to the practitioner;
 - (iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;
 - (iv) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;
 - (v) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and
 - (vi) any other attestations or information required by the agreement or requested by the Medical Center.

This information shall be provided to the Executive Committee for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Medical Center may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in these Bylaws.

- (c) Telemedicine privileges, if granted, shall be for a period of not more than two years.
- (d) Individuals granted telemedicine privileges shall be subject to the Medical Center's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine

services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

- (e) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

10.B: TEMPORARY CLINICAL PRIVILEGES

10.B.1. Eligibility to Request Temporary Clinical Privileges:

- (a) Applicants. Temporary privileges for an applicant for initial appointment may be granted by the CEO, upon recommendation of the CMO, President of the Medical Staff, Chair of the Credentials Committee, and appropriate Department Chair and/or Section Chief, under the following conditions:
 - (1) the applicant has submitted a complete application, along with the application fee, if applicable;
 - (2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from Office of Inspector General queries;
 - (3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;
 - (4) the application is pending review by the Executive Committee and the Board, following a favorable recommendation by the Credentials Committee (or its Chair); and
 - (5) temporary privileges for a Medical Staff applicant will be granted for a maximum period of 120 consecutive days.
- (b) Locum Tenens and Lapse of Services. The CEO, upon recommendation of the CMO, President of the Medical Staff, Chair of the Credentials Committee, and appropriate Department Chair and Section Chief, may grant temporary privileges (both admitting and treatment) to (i) an individual serving as a locum tenens for a member of the Medical Staff who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time, or (ii) when necessary to prevent a lack or lapse of services in a needed specialty area, under the following conditions:

- (1) the applicant has submitted an appropriate application, along with the application fee;
- (2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence (verification of good standing in all hospitals where the individual practiced for at least the previous two years), ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from Office of Inspector General queries;
- (3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;
- (4) the applicant will be subject to any focused professional practice requirements established by the Medical Center; and
- (5) the individual may exercise locum tenens privileges for a maximum of 180 days, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions:
 - (i) the individual must notify Medical Staff Services prior to each time that he or she will be exercising these privileges; and
 - (ii) along with this notification, the individual must inform Medical Staff Services of any change that has occurred to any of the information provided on the initial application for locum tenens privileges.

In extraordinary circumstances, the CEO may recommend renewal of locum tenens temporary privileges, for a time period not to exceed 120 days, upon the recommendation of the CMO, President of the Medical Staff, Chair of the Credentials Committee, and relevant Department Chair.

- (c) Visiting. Temporary privileges may also be granted in other limited situations by the CEO, upon recommendation of the CMO, President of the Medical Staff, Chair of the Credentials Committee, and appropriate Department Chair and Section Chief, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following:

- (1) the care of a specific patient; or
- (2) when a proctoring or consulting physician is needed, but is otherwise unavailable.

The following factors will be considered and verified prior to the granting of temporary privileges in these situations: current licensure, current competence (verification of good standing in the individual's most recent hospital), current professional liability coverage acceptable to the Medical Center, and results of a query to the National Practitioner Data Bank and from Office of Inspector General queries. The grant of clinical privileges in these situations will not exceed 60 days. The verifications for such grants of privileges shall generally be accomplished in advance; however, in an emergency situation, where life-threatening circumstances exist, the verifications listed above may be completed immediately after the grant of privileges. In exceptional situations, this period of time may be extended in the discretion of the CEO, CMO, and the President of the Medical Staff.

- (d) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures, and protocols of the Medical Staff and the Medical Center.
- (e) Automatic Expiration. All grants of temporary privileges shall automatically expire upon the date specified at the time of initial granting unless further affirmative action is taken by the CEO, CMO, President of the Medical Staff, Chair of the Credentials Committee, and appropriate Department Chair with approval of the Board to renew such temporary privileges.
- (f) FPPE. Individuals who are granted temporary privileges will be subject to the Medical Center policy regarding focused professional practice evaluation.

10.B.2. Supervision Requirements:

In exercising temporary privileges, the individual shall act under the supervision of the Department Chair and/or Section Chief. Special requirements of supervision and reporting may be imposed by the Department Chair and/or Section Chief on any individual granted temporary clinical privileges.

10.B.3. Withdrawal of Temporary Clinical Privileges:

- (a) The CEO or the CMO may, at any time after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, or the Department Chair or Section Chief, withdraw temporary admitting privileges. Clinical privileges shall then expire when the individual's inpatients are discharged.

- (b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the CEO, the CMO, the Department Chair, the Section Chief, or the President of the Medical Staff may immediately withdraw all temporary privileges. The Department Chair, the Section Chief, or the President of the Medical Staff shall assign to another member of the Medical Staff responsibility for the care of such terminated individual's patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

10.C: EMERGENCY SITUATIONS

- (1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.
- (2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges. Similarly, in an emergency situation, any practitioner who is not currently appointed to the Medical Staff may administer treatment to the extent permitted by his or her license.
- (3) When the emergency situation no longer exists, the patient shall be assigned by the Department Chair, the Section Chief, or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

10.D: DISASTER PRIVILEGES

- (1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CEO or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.
- (2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.
 - (a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).
 - (b) A volunteer's license may be verified in any of the following ways:
 - (i) current Medical Center picture ID card that clearly identifies the individual's professional designation;
 - (ii) current license to practice;
 - (iii) primary source verification of the license;
 - (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance

Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current Medical Center employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

- (3) Primary source verification of a volunteer's license shall begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Medical Center.
- (4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
- (5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Medical Center.

10.E: CONTRACTS FOR SERVICES

- (1) From time to time, the Medical Center may enter into contracts with practitioners and/or groups of practitioners for the performance of clinical and administrative services at the Medical Center. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Medical Center, in accordance with the terms of these Bylaws.
- (2) To the extent that:
 - (a) any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or
 - (b) the Board by resolution limits the practitioners who may exercise privileges in any clinical specialty to employees of the Medical Center or its affiliates,

no other practitioner except those authorized by or pursuant to the contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized practitioners are eligible to apply for appointment or reappointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.

- (3) Prior to the Medical Center signing any exclusive contract and/or passing any Board resolution described in paragraph (2) in a specialty service and/or specialty area that has not previously been subject to such a contract or resolution, the Board will request the Executive Committee's review of the matter. The Executive Committee (or a subcommittee of its members appointed by the President of the Medical Staff) will review the quality of care and service implications of the proposed exclusive contract or Board resolution, and provide a report of its findings and recommendations to the Board within 30 days of the Board's request. As part of its review, the Executive Committee (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) members of the applicable specialty involved, (ii) members of other specialties who directly utilize or rely on the specialty in question, and (iii) Medical Center administration. However, the actual terms of any such exclusive arrangement or employment contract, and any financial information related to them, including but not limited to the remuneration to be paid to Medical Staff members who may be a party to the arrangement, are not relevant and shall neither be disclosed to the Executive Committee nor discussed as part of the Executive Committee's review. (Note: If more than one physician in a relevant specialty area will be affected by the determination of the Board, the following procedures will be coordinated to address all requested meetings in a combined and consolidated manner.)
- (4) After receiving the Executive Committee's report, the Board shall determine whether or not to proceed with the exclusive contract or Board resolution. If the Board determines to do so, and if that determination would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and review procedures:
 - (a) The affected member shall be given at least 30 days' advance notice of the anticipated effective date of the exclusive contract or Board resolution and shall have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the contract in question being signed by the Medical Center or the Board resolution becoming effective. Any such meeting must be requested by the affected member and held within 30 days of the notice, unless this time frame is extended by mutual agreement.
 - (b) At the meeting, the affected member shall be entitled to present any information that he or she deems relevant to the Board's initial determination to enter into the exclusive contract or enact the resolution.
 - (c) If, following this meeting, the Board confirms its initial determination to enter into the exclusive contract or enact the Board resolution, the affected member shall be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board resolution. In that circumstance, the ineligibility begins as of the effective date of the

exclusive contract or Board resolution and continues for as long as the contract or Board resolution is in effect.

- (d) The affected member shall not be entitled to any procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 7 of these Bylaws.
 - (e) The inability of a physician to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.
- (5) Except as provided in paragraph (1), in the event of any conflict between these Bylaws or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 11

PROCEDURE FOR REAPPOINTMENT

11.A: PROCEDURES FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

11.A.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

- (a) completed all medical records and be current at the time of reappointment;
- (b) completed all continuing medical education requirements;
- (c) satisfied all medical staff responsibilities, including payment of dues, fines, and assessments;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;
- (e) if applying for clinical privileges, had sufficient patient contacts to enable the Department Chair and Section Chief to assess current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Medical Center must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization), before the application will be considered complete and processed further; and
- (f) paid the reappointment processing fee when applicable.

11.A.2. Factors for Evaluation:

In considering an individual's application for reappointment, the factors listed in Section 8.A.3 of these Bylaws shall be considered. Additionally, the following factors shall be evaluated as part of the reappointment process:

- (a) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Medical Center;

- (b) participation in Medical Staff duties, including committee assignments, emergency call, consultation requests, quality of medical record documentation, cooperation with case management, and participation in quality improvement and utilization activities;
- (c) the results of the Medical Center's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);
- (d) any focused professional practice evaluations;
- (e) verified complaints received from patients, families, and/or staff; and
- (f) other reasonable indicators of continuing qualifications.

11.A.3. Applications for Reappointment:

- (a) An application for reappointment shall be furnished to members at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the CMO within 30 days of receipt.
- (b) Failure to return a completed application within this time frame will result in the assessment of an additional reappointment processing fee. In addition, except as provided below, failure to submit an application at least two months prior to the expiration of the member's current term may result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment, and the individual may not practice until an application is processed unless the application can still be processed in the normal course, without extraordinary effort on the part of Medical Staff Services and the Medical Staff Leaders.
- (c) Reappointment, if granted, shall be for a period of not more than two years.
- (d) If an application for reappointment is submitted timely, but the Medical Staff and/or Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. Subsequent Board action may be to grant reappointment and renewal of clinical privileges using the filed application in accordance with the expedited process set forth in Section 9.A.7.
- (e) The application will be reviewed by the CMO to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment and for the clinical privileges requested.

- (f) The CMO shall oversee the process of gathering and verifying all relevant information. The CMO shall also be responsible for confirming that all relevant information has been received.

11.A.4. Reappointment Process:

- (a) The CMO shall forward the application to the relevant Department Chair and Section Chief, and the application for reappointment shall be processed in the same manner as applications for initial appointment.
- (b) Additional information may be requested from the applicant if any questions or concerns are raised about the application or if new privileges are requested.

11.A.5. Conditional Reappointments:

- (a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., practitioner code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 13.A.1(a) of these Bylaws, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article 13 of these Bylaws.
- (b) Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 13.
- (c) In addition, in the event the applicant for reappointment is the subject of an unresolved professional practice evaluation concern, a formal investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

11.A.6. Potential Adverse Recommendation:

- (a) If the Credentials Committee or the Executive Committee is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chairperson will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.
- (b) Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.

- (c) At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation.
- (d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be accompanied by legal counsel at this meeting and no recording (audio or video) of the meeting shall be permitted or made.

11.A.7. Time Periods for Processing:

All applications for reappointment shall be processed in a timely manner. Absent a concern with the application, each complete application that proceeds through the full Credentials Committee procedure shall be processed within 120 days from the date it is deemed complete. These time periods are intended to be guidelines designed to assist the individuals/bodies in accomplishing their tasks. They shall not be deemed to create any right for the applicant to have an application processed within these precise time periods.

PART FOUR:

**PEER REVIEW AND
FAIR HEARING PROCEDURES**

ARTICLE 12

QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

12.A: COLLEGIAL EFFORTS AND PROGRESSIVE STEPS

- (1) These Bylaws encourages the use of collegial efforts and progressive steps by Medical Staff Leaders and Medical Center management to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.
- (2) Collegial efforts and progressive steps include, but are not limited to:
 - (a) informal mentoring, coaching, or counseling by a Medical Staff Leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call obligations, or the timely and adequate completion of medical records);
 - (b) sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming his or her practice to appropriate norms;
 - (c) addressing minor performance issues through an informational letter;
 - (d) sending an educational letter that describes opportunities for improvement and provides guidance and suggestions;
 - (e) facilitating a formal Collegial Intervention (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it; and
 - (f) developing a performance improvement plan, which may include a wide variety of tools and techniques that can result in a constructive and successful resolution of the concern.
- (3) All of these efforts are fundamental and integral components of the Medical Center's professional practice evaluation activities, and are confidential and protected in accordance with state law.
- (4) Copies of any formal documentation that is prepared by a Medical Staff Leader regarding such collegial efforts, including letters that follow a formal Collegial Intervention, will be included in an individual's confidential file. The individual shall have an opportunity to review any such documentation and respond in writing.

The response shall be maintained in that individual's file along with the original documentation.

- (5) Collegial efforts and progressive steps are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders and Medical Center management. When a question arises, the Medical Staff and/or Medical Center Leaders may:
 - (a) address it pursuant to the collegial efforts and progressive steps provisions of this Section;
 - (b) refer the matter for review in accordance with the peer review plan, code of conduct policy, physician health policy, and/or other relevant policy; or
 - (c) refer it to the Executive Committee for its review and consideration in accordance with Section 12.C of this Article.
- (6) Should any recommendation be made or an action taken that entitles an individual to a hearing in accordance with these Bylaws, the individual is entitled to be accompanied by legal counsel at that hearing. However, Medical Staff members do not have the right to be accompanied by counsel when the Medical Staff Leaders and Medical Center management are engaged in collegial efforts or other progressive steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) or transcript made of any meetings that involve collegial efforts or progressive steps activities.

12.B: ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATIONS

All ongoing and focused professional practice evaluations shall be conducted in accordance with the professional practice evaluation policy. Matters that cannot be appropriately resolved through collegial intervention or through the Peer Review Plan shall be referred to the Executive Committee for its review in accordance with Section 12.C below. Such interventions and evaluations, however, are not mandatory prerequisites to Executive Committee review.

12.C: INVESTIGATIONS

12.C.1. Initial Review:

- (a) Where collegial efforts or actions under one or more of the policies referenced in this Article have not resolved an issue, and/or when there is a single instance of such severity that in the discretion of Medical Staff Leaders it requires further review, regarding:

- (1) the clinical competence or clinical practice of any members of the Medical Staff, including the care, treatment or management of a patient or patients;
- (2) the safety or proper care being provided to patients;
- (3) the known or suspected violation by any members of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules or Regulations of the Medical Center or the Medical Staff; and/or
- (4) conduct by any members of the Medical Staff is considered lower than the standards of the Medical Center or disruptive to the orderly operation of the Medical Center or its Medical Staff, including the inability of the member to work harmoniously with others,

the matter may be referred to the President of the Medical Staff, the Department Chair, the Section Chief, the chair of a standing committee, the CMO, or the CEO. (Matters of concern involving the CMO shall be referred directly to the CEO.)

- (b) In addition, if the Board becomes aware of information that raises concerns about any Medical Staff member, the matter shall be referred to the President of the Medical Staff, the Department Chair, the Section Chief, the chair of a standing committee, the CMO, or the CEO for review and appropriate action in accordance with these Bylaws. (Matters of concern involving the CMO shall be referred directly to the CEO.)
- (c) The person to whom the matter is referred shall conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, shall forward it in writing to the Executive Committee.
- (d) No action taken pursuant to this Section shall constitute an investigation.

12.C.2. Initiation of Investigation:

- (a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Executive Committee, the Executive Committee shall review the matter and determine whether to conduct an investigation, or to direct the matter to be handled pursuant to another policy (e.g., code of conduct policy, physician health policy, peer review plan), or to proceed in another manner. In making this determination, the Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Executive Committee to do so.
- (b) The Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Medical Center or Medical Staff.

- (c) The CMO shall keep the CEO fully informed of all action taken in connection with an investigation.

12.C.3. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the Executive Committee shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation. Any ad hoc committee shall not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician or dentist).
- (b) The committee conducting the investigation (“investigating committee”) shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Medical Center, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Medical Center and investigating committee that:
 - (1) the clinical expertise needed to conduct the review is not available on the Medical Staff; or
 - (2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or
 - (3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded; or
 - (4) the thoroughness and objectivity of the investigation would be aided by such an external review.

When an external review is obtained pursuant to this Section, the results of the review will be shared with the individual under investigation and he or she will be provided an opportunity to respond to the findings of the external review in writing.

- (c) At the discretion of the Medical Center, the investigating committee may require a physical, mental, and/or behavioral examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing
 - (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and
 - (ii) the health care professional(s) conducting the examination to discuss and

provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual.

- (d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be prepared by the investigating committee and included with its report. No recording (audio or video) of the meeting shall be permitted or made. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be accompanied by legal counsel at this meeting.
- (e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.
- (f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions and recommendations and forward that information to the Executive Committee.
- (g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Medical Center, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committees may consider:
 - (1) relevant literature and clinical practice guidelines, as appropriate;
 - (2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);
 - (3) any information or explanations provided by the individual under review; and
 - (4) other information as deemed relevant, reasonable, and necessary by the investigating committee.

12.C.4. Recommendation:

- (a) The Executive Committee may accept, modify, or reject any recommendation it receives from the Credentials Committee or an ad hoc investigating committee. Specifically, the Executive Committee may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose conditions for continued appointment;
 - (4) impose a requirement for monitoring or proctoring;
 - (5) impose a requirement for consultation;
 - (6) impose a requirement for additional training or education;
 - (7) recommend reduction of clinical privileges;
 - (8) recommend suspension of clinical privileges for a term;
 - (9) recommend revocation of appointment and/or clinical privileges; or
 - (10) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the Executive Committee that would entitle the individual to request a hearing pursuant to Section 13.A.1 shall be forwarded to the CEO, who shall promptly inform the individual by Special Notice. The CEO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.
- (c) If the determination of the Executive Committee does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board. The individual shall be informed of the outcome of the investigation in writing.
- (d) In the event the Board considers a modification to the recommendation of the Executive Committee that would entitle the individual to request a hearing, the CEO shall inform the individual by Special Notice. No final action shall occur until the individual has completed or waived a hearing and appeal.
- (e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff Leaders on

an ongoing basis through the Medical Center's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

12.D: PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES

12.D.1. Grounds for Precautionary Suspension:

- (a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the Executive Committee, or the President of the Medical Staff, a Department Chair, or a Section Chief, acting in conjunction with the CMO, the CEO, or the Board Chair, shall have the authority to (1) afford an individual an opportunity to voluntarily refrain from exercising privileges pending a further review of the circumstances; or (2) suspend or restrict all or any portion of an individual's clinical privileges as a precaution.
- (b) A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Executive Committee that would entitle the individual to request a hearing.
- (c) 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 shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.
- (d) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO and the President of the Medical Staff, and shall remain in effect unless it is modified by the CEO or Executive Committee.
- (e) Within three days of the imposition of the suspension, the individual in question shall be provided a letter via Special Notice that memorializes the individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension and terms related to the same. The correspondence shall also contain a brief written description of the reason(s) for the precautionary suspension, including the names and medical record numbers of the patient(s) involved (if any).

12.D.2. Executive Committee Procedure:

- (a) The Executive Committee shall review the matter resulting in a precautionary suspension or restriction (or the individual's agreement to voluntarily refrain from exercising clinical privileges) within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Executive Committee. The individual may

propose ways other than precautionary suspension or restriction to protect patients and/or employees, depending on the circumstances. Neither the Executive Committee nor the individual shall be accompanied by counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting shall be prepared.

- (b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Executive Committee shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review or a formal investigation or recommending some other action that is appropriate under the circumstances. The Executive Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the focused review or investigation (and hearing and appeal, if applicable).
- (c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

12.D.3. Care of Suspended Individual's Patients:

- (a) Immediately upon the imposition of a precautionary suspension or restriction, the CMO shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.
- (b) All members of the Medical Staff have a duty to cooperate with the CMO, the Department Chair, the Section Chief, the Executive Committee, and the CEO in enforcing suspensions.

12.E: AUTOMATIC RELINQUISHMENT

12.E.1. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

- (a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or any failure to satisfy any of the threshold eligibility criteria set forth in these Bylaws, must be promptly reported by the Medical Staff member to the President of the Medical Staff and the CMO.
- (b) An individual's appointment and clinical privileges shall be automatically relinquished, without the right to the procedural rights outlined in these Bylaws, if an individual fails to satisfy any of the threshold eligibility criteria set forth in Section 8.A.1 of these Bylaws on a continuous basis (except for board certification

requirements, which shall be assessed at time of reappointment). This includes, but is not limited to, the following occurrences:

- (1) Licensure: Revocation, suspension, expiration, or the placement of restrictions on an individual's license.
 - (2) Controlled Substance Authorization: Revocation, suspension, expiration, or the placement of restrictions on an individual's federal or state controlled substance certificate.
 - (3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Medical Center or to cease to be in effect, in whole or in part.
 - (4) Medicare and Medicaid Participation: Termination, exclusion, preclusion, or debarment by government action from participation in the Medicare or Medicaid programs.
 - (5) Criminal Activity: Arrest, charge, indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another. (DUIs will be addressed in the manner outlined in Section 8.B.1(f).)
- (c) Automatic relinquishment shall take effect immediately upon notice to the Medical Center and continue until the matter is resolved, if applicable. If an individual engages in any patient contact at the Medical Center after the occurrence of an event that results in automatic relinquishment, without notifying the Medical Center of that event, then the relinquishment shall be deemed permanent.
- (d) If the underlying matter leading to automatic relinquishment is resolved within 90 days, the individual may request reinstatement. Failure to resolve the matter within 90 days of the date of relinquishment shall result in an automatic resignation from the Medical Staff.
- (e) Request for Reinstatement.
- (1) Requests for reinstatement following the expiration of a license, controlled substance authorization, and/or insurance coverage will be processed by Medical Staff Services. If any questions or concerns are noted, Medical Staff Services will refer the matter for further review in accordance with (e)(2) below.

- (2) All other requests for reinstatement shall be presented to and reviewed by the Section Chief, the Department Chair, the Chair of the Credentials Committee, the President of the Medical Staff, and the CEO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Medical Center. This determination shall then be forwarded to the Credentials Committee, Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Executive Committee, and Board for review and recommendation.

12.E.2. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for appointment, reappointment, or clinical privileges, in response to a written request from the Credentials Committee, the Executive Committee, the CEO, the CMO, or any other committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment will continue in effect until the information is provided to the satisfaction of the requesting party. If the requested information is not provided within 30 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

12.E.3. Failure to Complete or Comply with Training or Educational Requirements:

Failure to complete and/or comply with training or educational requirements, as well as any orientation requirements that are adopted by the Executive Committee, including, but not limited to, those pertinent to electronic medical records, computerized physician order entry ("CPOE"), patient safety, and infection control, shall result in the automatic relinquishment of all clinical privileges. Any relinquishment will continue in effect until documentation of compliance is provided to the satisfaction of the requesting party. If the requested information is not provided within 30 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

12.E.4. Failure to Attend Special Meeting:

- (a) Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, the Department Chair, the Section Chief, or the President of the Medical Staff may require the individual to attend a special meeting with Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff.
- (b) The notice to the individual regarding this meeting shall be given by Special Notice at least three days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.

- (c) No legal counsel shall be present at this meeting, and no recording (audio or video) shall be permitted or made.
- (d) Failure of the individual to attend the meeting shall result in the automatic relinquishment of all clinical privileges until such time as the individual does attend the special meeting. If the individual does not attend the special meeting within 30 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

12.F: LEAVES OF ABSENCE

- (1) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the CEO. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.
- (2) Any absence from medical staff and/or from patient care responsibilities for longer than 60 days shall require an individual to request a leave of absence. In addition, members of the Medical Staff must report to the CEO any time they are away from medical staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the CEO, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence.
- (3) The CEO will determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the CEO shall consult with the CMO and the relevant Department Chair and/or Section Chief. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.
- (4) During the leave of absence, the individual shall not exercise any clinical privileges at the Medical Center. In addition, the individual shall be excused from all medical staff citizenship responsibilities (e.g., meeting attendance; committee service; emergency service call obligations) during this period.
- (5) No later than 30 days prior to the conclusion of the leave of absence, individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Medical Center. Requests for reinstatement shall then be reviewed by the relevant Section Chief, Department Chair, the Chair of the Credentials Committee, the President of the Medical Staff, the CMO, and the CEO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Medical Center. This determination shall then be forwarded to the Credentials Committee, the Executive

Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Executive Committee, and Board for review and recommendation. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

- (6) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested and the request shall be processed in accordance with the physician health policy.
- (7) Absence for longer than one year shall result in automatic relinquishment of medical staff appointment and clinical privileges unless an extension is granted by the CEO. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Medical Center.
- (8) If an individual's current appointment is due to expire during the leave, the individual must either apply for reappointment in accordance with the provisions of these Bylaws or have his/her appointment and clinical privileges lapse at the end of the appointment period.
- (9) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of Medical Staff appointment and clinical privileges.
- (10) Leaves of absence and reinstatement are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

ARTICLE 13

HEARING AND APPEAL PROCEDURES

13.A: INITIATION OF HEARING

13.A.1. Grounds for Hearing:

- (a) An individual is entitled to request a hearing whenever the Executive Committee makes one of the following recommendations:
 - (1) denial of initial appointment to the Medical Staff;
 - (2) denial of reappointment to the Medical Staff;
 - (3) revocation of appointment to the Medical Staff;
 - (4) denial of requested clinical privileges;
 - (5) revocation or reduction of clinical privileges;
 - (6) suspension of clinical privileges for more than 30 days (other than precautionary suspension);
 - (7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
 - (8) denial of a request for reinstatement after a leave of absence if the reasons relate to clinical competence or professional conduct.
- (b) No other recommendations shall entitle the individual to a hearing.
- (c) If the Board makes any of these determinations without an adverse recommendation by the Executive Committee, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Executive Committee. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the “Executive Committee” shall be interpreted as a reference to the “Board.”

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

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

- (a) determination that an applicant for membership fails to meet the threshold eligibility qualifications or criteria for membership;
- (b) ineligibility to request membership or privileges, or to continue privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement;
- (c) failure to process a request for a privilege when the individual does not meet the eligibility criteria to hold the privilege;
- (d) determination that an application is incomplete or untimely;
- (e) determination that an application shall not be processed due to a misstatement or omission;
- (f) change in assigned staff category or a determination that an individual is not eligible for a specific staff category;
- (g) expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;
- (h) issuance of a letter of guidance, counsel, warning, or reprimand;
- (i) determination that conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment) is appropriate for an individual;
- (j) determination that a requirement for additional training or continuing education is appropriate for an individual;
- (k) the voluntary acceptance of a Performance Improvement Plan;
- (l) any requirement to complete a health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;
- (m) conducting an investigation into any matter or the appointment of an ad hoc investigating committee;
- (n) grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than two years;
- (o) refusal of the Medical Center to consider a request for appointment, reappointment, or privileges within five years of a final adverse decision regarding such request;
- (p) precautionary suspension;

- (q) automatic relinquishment of appointment or privileges or automatic resignation;
- (r) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;
- (s) removal from the on-call roster or any other reading panel;
- (t) withdrawal of temporary privileges;
- (u) requirement to appear for a special meeting; and
- (v) termination of any contract with or employment by the Medical Center.

13.A.3. Notice of Recommendation:

The CMO shall promptly give Special Notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

- (a) a statement of the recommendation and the general reasons for it;
- (b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
- (c) a copy of this Article.

13.A.4. Request for Hearing:

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

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

- (a) The CMO shall schedule the hearing and provide, by Special Notice to the individual requesting the hearing, the following:
 - (1) the time, place, and date of the hearing;
 - (2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

- (3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
 - (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.
- (b) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

13.A.6. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The CMO, after consulting with the President of the Medical Staff, shall appoint a Hearing Panel in accordance with the following guidelines:

- (1) The Hearing Panel shall consist of at least three members and may include any combination of:
 - (i) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level, and/or
 - (ii) physicians or laypersons not connected with the Medical Center (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Medical Center).
- (2) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.
- (3) Employment by, or other contractual arrangement with, the Medical Center or an affiliate shall not preclude an individual from serving on the Panel.
- (4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.
- (5) The Panel shall not include any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing.

- (6) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(b) Presiding Officer:

- (1) The CMO, in consultation with the President of the Medical Staff, shall appoint a Presiding Officer who shall be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent the Medical Center in any legal matters. The Presiding Officer shall not act as an advocate for either side at the hearing.
- (2) The Presiding Officer shall:
 - (i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
 - (ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, abusive, or that causes undue delay;
 - (iii) maintain decorum throughout the hearing;
 - (iv) determine the order of procedure;
 - (v) rule on all matters of procedure and the admissibility of evidence; and
 - (vi) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.
- (3) The Presiding Officer may be advised by legal counsel to the Medical Center with regard to the hearing procedure.
- (4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(c) Hearing Officer:

- (1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the CMO, after consulting with the President of the Medical Staff and the CEO, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer

may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

- (2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the “Hearing Panel” or “Presiding Officer” shall be deemed to refer to the Hearing Officer.

(d) Objections:

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

(e) Compensation:

The Hearing Panel, Presiding Officer, and/or Hearing Officer may be compensated by the Medical Center, but the individual requesting the hearing may participate in any such compensation should the individual wish to do so.

13.A.7. Counsel:

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

13.B: PRE-HEARING PROCEDURES

13.B.1. General Procedures:

- (a) The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.
- (b) Neither party has the right to issue subpoenas, depose, interrogate, or interview witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process.
- (c) Neither the individual who has requested the hearing, nor any other person acting on behalf of the individual, may contact Medical Center employees or Medical Staff members whose names appear on the Executive Committee’s witness list or in documents provided pursuant to this Article concerning the subject matter of the hearing, until the Medical Center has been notified and has contacted the individuals about their willingness to be interviewed. The Medical Center will advise the individual who has requested the hearing once it has contacted such

employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

13.B.2. Time Frames:

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

- (a) the pre-hearing conference shall be scheduled at least 14 days prior to the hearing;
- (b) the parties shall exchange witness lists and proposed documentary exhibits at least 15 days prior to the pre-hearing conference; and
- (c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

13.B.3. Witness List:

- (a) At least 15 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
- (b) The witness list shall include a brief summary of the anticipated testimony.
- (c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.
- (d) Individuals who agree to serve as witnesses in the hearing must sign confidentiality agreements in which they agree to maintain appropriate peer review confidentiality.

13.B.4. Provision of Relevant Information:

- (a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.
- (b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:
 - (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

- (2) reports of experts relied upon by the Executive Committee;
- (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
- (4) copies of any other documents relied upon by the Executive Committee.

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

- (c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff.
- (d) At least 15 days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses shall be submitted in writing at least five days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause or substantial lack of fairness if the objection is not entertained.
- (e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

13.B.5. Pre-Hearing Conference:

- (a) The Presiding Officer shall require the individual or a representative (who may be counsel) for the individual and for the Executive Committee to participate in a pre-hearing conference, which shall be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination.
- (b) It is expected that the hearing shall last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

13.B.6. Stipulations:

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

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

The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference, (without the need for authentication); and (c) stipulations agreed to by the parties.

13.C: THE HEARING

13.C.1. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing. The matter, along with the recommendation of the Executive Committee, shall be transmitted to the Board for final action.

13.C.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Medical Center. Copies of the transcript shall be available to the individual at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

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

- (a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - (1) to call and examine witnesses, to the extent they are available and willing to testify;
 - (2) to introduce exhibits;
 - (3) to cross-examine any witness on any matter relevant to the issues;
 - (4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and
 - (5) to submit proposed findings, conclusions and recommendations to the Hearing Panel as part of the post-hearing statement referenced later in this Article after the conclusion of the hearing session(s).

- (b) The individual who requested the hearing and who does not testify may be called and questioned.
- (c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

13.C.4. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contain information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

13.C.5. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

13.C.6. Persons to be Present:

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

13.C.7. Postponements and Extensions:

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

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

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

13.D: HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

13.D.1. Order of Presentation:

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

13.D.2. Basis of Hearing Panel Recommendation:

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

13.D.3. Deliberations and Recommendation of the Hearing Panel:

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

13.D.4. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the CMO and the President of the Medical Staff. The CMO shall send, in person or by certified mail, return receipt requested, a copy of the report to the individual who requested the hearing. The CMO shall also provide a copy of the report to the Executive Committee and the CEO.

13.E: APPEAL PROCEDURE

13.E.1. Time for Appeal:

- (a) Within ten business days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the CMO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.
- (b) If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

13.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

- (a) there was substantial failure by the Hearing Panel to comply with these Bylaws during the hearing, so as to deny a fair hearing; and/or

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

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

Whenever an appeal is requested as set forth in the preceding sections, the Chair of the Board shall schedule and arrange for an appeal. The individual shall be given Special Notice of the time, place, and date of the appeal which shall be conducted in closed session. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

13.E.4. Nature of Appellate Review:

- (a) Just like the Medical Staff investigation and hearing process, the appellate review is a component part of the peer review process. As such, its proceedings and activities are confidential and are covered by the peer review protections described in Article 8.
- (b) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Medical Center, to consider the record upon which the recommendation before it was made and recommend final action to the Board.
- (c) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.
- (d) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

13.F: BOARD ACTION

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

- (a) Within 30 days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.

- (b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Executive Committee, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Medical Center and the quality of care provided.
- (c) The Board shall render its final decision in writing, including specific reasons, and shall send Special Notice to the individual. A copy shall also be provided to the Executive Committee for its information.

13.F.2. Further Review:

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

13.F.3. Right to One Hearing and One Appeal Only:

No applicant or member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment, or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

**PART FIVE:
ALLIED HEALTH
PROFESSIONALS**

ARTICLE 14

SCOPE AND OVERVIEW

14.A: SCOPE OF PART

This Part of the Bylaws addresses those Allied Health Professionals who are permitted to provide services at the Broadlawns Medical Center and sets forth the credentialing process and the general practice parameters for Allied Health Professionals, as well as guidelines for determining the need for additional categories of Allied Health Professionals at the Medical Center.

14.B: CATEGORIES OF ALLIED HEALTH PROFESSIONALS

- (1) Only those specific categories of Allied Health Professionals that have been approved by the Board shall be permitted to practice at the Medical Center. All Allied Health Professionals who are addressed in these Bylaws shall be classified as either Category I, Category II, or Category III practitioners.
- (2) Current listings of the specific categories of Allied Health Professionals functioning in the Medical Center as Category I, Category II, and Category III practitioners are attached to these Bylaws as Appendices A, B, and C, respectively. The Appendices may be modified or supplemented by action of the Board after receiving the recommendations of the Credentials Committee and the Executive Committee, without the necessity of further amendment of the Bylaws.

14.C: ADDITIONAL POLICIES

The Board shall adopt a separate policy for each category of Allied Health Professional that it approves to practice in the Medical Center. These separate policies shall supplement these Bylaws and shall address the specific matters set forth in Section 15.B of this Part.

ARTICLE 15

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

15.A: DETERMINATION OF NEED

Whenever an Allied Health Professional in a category that has not been approved by the Board requests permission to practice at the Medical Center, the AHP Committee shall evaluate the need for that particular category of Allied Health Professional and report its findings to the Credentials and Executive Committees. As part of the process of determining need, the Allied Health Professional shall be invited to submit information about the nature of the proposed practice, why Medical Center access is sought, and the potential benefits to the community by having such services available at the Medical Center. The AHP Committee may consider the following factors when making a report to the Credentials and Executive Committees as to the need for the services of this category of Allied Health Professional:

- (1) the nature of the services that would be offered;
- (2) any state license or regulation which outlines the scope of practice the Allied Health Professional is authorized by law to perform;
- (3) any state “non-discrimination” or “any willing provider” laws that would apply to the Allied Health Professional;
- (4) the business and patient care objectives of the Medical Center;
- (5) how well the community’s needs are currently being met and whether they could be better met if the services offered by the Allied Health Professional were provided by the Medical Center or as part of its facilities;
- (6) the type of training that is necessary to perform the services that could be offered and whether there are individuals with more training currently providing those services;
- (7) the availability of supplies, equipment, and other necessary Medical Center resources;
- (8) the need for and availability of trained staff to support the services that would be offered;
- (9) patient convenience; and
- (10) the ability to appropriately supervise performance.

15.B: DEVELOPMENT OF POLICY

If the AHP Committee determines that there is a need for a particular category of Allied Health Professional at the Medical Center, the committee shall recommend to the Credentials and Executive Committees a separate policy for these practitioners that addresses: (1) any specific qualifications and/or training that they must possess beyond those set forth in this Part; (2) a detailed description of their authorized scope of practice or clinical privileges (as applicable); (3) any specific conditions that apply to their functioning within the Medical Center; (4) all supervision requirements, if applicable; and (5) malpractice insurance requirements. In developing such policies, the AHP Committee shall consult the appropriate Department Chair(s) and Section Chief(s) and applicable state law and may contact applicable professional societies or associations. The AHP Committee may also recommend to the Credentials and Executive Committees the number of Allied Health Professionals that are needed in a particular category. Based on the findings of the AHP Committee, the Credentials Committee shall make a recommendation to the Executive Committee which shall, in turn, make a recommendation to the Board.

ARTICLE 16

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

16.A: QUALIFICATIONS

16.A.1. General Qualifications:

To be eligible to apply for initial and continued permission to practice at the Medical Center, an Allied Health Professional must:

- (a) have a current unrestricted Iowa license, certification, or registration to practice his or her profession and have never had a license, certification, or registration revoked or suspended by any state licensing agency;
- (b) when applicable to his or her practice, have a current, unrestricted DEA registration and state controlled substance license;
- (c) be available on a continuous basis, either personally or by arranging appropriate coverage, to (i) respond to the needs of any of their patients who have been admitted to the Medical Center and (ii) respond to Emergency Department patients during those times when they are on call in a prompt, efficient, and conscientious manner. (“Appropriate coverage” means coverage by another member of the Medical Staff with appropriate specialty-specific privileges as determined by the Credentials Committee.) Compliance with this eligibility requirement means that the practitioner must document that he or she is willing and able to:
 - (1) respond within 15 minutes, via phone, to an initial contact from the Medical Center; and
 - (2) appear in person (or via technology-enabled direct communication and evaluation, i.e., telemedicine) to attend to a patient within 60 minutes of being requested to do so (or more quickly as required for a particular specialty as recommended by the Executive Committee and approved by the Board);
- (d) be covered by current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Medical Center;
- (e) have never been convicted of, or pled guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third party payer fraud or program abuse or have been required to pay civil monetary penalties for the same;

- (f) have never been, and not currently be, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health program;
- (g) have never been convicted of, or pled guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;
- (h) have never had clinical privileges or scope of practice denied, revoked, suspended, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (i) have never resigned or relinquished clinical privileges or scope of practice during an investigation or in exchange for not conducting an investigation;
- (j) satisfy all additional eligibility qualifications relating to his or her specific area of practice that may be established by the Medical Center;
- (k) document compliance with all applicable training and/or educational protocols as well as orientation requirements that may be adopted by the Executive Committee, including, but not limited to, those involving electronic medical records, patient safety, and infection control;
- (l) if seeking to practice as a Category II or Category III practitioner, have a supervision agreement with a Supervising Physician/Provider who is appointed to the Medical Staff; and
- (m) satisfy any additional employment requirements that may be in effect at the Medical Center, as applicable.

16.A.2. Factors for Evaluation:

The six general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as applicable, as part of a request for permission to practice, as reflected in the following factors:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients, families, and their profession;

- (c) ability to safely and competently perform the clinical privileges or scope of practice requested;
- (d) good reputation and character;
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, the Medical Center's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

16.A.3. Waiver of Criteria:

- (a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating (i) that he/she is otherwise qualified, and (ii) exceptional circumstances exist (e.g., when there is a demonstrated Medical Center or Medical Staff need for the services in question). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of an applicant.
- (b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee and the Executive Committee, the specific qualifications of the individual in question, and the best interests of the Medical Center and the community it serves. The granting of a waiver in a particular case does not set a precedent for any other individual or group of individuals.
- (c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent recredentialing cycles.
- (d) A determination that an individual is not entitled to a waiver is not a "denial" of permission to practice, clinical privileges, or scope of practice.
- (e) The granting of a waiver in a particular case does not set a precedent for any other individual or group of individuals.
- (f) An application form that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

16.A.4. No Entitlement to Medical Staff Appointment:

Allied Health Professionals shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment. However, Allied Health Professionals may:

- (a) attend department meetings, without vote;
- (b) be appointed to serve on Medical Staff committees;
- (c) participate in the peer review and performance improvement processes; and
- (d) attend Medical Staff and Medical Center educational programs.

16.A.5. Non-Discrimination Policy:

No individual shall be denied permission to practice at the Medical Center on the basis of sex, age, race, creed, or national origin.

16.B: GENERAL CONDITIONS OF INITIAL AND CONTINUED AFFILIATION

16.B.1. Assumption of Duties and Responsibilities:

As a condition of permission to practice at the Medical Center, all Allied Health Professionals (and their Supervising Physicians/Providers, as applicable) shall specifically agree to the following:

- (a) to provide continuous and timely care to all patients in the Medical Center for whom the individual has responsibility;
- (b) to abide by all bylaws and policies of the Medical Center, including all applicable bylaws, policies, rules and regulations of the Medical Staff in force during the time the individual is granted permission to practice in the Medical Center;
- (c) to accept committee assignments, participation in performance improvement, quality monitoring, and peer review activities, and such other reasonable duties and responsibilities as assigned;
- (d) to comply with clinical practice or evidence-based protocols and pathways that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance and then meet with the Medical Staff Leaders or committees to discuss the variance, as requested;

- (e) to comply with clinical practice or evidence-based medicine pathways or protocols pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or to clearly document the clinical reasons for variance and then meet with the Medical Staff Leaders or committees to discuss the variance, as requested;
- (f) to notify the CMO of any change in the practitioner's status or any change in the information provided on the practitioner's application form. This information will be provided with or without request, at the time the change occurs, and will include, but not be limited to:
- changes in licensure or certification status, DEA controlled substance authorization, or professional liability insurance coverage;
 - changes in the practitioner's status at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities;
 - knowledge of a criminal investigation involving the practitioner, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation;
 - exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;
 - any referral to a state board health-related program;
 - any changes in the practitioner's ability to safely and competently exercise clinical privileges, or scope of practice, or to perform the duties and responsibilities of permission to practice because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the practitioner health policy); and
 - any charge of, or arrest for, driving under the influence ("DUI") (Any DUI incident will be reviewed by the President of the Medical Staff and the CMO so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under the physician health policy or these Bylaws);
- (g) to appear for personal interviews as may be requested;
- (h) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

- (i) to refrain from assuming responsibility for diagnoses or care of hospitalized patients for which he or she is not qualified or without adequate supervision;
- (j) to refrain from deceiving patients as to the individual's status as an Allied Health Professional;
- (k) to seek consultation whenever necessary and/or whenever required by the Medical Staff or Departmental Rules and Regulations;
- (l) to abide by generally recognized ethical principles applicable to the individual's profession;
- (m) to participate in the performance improvement and quality monitoring activities of the Medical Center;
- (n) to complete, in a timely manner, the medical and other required records for all patients as required by the Medical Staff bylaws, policies, rules and regulations, and other applicable policies of the Medical Center and to utilize the electronic record as required;
- (o) to work cooperatively and professionally with Medical Staff members, other Allied Health Professionals, nurses, and other Medical Center personnel;
- (p) to satisfy applicable continuing education requirements;
- (q) to participate in an Organized Health Care Arrangement with the Medical Center, to abide by the terms of the Medical Center's Notice of Privacy Practices with respect to health care delivered in the Medical Center, and to provide patients with a Notice of Organized Health Care Arrangement as a supplement to their own Notice of Privacy Practices (as applicable);
- (r) to strictly comply with the standards of practice applicable to the functioning of Category II practitioners in the inpatient hospital setting, as set forth in Section 18.A of these Bylaws;
- (s) to immediately submit to an appropriate evaluation which may include diagnostic testing (such as blood and/or urine test) or to a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the administrative team) are concerned with the individual's ability to safely and competently care for patients and request such testing and/or evaluation. The health care professional(s) to perform the testing and/or evaluations will be determined by the Medical Staff Leaders, and the Allied Health Professional will execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders. The evaluation must be completed within the time frame required by the individuals requiring the evaluation;

- (t) to comply with all applicable training and/or educational protocols as well as orientation requirements that may be adopted by the Executive Committee, including, but not limited to, those involving electronic medical records, patient safety, and infection control;
- (u) to maintain a current e-mail address with Medical Staff Services, which will be the official mechanism used to communicate all information to the individual other than peer review information pertaining to the individual and/or protected health information of patients; and
- (v) that, if there is any misstatement in, or omission from, the application, the Medical Center may stop processing the application (or, if permission to practice has been granted prior to the discovery of a misstatement or omission, the permission may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to the procedural rights provided in this Part. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration. If the determination is made to not process an application or that appointment and privileges should be automatically relinquished pursuant to this provision, the individual may not reapply to the Medical Staff for a period of at least two years.

16.B.2. Burden of Providing Information:

- (a) Allied Health Professionals shall have the burden of producing information deemed adequate by the Medical Center for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.
- (b) These individuals have the burden of providing evidence that all the statements made and information given on the application are accurate.
- (c) Complete Application: An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (d) It is the responsibility of the individual seeking permission to practice to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

16.C: APPLICATION

16.C.1. Application Form:

- (a) The application forms for both initial and renewed permission to practice as an Allied Health Professional shall require detailed information concerning the applicant's professional qualifications. The Allied Health Professional applications existing now and as may be revised are incorporated by reference and made a part of this Part. In addition to other information, the applications shall seek the following:
- (1) information as to whether the applicant's clinical privileges, scope of practice, permission to practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, denied, revoked, suspended, reduced, subjected to probationary or other conditions, or not renewed at any hospital or health care facility;
 - (2) information as to whether the applicant's license or certification to practice any profession in any state, or Drug Enforcement Administration registration or state controlled substance license (if applicable), is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being investigated or challenged;
 - (3) information as to whether the individual has opted out of any federal health care program, as well as the results of a query to the System for Award Management;
 - (4) information concerning the applicant's malpractice litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the Medical Center may deem appropriate;
 - (5) information regarding the applicant's ability to perform, safely and competently, the scope of practice or clinical privileges requested and the duties of Allied Health Professionals; and
 - (6) a copy of U.S. government-issued photo identification.
- (b) The applicant shall sign the application and certify that he or she is able to perform the scope of practice or clinical privileges requested and the responsibilities of Allied Health Professionals.

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

By requesting an application and/or applying for permission to practice, the individual expressly accepts the following conditions:

(a) Immunity:

To the fullest extent permitted by law, the Allied Health Professional releases from any and all liability, extends absolute immunity to, and agrees not to sue the Medical Center, any member of the Medical Staff, their authorized representatives, and third parties who provide information for any matter relating to permission to practice, clinical privileges, scope of practice at the Medical Center, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Medical Center, its authorized agents, or appropriate third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The Allied Health Professional specifically authorizes the Medical Center, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the Allied Health Professional's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for permission to practice at the Medical Center, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The Allied Health Professional also specifically authorizes third parties to release this information to the Medical Center and its authorized representatives upon request. If applicable, the Allied Health Professional also agrees to sign any necessary authorizations to permit a consumer reporting agency to conduct a criminal background check and report the results to the Medical Center.

(c) Authorization to Release Information to Third Parties:

The Allied Health Professional also authorizes Medical Center representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, permission to practice, scope of practice, and/or participation status at the requesting organization/facility, and any license or regulatory matter.

(d) Procedural Rights:

The Allied Health Professional agrees that the procedural rights set forth in this Part shall be the sole and exclusive remedy with respect to any professional review action taken by the Medical Center.

(e) Legal Actions:

If, notwithstanding the provisions in this Section, an Allied Health Professional institutes legal action challenging any credentialing, privileging, peer review, or other action and does not prevail, he or she shall reimburse the Medical Center and any of its authorized representatives named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(f) Scope of Section:

All of the provisions in this Section are applicable in the following situations:

- (1) whether or not permission to practice, clinical privileges, or scope of practice is granted;
- (2) throughout the term of any affiliation with the Medical Center and thereafter;
- (3) should permission to practice, clinical privileges, or scope of practice be denied, revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Medical Center's professional review activities; and
- (4) as applicable, to any third-party inquiries received after the individual leaves the Medical Center about his or her tenure as a member of the Allied Health Professional Staff.

16.D: ACCESS TO INFORMATION BY INDIVIDUALS

- (1) Upon request, applicants will be informed of the status of their applications for appointment, clinical privileges, or scope of practice.
- (2) Except during the hearing and appeal processes, which are governed by Articles 13 and 18 of these Bylaws, an individual may review information obtained or maintained by the Medical Center only upon request and only if the identity of the individual who provided the information will not be revealed.
- (3) If an individual disputes any information obtained or maintained by the Medical Center, the individual may submit, in writing, a correction or clarification of the relevant information which will be maintained in the individual's file.

ARTICLE 17

CREDENTIALING PROCEDURE

17.A: PROCEDURE FOR INITIAL CREDENTIALING

17.A.1. Request and Initial Review of Application:

- (a) Applications seeking permission to practice as an Allied Health Professional at the Medical Center shall be in writing and shall be on forms approved by the Credentials Committee.
- (b) An individual seeking permission to practice shall be sent a letter that outlines the threshold eligibility criteria and the application form.
- (c) A completed application, with copies of all required documents, must be submitted to the Medical Staff Services Department within 30 days after receipt of the application if the Allied Health Professional desires further consideration. The application must be accompanied by the application processing fee.
- (d) As a preliminary step, the application will be reviewed by the CMO (or designee) to determine that all questions have been answered and that the individual satisfies all threshold criteria. Individuals who fail to return completed applications or fail to meet the eligibility criteria set forth in Section 16.A.1 of these Bylaws will be notified that they are not eligible for permission to practice at the Medical Center and that their application will not be processed. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 20 of these Bylaws.
- (e) After the CMO (or designee) reviews the application to determine that all questions have been answered, all references and other information or materials have been received, and pertinent information provided on the application form has been verified by primary sources, the CMO (or designee) shall transmit the completed application (along with all supporting materials) to the appropriate Section Chief or Department Chair.

17.A.2. Review by Section Chief or Department Chair:

- (a) The primary duty to evaluate applications is delegated to the Section Chief. In the absence of a Section Chief, this evaluation will be completed by the Department Chair.
- (b) The Section Chief or Department Chair shall evaluate the applicant's education, training, and experience and provide the Chair of the Credentials Committee with a written report concerning the applicant's qualifications for the requested scope of

practice or clinical privileges. As part of the process of making this report, the Section Chief or Department Chair has the right to meet with the applicant and the employing or Supervising Physician/Provider (if applicable) to discuss any aspect of the application, qualifications, and requested scope of practice or clinical privileges. The Section Chief or Department Chair may also confer with experts within the department and outside of the department in preparing the report (e.g., other physicians; relevant Medical Center department or section heads; nurse managers).

17.A.3. Credentials Committee Procedure:

- (a) The Credentials Committee shall review the report from the appropriate Section Chief or Department Chair and the information contained in references given by the applicant and from other available sources. The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges or scope of practice requested.
- (b) The Credentials Committee may use the expertise of any individual on the Medical Staff, or an outside consultant, if additional information is required regarding the applicant's qualifications. The Credentials Committee may also meet with the applicant and, when applicable, the Supervising Physician/Provider. The appropriate Section Chief or Department Chair may participate in this interview.
- (c) After determining that an applicant is otherwise qualified for permission to practice and the scope of practice or clinical privileges requested, the Credentials Committee shall review the applicant's Health Questionnaire to determine if there is any question about the applicant's ability to perform the scope of practice or privileges requested and the responsibilities of permission to practice. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered an incomplete application and all processing of the application shall cease.
- (d) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of education requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

- (e) The Credentials Committee shall forward its recommendations, along with the application and all supporting materials, to the Executive Committee for review and recommendation to the Board.

17.A.4. Executive Committee Procedure:

- (a) After considering the Credentials Committee's recommendation and the Section Chief's or Department Chair's report, the Executive Committee shall:
 - (1) adopt the findings and recommendations of the Credentials Committee as its own; or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Executive Committee prior to its final recommendation; or
 - (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation. Thereafter, the Executive Committee's recommendation shall be forwarded, together with the Credentials Committee's findings and recommendations, through the CEO to the Board.
- (b) If the Executive Committee's recommendation is favorable to the applicant, the Committee shall forward its recommendation to the Board, including the findings and recommendation of the Section Chief or Department Chair and Credentials Committee. The Executive Committee's recommendation must specifically address the clinical privileges or scope of practice requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges or scope of practice.
- (c) If the Executive Committee's recommendation is that the applicant not be granted permission to practice at the Medical Center, the applicant and, when applicable, the supervising physician shall be entitled to the procedural rights outlined in Article 20 of this Part before the Executive Committee's recommendation is considered by the Board.

17.A.5. Board Action:

- (a) Expedited Review. The Board may delegate to a committee, consisting of at least two Board members, action on applications if there has been a favorable recommendation from the Credentials Committee and the Executive Committee (or their designees) and there is no evidence of any of the following:
 - (1) a current or previously successful challenge to any license, certification, or registration;

- (2) an involuntary termination, limitation, reduction, denial, or loss of permission to practice, clinical privileges, or scope of practice at any other hospital or other entity; or
- (3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board committee to appoint and grant the clinical privileges or scope of practice requested shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

- (b) Full Board Review. When there has been no delegation to a Board committee, upon receipt of a recommendation that the applicant be granted permission to practice and clinical privileges or scope of practice requested, the Board may:
 - (1) grant the applicant permission to practice and clinical privileges or scope of practice as recommended; or
 - (2) refer the matter back to the Credentials Committee or Executive Committee or to another source inside or outside the Medical Center for additional research or information; or
 - (3) reject or modify the recommendation.
- (c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the President of the Medical Staff. If the Board's determination remains unfavorable to the applicant, the CMO shall promptly send Special Notice to the applicant that the applicant is entitled to request the procedural rights as outlined in Article 20 of this Part.
- (d) Any final decision by the Board to grant, deny, revise, or revoke permission to practice and/or clinical privileges or scope of practice will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

17.B. CLINICAL PRIVILEGES

17.B.1. General:

The clinical privileges recommended to the Board for Category I and Category II practitioners will be based upon consideration of the following factors:

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

- (b) ability to perform the privileges requested competently and safely;
- (c) information resulting from ongoing and focused professional practice evaluation and performance improvement activities, as applicable;
- (d) adequate professional liability insurance coverage for the clinical privileges requested;
- (e) the Medical Center's available resources and personnel;
- (f) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
- (g) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
- (h) practitioner-specific data as compared to aggregate data, when available;
- (i) morbidity and mortality data, when available; and
- (j) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

17.B.2. Focused Professional Practice Evaluation:

All new clinical privileges for Category I and Category II practitioners, regardless of when they are granted (initial permission to practice, renewal of permission to practice, or at any time in between), will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in the Peer Review Plan.

17.C. TEMPORARY CLINICAL PRIVILEGES

17.C.1. Request for Temporary Clinical Privileges:

- (a) Applicants: Temporary privileges for an applicant for initial permission to practice may be granted by the CEO, upon recommendation of the CMO, the President of the Medical Staff, the Chair of the Credentials Committee, and the Department Chair and/or Section Chief, when a Category I or Category II practitioner has submitted a completed application and the application is pending review by the Executive Committee and the Board. Prior to temporary privileges being granted in this situation, the credentialing process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current

competence, ability to exercise the privileges requested, and compliance with criteria, and consideration of information from the National Practitioner Data Bank and from a criminal background check. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility.

- (b) Locum Tenens: The CEO, upon recommendation of the CMO, the President of the Medical Staff, the Chair of the Credentials Committee, and the Department Chair and/or Section Chief, may grant temporary privileges to a Category I or Category II practitioner serving as a locum tenens for an individual who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time. Prior to temporary privileges being granted in this situation, the verification process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and compliance with criteria, and consideration of information from the National Practitioner Data Bank and from a criminal background check. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility.
- (c) Bylaws: Prior to temporary privileges being granted, the individual must agree in writing to be bound by all applicable bylaws, rules and regulations, and policies, procedures, and protocols.
- (d) Automatic Expiration: Temporary privileges will be granted for a specific period of time, not to exceed 120 days, and will automatically expire at the end of the time period for which they are granted.

17.C.2. Withdrawal of Temporary Clinical Privileges:

The CEO may, at any time after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, the Department Chair or Section Chief, or the CMO, withdraw temporary privileges for any reason.

17.D: PROCESSING APPLICATIONS FOR RENEWAL TO PRACTICE

17.D.1. Submission of Application:

- (a) Permission to practice at the Medical Center as an Allied Health Professional is a courtesy extended by the Board and, if granted, shall be for a period not to exceed

two years. A request to renew clinical privileges or scope of practice shall be considered only upon submission of a completed renewal application.

- (b) Failure to submit an application at least two months prior to the expiration of the individual's current term shall result in automatic expiration of clinical privileges or scope of practice at the end of the then current term, unless the application can still be processed in the normal course, without extraordinary effort on the part of Medical Staff Services and the Medical Staff Leaders.
- (c) Once an application for renewal of permission to practice has been completed and submitted to Medical Staff Services, it shall be evaluated in the same manner and follow the same procedures outlined in Section 17.A of this Part regarding initial applications.

17.D.2. Renewal Process for Category I and Category II Practitioners:

- (a) The procedures pertaining to an initial request for clinical privileges, including eligibility criteria and factors for evaluation, will be applicable in processing requests for renewal for these practitioners.
- (b) As part of the process for renewal of clinical privileges, the following factors will be considered:
 - (1) an assessment prepared by the applicable Section Chief or Department Chair and documented on a biennial evaluation form;
 - (2) an assessment prepared by a peer, if possible;
 - (3) results of the Medical Center's performance improvement and ongoing and focused professional practice evaluation activities, taking into consideration, when applicable, practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);
 - (4) resolution of any verified complaints received from patients or staff; and
 - (5) any focused professional practice evaluations.
- (c) For Category II practitioners, the following also apply in the renewal process:
 - (1) an assessment must be prepared by the Supervising Physician/Provider(s); and
 - (2) when possible, an assessment will also be prepared by the applicable Medical Center supervisor (i.e., OR Supervisor, Nursing Supervisor) documented on a biennial evaluation form.

17.D.3. Renewal Process for Category III Practitioners:

- (a) The procedures pertaining to an initial request for a scope of practice, including eligibility criteria and factors for evaluation, will be applicable in processing requests for renewal for these practitioners.
- (b) As part of the process for renewal of scope of practice, the following factors will be considered:
 - (1) the annual competency assessments of the individual performed by the Supervising Physician/Provider(s) and/or the applicable Medical Center department heads (i.e., OR Supervisor, Nursing Supervisor); and
 - (2) resolution of any validated complaints received from patients or staff.

ARTICLE 18

CONDITIONS OF PRACTICE APPLICABLE TO CATEGORY II AND CATEGORY III PRACTITIONERS

18.A: STANDARDS OF PRACTICE FOR THE UTILIZATION OF CATEGORY II PRACTITIONERS IN THE INPATIENT MEDICAL CENTER SETTING

- (1) Category II practitioners are not permitted to function independently in the inpatient Medical Center setting. As a condition of being granted permission to practice at the Medical Center, all Category II practitioners specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of Category II practitioners in the Medical Center, all Medical Staff members who serve as Supervising Physicians/Providers to such individuals also specifically agree to abide by the standards set forth in this Section.
- (2) The following standards of practice apply to the functioning of Category II practitioners in the inpatient Medical Center setting:
 - (a) Exercise of Clinical Privileges. Category II practitioners may exercise those clinical privileges as have been granted pursuant to their approved delineation of clinical privileges, which delineations specify the requisite levels of supervision that apply to their privileges (general, direct, or personal, as defined in these Bylaws), of which only “personal” supervision requires the actual physical presence of the Supervising Physician/Provider.
 - (b) Admitting Privileges. Category II practitioners are not granted inpatient admitting privileges and therefore may not admit patients independent of the Supervising Physician/Provider.
 - (c) Consultations. Category II practitioners may not independently provide patient consultations in lieu of the practitioners’ Supervising Physicians/Providers. A Category II practitioner may gather data and order tests; however, the Supervising Physician/Provider must personally perform the requested consultation within 24 hours (or more timely in the case of any emergency consultation request).
 - (d) Emergency On-Call Coverage. Category II practitioners may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Physicians/Providers), in lieu of the Supervising Physician/Provider. It shall be within the discretion of the Medical Center personnel requesting assistance whether it is appropriate to contact a Category II practitioner prior to the Supervising Physician/Provider. However, when contacted by the Emergency Department, the Supervising Physician/Provider (or his or her covering

physician) must personally respond to all calls in a timely manner. Following discussion with the Emergency Department, the Supervising Physician/Provider may direct a Category II practitioner to see the patient, gather data, and order tests for further review by the Supervising Physician/Provider. However, the Supervising Physician/Provider must personally see the patient when requested by the Emergency Department physician.

- (e) Calls Regarding Supervising Physician/Provider's Hospitalized Inpatients. It shall be within the discretion of the Medical Center personnel requesting assistance whether it is appropriate to contact a Category II practitioner prior to the Supervising Physician/Provider. However, the Supervising Physician/Provider must personally respond to all calls directed to him or her in a timely manner. Category II practitioners may not independently respond to calls from the floor or special care units regarding hospitalized inpatients that were specifically directed to the Supervising Physician/Provider.
- (f) Daily Inpatient Rounds. Category II practitioners may not independently perform daily inpatient rounds in lieu of their Supervising Physicians/Providers. A Category II practitioner is permitted to perform daily inpatient rounds; however, all inpatients must also be visited daily by the Supervising Physician/Provider (or a designated physician).

Exceptions to the above Standards of Practice may be granted by the Executive Committee to a practitioner in a particular clinical situation, upon demonstration of good cause shown. When the Executive Committee grants such an exception, the committee will follow the same process as set forth in Section 16.A.3 of these Bylaws.

18.B: SUPERVISION BY SUPERVISING PHYSICIAN/PROVIDER

- (1) Any activities permitted by the Board to be done at the Medical Center by a Category II or Category III practitioner shall be done only under the supervision of the Supervising Physician/Provider.
- (2) Category II or Category III practitioners may function in the Medical Center only so long as (i) they are supervised by a Supervising Physician/Provider who is appointed to the Medical Staff, and (ii) they have a current, written supervision agreement with that individual. In addition, should the Medical Staff appointment or clinical privileges of the Supervising Physician/Provider be revoked or terminated, the individual's permission to practice at the Medical Center and clinical privileges or scope of practice shall be automatically relinquished (unless the individual will be supervised by another individual appointed to the Medical Staff).

- (3) As a condition for permission to practice at the Medical Center, each Category II or Category III practitioner and his/her Supervising Physician/Provider must submit a copy of their written supervision agreement to the Medical Center. This agreement must meet the requirements of any applicable Iowa statutes and regulations, as well as any additional requirements of the Medical Center. It is also the responsibility of the Category II or Category III practitioner and his/her Supervising Physician/Provider to provide the Medical Center, in a timely manner, with any revisions or modifications that are made to any such agreement.

18.C: QUESTIONS REGARDING AUTHORITY OF A CATEGORY II OR CATEGORY III PRACTITIONER

- (1) Should any Medical Staff member or Medical Center employee who is licensed or certified by the state have any question regarding the clinical competence or authority of a Category II or Category III practitioner either to act or to issue instructions outside the physical presence of the Supervising Physician/Provider in a particular instance, the Medical Staff member or Medical Center employee shall have the right to require that the Category II or Category III practitioner's employer or supervisor validate, either at the time or later, the instructions of the Category II or Category III practitioner. Any act or instruction of the Category II or Category III practitioner shall be delayed until such time as the staff member or Medical Center employee can be certain that the act is clearly within the scope of the individual's permitted activities. In these situations, the Medical Staff member or Medical Center employee shall first discuss the matter with the Supervising Physician/Provider. If that does not resolve the matter, the President of the Medical Staff will be contacted.
- (2) Any question regarding the clinical practice or professional conduct of a Category II or Category III practitioner shall be reported to the Chair of the Credentials Committee, the Chair of the relevant department or Chief of the relevant section, the CMO or the CEO, who shall undertake such action as may be appropriate under the circumstances. The individual to whom the concern has been reported will also discuss the matter with the Supervising Physician/Provider.

18.D: RESPONSIBILITIES OF SUPERVISING PHYSICIAN/PROVIDER

- (1) Physicians who wish to utilize the services of a Category II or Category III practitioner in their clinical practice at the Medical Center must notify Medical Staff Services of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with these Bylaws before the Category II or Category III practitioner participates in any clinical or direct patient care of any kind in the Medical Center.
- (2) The Supervising Physician/Provider shall be responsible for the actions of the Category II or Category III practitioner in the Medical Center.

- (3) Supervising Physicians/Providers who wish to utilize the services of Category II practitioners in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 18.A above.
- (4) The number of Category II or Category III practitioners acting under the supervision of a Supervising Physician/Provider, as well as the acts they may undertake, shall be consistent with applicable Iowa statutes and regulations, the rules and regulations of the Medical Staff, and the policies of the Board. The Supervising Physician/Provider will make all appropriate filings with the Iowa Board of Medicine regarding the supervision and responsibilities of the Category II or Category III practitioner, to the extent that such filings are required, and shall provide a copy of the same to Medical Staff Services.
- (5) Unless provided by the Medical Center, it shall be the responsibility of the physician employing or supervising the Category II or Category III practitioner to provide, or to arrange for, professional liability insurance coverage for the Category II or Category III practitioner in amounts required by the Board (or its designated committee) that covers any activities of the Category II or Category III practitioner at the Medical Center, and to furnish evidence of such coverage to the Medical Center. The Category II or Category III practitioner shall act at the Medical Center only while such coverage is in effect.

ARTICLE 19

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING ALLIED HEALTH PROFESSIONALS

19.A: COLLEGIAL INTERVENTION

- (1) As part of the Medical Center's performance improvement and professional practice evaluation activities, these Bylaws encourage the use of collegial efforts and progressive steps with Allied Health Professionals (and their Supervising Physicians/Providers, as applicable) by Medical Staff Leaders and Medical Center management in order to arrive at voluntary, responsive actions by individuals to resolve questions that have been raised. Collegial intervention efforts are not mandatory and shall be within the discretion of the appropriate Medical Staff Leaders.
- (2) Collegial intervention efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education. All such efforts shall be documented in an individual's confidential file.
- (3) Collegial intervention efforts are a part of the Medical Center's ongoing and focused professional practice evaluation activities.
- (4) The President of the Medical Staff, in conjunction with the CEO, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., professionalism policy; practitioner health policy; professional practice evaluation policy) or to direct the matter to the Executive Committee for further review and/or investigation.

19.B: ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATIONS

All ongoing and focused professional practice evaluations shall be conducted in accordance with the Medical Center's Peer Review Plan. Matters that are not satisfactorily resolved through collegial intervention or through the Peer Review Plan shall be referred to the Executive Committee for its review in accordance with Section 19.C below. Such interventions and evaluations, however, are not mandatory prerequisites to Executive Committee review.

19.C: INVESTIGATIONS

19.C.1. Initiation of Investigation:

When a question involving clinical competence or professional conduct of an Allied Health Professional is referred to, or raised by, the Executive Committee, the Executive

Committee will review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy, or to proceed in another manner.

19.C.2. Investigative Procedure:

- (a) The Executive Committee will either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation (“investigating committee”). The investigating committee will not include relatives or financial partners of the Allied Health Professional or, where applicable, the Allied Health Professional’s Supervising Physician/Provider.
- (b) The investigating committee will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Medical Center.
- (c) The investigating committee will also have the authority to use outside consultants, if needed.
- (d) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by a health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual.
- (e) The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. No recording (audio or video) or transcript of the meeting shall be permitted or made. A summary of the interview will be prepared. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual being investigated will not have the right to be represented by legal counsel at this meeting.
- (f) The investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve only as guidelines.

- (g) At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.

19.C.3. Recommendation:

- (a) The Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Executive Committee may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose conditions for continued permission to practice;
 - (4) impose a requirement for monitoring, proctoring, or consultation;
 - (5) impose a requirement for additional training or education;
 - (6) recommend reduction of clinical privileges or scope of practice;
 - (7) recommend suspension of clinical privileges or scope of practice for a term;
 - (8) recommend revocation of clinical privileges or scope of practice; or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the Executive Committee that would entitle the individual to request a hearing will be forwarded to the CEO, who will promptly inform the individual by Special Notice. The CEO will hold the recommendation until after the individual has completed or waived a hearing and appeal.
- (c) If the Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.

19.D: ADMINISTRATIVE SUSPENSION

- (1) The Executive Committee, or the President of the Medical Staff, a Department Chair, or a Section Chief, acting in conjunction with the CMO or the CEO, shall each have the authority to impose an administrative suspension of all or any portion of the scope of practice or clinical privileges of any Allied Health Professional whenever a concern has been raised about such individual's clinical practice or conduct.

- (2) An administrative suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO and the President of the Medical Staff, and shall remain in effect unless or until modified by the CEO or the Executive Committee.
- (3) Upon receipt of notice of the imposition of an administrative suspension, the CEO and the President of the Medical Staff shall forward the matter to the full Executive Committee, which shall review and consider the question(s) raised and thereafter make an appropriate recommendation to the Board. If the Executive Committee's recommendation is to restrict or terminate the Allied Health Professional's scope of practice or clinical privileges, the individual and, when applicable, the supervising physician shall be entitled to the procedural rights outlined in Article 20 before the Executive Committee's recommendation is considered by the Board.

19.E: AUTOMATIC RELINQUISHMENT OF SCOPE OF PRACTICE OR CLINICAL PRIVILEGES

- (1) An Allied Health Professional's clinical privileges or scope of practice shall be automatically relinquished, without entitlement to the procedural rights outlined in Article 20, in the following circumstances:
 - (a) the Medical Staff appointment or clinical privileges of a Supervising Physician/Provider supervising a Category II or Category III practitioner are revoked or terminated for any reason (unless the Category II or Category III practitioner will be supervised by another Medical Staff member);
 - (b) a Category II or Category III practitioner ceases to be supervised by a physician currently appointed to the Medical Staff for any reason (unless the Category II or Category III practitioner will be supervised by another Medical Staff member);
 - (c) an Allied Health Professional's license, certification, or registration expires, is revoked, or is suspended or restricted;
 - (d) the Allied Health Professional no longer satisfies any of the threshold eligibility criteria set forth in Section 16.A.1 or any additional threshold credentialing qualification set forth in the specific Medical Center policy relating to his or her discipline;
 - (e) the Allied Health Professional is arrested, charged, indicted, convicted, or enters a plea of guilty or no contest to, any felony; or to any misdemeanor related to or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another (DUIs will be addressed in the manner outlined in Section 16.B.1(f) of these Bylaws);

- (f) the Allied Health Professional fails to provide information pertaining to his or her qualifications for the scope of practice or clinical privileges in response to a written request from the Credentials Committee, the Executive Committee, the President, or any other committee authorized to request such information;
 - (g) a determination is made by the Board, in consultation with the Executive Committee, that there is no longer a need for the services that are being provided by the Allied Health Professional; or
 - (h) any Allied Health Professional employed by or contracted with the Medical Center has his or her employment terminated.
- (2) Requests for Reinstatement.
- (a) Requests for reinstatement following the expiration of a license/certification/registration, controlled substance authorization, and/or insurance coverage will be processed by Medical Staff Services. If any questions or concerns are noted, Medical Staff Services will refer the matter for further review in accordance with (b) below.
 - (b) All other requests for reinstatement will be reviewed by the President of the Medical Staff, Section Chief, and the CMO. If these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Medical Center. This determination will then be forwarded to the Credentials Committee, the Executive Committee, and the Board for ratification. If, however, any of these individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Executive Committee, and Board for review and recommendation.

19.F: LEAVE OF ABSENCE

- (1) An Allied Health Professional may request a leave of absence, for a period not to exceed a year, by submitting a written request to the CMO. The CMO will determine whether a request for a leave of absence shall be granted.
- (2) Allied Health Professionals must report to the CMO any time they are away from patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the CMO, in consultation with the Chair of the Credentials Committee, may trigger an automatic leave of absence.

- (3) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Medical Center at least 30 days prior to the conclusion of the leave of absence. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges or scope of practice requested and the request shall be processed in accordance with the physician health policy.
- (4) Requests for reinstatement shall then be reviewed by the relevant Department Chair, the Section Chief, the Chair of the Credentials Committee, the CMO, and the CEO. If all these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Medical Center. This determination shall then be forwarded to the Credentials Committee, the Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Executive Committee, and Board for review and recommendation. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to the procedural rights set forth in Article 20 of this Part.

ARTICLE 20

PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

20.A: GENERAL

Allied Health Professionals shall not be entitled to the hearing and appeals procedures set forth in Article 13 of these Bylaws. Any and all procedural rights to which these individuals are entitled are set forth in this Article 20.

20.B: PROCEDURAL RIGHTS FOR EMPLOYED ALLIED HEALTH PROFESSIONALS

- (1) Except as provided in (2), any and all issues related to disciplinary matters involving Category I, Category II, or Category III practitioners who are employed by the Medical Center shall be handled in accordance with applicable Human Resources grievance procedures and/or the terms of any applicable employment contract.
- (2) If the disciplinary action in question is recommended by the Medical Staff, the provisions of this Article 20 shall be followed and a report provided to Human Resources.

20.C: PROCEDURAL RIGHTS FOR CATEGORY III PRACTITIONERS

The procedural rights for Category III practitioners who are not employed by the Medical Center shall be as follows:

- (1) In the event that a recommendation is made by the Executive Committee that a Category III practitioner not be granted the scope of practice requested or that a scope of practice previously granted be restricted or terminated, the individual shall be notified of the recommendation. The notice shall include a specific statement of the reasons for the recommendation and shall advise the individual that he or she may request a meeting with the Executive Committee before its recommendation is forwarded to the Board for final action.
- (2) If the Category III practitioner desires to request a meeting, he or she must make such request in writing and direct it to the CMO within 30 days after receipt of the written notice of the adverse recommendation.
- (3) If a meeting is requested in a timely manner, it shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The Category III practitioner and his or her Supervising Physician/Provider shall both be permitted to attend and participate in the meeting. However, no counsel for either the Category III practitioner or the Executive Committee shall be present.

- (4) Following this meeting, the Executive Committee shall make its final recommendation to the Board.

20.D: PROCEDURAL RIGHTS FOR CATEGORY I AND CATEGORY II PRACTITIONERS

20.D.1. Pre-Hearing Procedures:

- (a) In the event that a recommendation is made by the Executive Committee that a non-Medical Center employed Category I or Category II practitioner not be granted the clinical privileges requested, or that the clinical privileges previously granted be restricted for more than 30 days or terminated, the practitioner will receive Special Notice of the recommendation. The notice shall include the specific reasons for the recommendation and shall advise the individual that he or she may request a hearing before the adverse recommendation is transmitted to the Board for final action.
- (b) The rights and procedures in this Section will also apply if the Board, without a prior adverse recommendation from the Executive Committee, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted for more than 30 days, terminated, or not renewed. In this instance, all references in this Section to the Executive Committee will be interpreted as a reference to the Board.
- (c) If the Category I or Category II practitioner desires to request a hearing, he or she must make such request in writing and direct it to the CMO within 30 days after receipt of the written notice of the adverse recommendation.
- (d) The hearing will be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.
- (e) If a request for a hearing is made in a timely manner, the CMO, in conjunction with the President of the Medical Staff, shall appoint an Ad Hoc Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Allied Health Professionals, Medical Center management, individuals not connected to the Medical Center, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Medical Center. The Ad Hoc Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Category I or Category II practitioner, or any competitors of the affected individual.
- (f) As an alternative to the Ad Hoc Committee described in paragraph (c) of this Section, the CMO, in conjunction with the President of the Medical Staff, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Ad Hoc Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition

with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of an Ad Hoc Committee, all references in this Article to the Ad Hoc Committee shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

- (g) The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

20.D.2. Hearing Process for Category I and Category II Practitioners:

- (a) A record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the individual's expense.
- (b) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.
- (c) At the hearing, a representative of the Executive Committee will first present the reasons for the recommendation. The Category I or Category II practitioner will be invited to present information to refute the reasons for the recommendation.
- (d) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.
- (e) The Category I or Category II practitioner and the Executive Committee may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.
- (f) The Category I or Category II practitioner will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the Executive Committee was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Medical Center will be the paramount considerations.
- (g) The Category I or Category II practitioner and the Executive Committee will have the right to prepare a post-hearing memorandum for consideration by the Ad Hoc Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

20.D.3. Ad Hoc Committee Report:

- (a) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Ad Hoc Committee will prepare a written report and recommendation. The Ad Hoc Committee will forward the report and recommendation, along with all supporting information, to the CEO. The CEO will send a copy of the written report and recommendation by Special Notice to the Category I or Category II practitioner and to the Executive Committee.
- (b) Within ten days after notice of such recommendation, the Category I or Category II practitioner and/or the Executive Committee may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.
- (c) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with these Bylaws during the hearing, so as to deny a fair hearing, and/or that the recommendation of the Ad Hoc Committee was arbitrary, capricious, or not supported by substantial evidence.
- (d) The request for an appeal will be delivered to the CEO by Special Notice.
- (e) If a written request for appeal is not submitted within the ten-day time frame, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the CEO will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board will arrange for an appeal.

20.D.4. Appellate Review:

- (a) An Appellate Review Committee appointed by the Chair of the Board will consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Ad Hoc Committee may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 days after receiving the request for appeal.
- (b) The Category I or Category II practitioner and the Executive Committee will each have the right to present a written statement on appeal.
- (c) At the sole discretion of the Appellate Review Committee, the Category I or Category II practitioner and a representative of the Executive Committee may also appear personally to discuss their position.
- (d) Upon completion of the review, the Appellate Review Committee will provide a report and recommendation to the full Board for action. The Board will then make

its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Medical Center.

- (e) The Category I or Category II practitioner will receive Special Notice of the Board's action. A copy of the Board's final action will also be sent to the Executive Committee for information.

ARTICLE 21

EMPLOYED ALLIED HEALTH PROFESSIONALS

- (a) A request for clinical privileges, on an initial basis or for renewal, submitted by a Category I or Category II practitioner who is seeking employment or who is employed by the Medical Center will be processed in accordance with the terms of Article 17 of this Part. The findings of the Board regarding each Allied Health Professional's qualifications will be forwarded to the Credentials Committee for informational purposes and to Medical Center management personnel or the Department of Human Resources (as appropriate) to assist the Medical Center in making employment decisions.
- (b) Except as provided in paragraph (c) below, any disciplinary concern or action with respect to an employed Allied Health Professional will be governed by the Medical Center's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. If an Allied Health Professional's employment is terminated by the Medical Center for any reason, the individual's permission to practice in the Medical Center will automatically expire without any procedural rights set forth in Article 20 of this Part.
- (c) If a concern about an employed Allied Health Professional's clinical competence or conduct originates with the Medical Staff, the concern will be reviewed and addressed in accordance with Articles 19 and 20 of this Part, after which a report will be provided to the Department of Human Resources.
- (d) Except as otherwise provided above, to the extent that the Medical Center's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Part of the Bylaws, the employment policies, manuals, and descriptions and terms of the individual's employment relationship and/or written contract will apply.

PART SIX:

**AMENDMENT, ADOPTION,
AND MEDICAL STAFF RULES
AND REGULATIONS**

ARTICLE 22

OTHER MEDICAL STAFF DOCUMENTS

22.A: MEDICAL STAFF RULES AND REGULATIONS

- (1) The Medical Staff Rules and Regulations shall be amended in the same manner as the Medical Staff Bylaws.
- (2) The present Rules and Regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with this Article. To the extent they are inconsistent, they are of no force and effect.

22.B: MEDICAL STAFF POLICIES

- (1) All other policies of the Medical Staff may be adopted and amended by a majority vote of the Executive Committee. No prior notice is required.
- (2) Amendments to Medical Staff policies may also be proposed by a petition signed by at least 10% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the Executive Committee, which may comment on the amendments before they are forwarded to the Board for its final action.

ARTICLE 23

AMENDMENTS

23.A: MEDICAL STAFF BYLAWS

- (1) Amendments to these Bylaws may be proposed by the Executive Committee or by a petition signed by at least 10% of the Active Staff.
- (2) In the discretion of the Executive Committee, amendments to the Bylaws shall be presented to the Medical Staff in one of the following two ways:
 - (a) Amendments Subject to Vote at a Meeting: The Executive Committee shall report on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a two-thirds (2/3) majority of the votes cast by the eligible voting staff at the meeting.
 - (b) Amendments Subject to Vote via Written or Electronic Ballot: The Executive Committee shall present proposed amendments to the voting staff by written or electronic ballot, to be returned by the date as indicated on the ballot, which date shall be at least 14 days after the proposed amendment was provided to the voting staff. Along with the proposed amendments, the Executive Committee shall provide a written report on the amendments either favorably or unfavorably. To be adopted, the amendment must receive a two-thirds (2/3) majority of the votes cast.
- (3) The Executive Committee shall have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, punctuation, spelling, or other errors of grammar or expression.
- (4) All amendments shall be effective only after approval by the Medical Staff and the Board.
- (5) If the Board has determined not to accept a recommendation submitted to it by the Executive Committee or the Medical Staff, the Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.

23.B: CONFLICT MANAGEMENT PROCESS

- (1) When there is a conflict between the Medical Staff and the Executive Committee with regard to:
 - (a) proposed amendments to the Medical Staff Rules and Regulations;
 - (b) a new policy proposed or adopted by the Executive Committee; or
 - (c) proposed amendments to an existing policy that is under the authority of the Executive Committee,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by not less than 10% of the Active Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

- (2) If the differences cannot be resolved, the Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting members of the Medical Staff, to the Board for final action.
- (3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.
- (4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the CEO, who will forward the request for communication to the Chair of the Board. The CEO will also provide notification to the Executive Committee by informing the President of the Medical Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

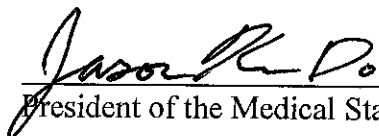
ARTICLE 24

ADOPTION

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

Adopted by the Medical Staff:


Date: January 30, 2020



President of the Medical Staff

Approved by the Board:

Date: February 18, 2020



Chair, Board of Trustees

Revisions:

Adopted by the Medical Staff:	January 29, 2015
Approved by the Board:	February 17, 2015
Adopted by the Medical Staff:	February 8, 2018
Approved by the Board:	February 20, 2018

APPENDIX A

Those individuals currently practicing as Category I Practitioners at Broadlawns Medical Center are as follows:

- Advanced Certified Alcohol & Drug Counselor (ACADC)/Certified Alcohol & Drug Counselor (CADC)
- Audiologists
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists (CRNAs)
- Licensed Independent Social Workers
- Nurse Practitioners
- Optometrists
- Psychologists
- Licensed Masters Social Workers (LMSW)
- Licensed Mental Health Counselors (LMHC)

Update for ACADC/CADC approved by Board of Trustees 07/17/2012.

APPENDIX B

Those individuals currently practicing as Category II Practitioners at Broadlawns Medical Center are as follows:

- Temporary Licensed Master Social Workers “T”
- Licensed Masters Social Workers Track to Licensed Independent Social Workers
- Physician Assistants

APPENDIX C

Those individuals currently practicing as Category III Practitioners at Broadlawns Medical Center are as follows:

- Mental Health Counselors

APPENDIX D

HISTORY AND PHYSICAL EXAMINATIONS

A complete history and physical examination shall be on the chart within 24 hours after admission.

- (1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or any procedure requiring anesthesia services) by an individual who has been granted privileges by the Medical Center to perform histories and physicals. For endoscopy requiring sedation, a short-form abbreviated history and physical is acceptable.
- (2) H&Ps Performed Prior to Admission:
 - (a) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.
 - (b) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record by an individual who has been granted clinical privileges by the Medical Center to perform histories and physicals.
 - (c) The update of the history and physical examination shall be based upon an examination of the patient and must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.
- (3) The required components for histories and physicals shall include the following:
 - (a) History:
 - (i) Chief complaint;
 - (ii) History of present illnesses;
 - (iii) Past medical history (including allergies and medications); and

- (iv) Review of systems;
 - (b) Physical examination;
 - (c) Assessment; and
 - (d) Plan.
- (4) When treating children or adolescents, an evaluation of developmental age factors and consideration of educational needs should be included if appropriate.

(5) Individuals Who May Perform H&Ps:

The following types of practitioners may generally perform histories and physicals at the Medical Center pursuant to appropriately granted Medical Staff appointment or permission to practice and clinical privileges:

- (1) physicians;
- (2) dentists (in accordance with Section 10.A.3 of these Bylaws);
- (3) advance practice registered nurses;
- (4) certified nurse midwives;
- (5) certified registered nurse anesthetists; and
- (6) physician assistants.