

BYLAWS OF THE MEDICAL STAFF
of
MARY GREELEY MEDICAL CENTER
Ames, Iowa

2025

MARY GREELEY MEDICAL CENTER

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PREAMBLE

WHEREAS, Mary Greeley Medical Center is a municipal hospital established and operated under the laws and ordinances of the State of Iowa and the City of Ames; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, education, and research; and

WHEREAS, it is recognized that the Board of Trustees has the ultimate authority and responsibility for all aspects of the Medical Center operation; and

WHEREAS, it is recognized that the Medical Staff has been delegated responsibility by the Board of Trustees for the quality of medical care in the Medical Center and accepts this responsibility; and

WHEREAS, it is recognized that the relationship between the Board of Trustees and the Medical Staff is one of mutual responsibility and interdependence, and the cooperative efforts of the Medical Staff, the Medical Center administration and staff, and the Board of Trustees are necessary to fulfill the foregoing responsibilities of the Medical Staff and the Medical Center's obligations to its patients; and

WHEREAS, only duly qualified physicians, dentists, podiatrists, and certified health service providers in psychology are eligible for Medical Staff membership, privileges and prerogatives; and

WHEREAS, some duly qualified advanced practice providers may be eligible for privileges in the provision of certain patient care services in the Medical Center setting;

THEREFORE, the physicians, dentists, podiatrists and certified health service providers in psychology practicing in this Medical Center hereby organize themselves into a Medical Staff in conformity with these Bylaws.

DEFINITIONS

1. **ADVANCED PRACTICE PROVIDER or APP** means an individual, other than a licensed physician, dentist, podiatrist or clinical psychologist, who exercises independent judgment within the areas of their professional competence and the limits established by the Board of Trustees, the Medical Staff, and the applicable State Practice Acts; who is qualified to render health services under the supervision or direction of a Medical Staff member in good standing; and who may be eligible to exercise Clinical Privileges and prerogatives in conformity with the rules adopted by the Board of Trustees and these Bylaws. APPs are not eligible for Medical Staff membership.
2. **ATTENDING provider** is the individual who has the overall responsibility for the patient's medical care and treatment during their inpatient stay.
3. **BOARD OF TRUSTEES (or "Governing Body")** means the governing body of the Medical Center. The Board of Trustees approves and complies with the Medical Staff Bylaws.
4. **CHIEF OF STAFF** means the chief officer of the Medical Staff.
5. **CLINICAL PRIVILEGES or PRIVILEGES** means the permission granted to a physician or Advanced Practice Provider to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.
6. **GOOD STANDING** means that no current adverse professional review action has been taken regarding the practitioner, including no involuntary limitation, restriction, suspension, revocation, denial, or non-renewal of the practitioner's staff membership and/or Clinical Privileges.
7. **LICENSED INDEPENDENT PRACTITIONER (also referred to herein as "Practitioner" or "Licensed Practitioner")** means an individual permitted by law to provide care, treatment, and services without direction or supervision, within the scope of the individual's license.
8. **MEDICAL CENTER** means Mary Greeley Medical Center.
9. **MEDICAL EXECUTIVE COMMITTEE (MEC)** means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Board of Trustees.
10. **MEDICAL STAFF or STAFF** means the body of practitioners privileged through the organized Medical Staff process that is subject to the Medical Staff Bylaws who are collectively responsible for adopting and amending Medical Staff Bylaws (that is, for those with voting privileges), and for

overseeing the quality of care, treatment, and services provided by all individuals with Clinical Privileges.

11. MEDICAL STAFF BYLAWS means a document or group of documents developed and adopted by the organized Medical Staff and approved by the Governing Body that defines the obligations of the organized Medical Staff and various officers, persons, and groups within the organized Medical Staff's structure; the self-governance functions of the organized Medical Staff; and the organized Medical Staff's working relationship with and accountability to the Governing Body. These Medical Staff Bylaws include four chapters: governance and structure, rules and regulations, credentialing policies, and approval mechanism that shall be applicable to all members of the Medical Staff and other individuals who have been granted Clinical Privileges or scope of practice. All Medical Staff rules and regulations and credentialing policies shall be considered an integral part of the Medical Staff Bylaws, subject to the amendment and adoption provisions contained in Chapter Four.
12. MEDICAL STAFF YEAR means the period from July 1 to June 30.
13. MEDICAL ADMINISTRATIVE OFFICER means a practitioner, employed by or otherwise serving the Medical Center on a full- or part-time basis, whose duties include certain responsibilities, which are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities which require a practitioner to exercise clinical judgment with respect to patient care and it includes the supervision of professional activities of practitioners under their direction.
14. PHYSICIAN means (1) a Doctor of Medicine or Osteopathy legally authorized to practice medicine and surgery by the State in which they performs such function or action, (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which they performs such function and who is acting within the scope of their license when they performs such functions, or (3) a doctor of podiatric medicine for the purposes of functions which they are legally authorized to perform as such by the State in which they performs them.
15. PRESIDENT (also referred to as the "CEO" or "Chief Executive Officer") means the person appointed by the Board of Trustees to act on its behalf in the overall management of the Medical Center, or their authorized representative.

16. PREROGATIVE means a participatory right granted, by virtue of Staff category or otherwise, to a Medical Staff member which is exercisable subject to and in accordance with the conditions imposed by these *Bylaws* and by other Medical Center and Medical Staff rules, regulations, or policies.

CHAPTER ONE
GOVERNANCE AND STRUCTURE

SECTION I

NAME

The name of this organization is the Medical Staff of Mary Greeley Medical Center.

SECTION II

PURPOSES

The purposes of this organization are:

1. To assure that all patients admitted to or treated in any of the facilities, departments, or services of the Medical Center shall receive the appropriate level and quality of care, regardless of their ability to pay.
2. To assure the quality of care rendered by licensed practitioners and APPs authorized to practice in the Medical Center, through the appropriate delineation of Clinical Privileges that each licensed practitioner may exercise in the Medical Center and of the Clinical Privileges that each APP may exercise in this Medical Center, and through an ongoing review and evaluation of the care rendered by licensed practitioners and APPs in the Medical Center.
3. To initiate and maintain the Bylaws for the Medical Staff to carry out its responsibility to be self-governing with respect to the professional work performed in the Medical Center, pursuant to the authority delegated by the Board of Trustees.
4. To provide means whereby issues concerning the Medical Staff and the Medical Center may be discussed by the Medical Staff with the Board of Trustees and/or the President and his or her designee.

SECTION III

MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

3.1-1 IN GENERAL

Membership in the Medical Staff and/or Clinical Privileges shall be extended only to professionally competent licensed independent practitioners who continuously meet the qualifications, standards, and requirements set forth in this chapter. Appointment to and membership in the Medical Staff shall confer on the member only such Clinical Privileges and prerogatives as have been granted by the Board of Trustees. No licensed independent practitioner shall admit patients or provide or order services to patients in the Medical Center unless they are a member of the Medical Staff or have been granted requisite privileges in accordance with the procedures set forth in Sections I and II of the Credentialing Policies chapter.

3.1-2 ONGOING EVALUATION OF NEEDS

Periodically, the Board of Trustees shall evaluate the number, category, admissions, and hospital activities of Medical Staff appointees in various specialty areas, so that an adequate number of individuals in each specialty is determined, maintained, and revised as needed, in light of the professional requirements of the hospital and the needs of the community.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

No practitioner shall be entitled to membership on the Medical Staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization. The following qualifications must be met by all practitioners who apply for Medical Staff appointment, reappointment, or Clinical Privileges:

- (a) The applicant must demonstrate that they have successfully graduated from an approved school of medicine as outlined in Section 3.2-2.
- (b) The applicant must have a current unrestricted state or federal license as a practitioner that is applicable to their profession and provides permission to practice within the state of Iowa.

- (c) The applicant must have a record that is free of current Medicare/Medicaid sanctions and not be on the Office of Inspector General's (OIG) list of excluded individuals/entities.
- (d) The applicant must have a record that is free of felony convictions within the last three years, or occurrences that would raise questions of undesirable conduct that could injure the reputation of the Medical Staff or hospital.
- (e) The applicant must have fulfilled appropriate training requirements for field of practice along with any board certification requirements.
- (f) The applicant must possess a current, valid, unrestricted Drug Enforcement Administration number and Iowa Controlled Substances registration, if applicable.
- (g) The applicant must have appropriate written and verbal English communication skills.
- (h) The applicant must abstain from any participation in fee-splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities.
- (i) The applicant must possess a history of consistently acting in a professional, appropriate, and collegial manner with others in previous clinical and professional settings. The applicant must report any restrictions in their practice at the time of their appointment and/or granting of Clinical Privileges, and anytime throughout the term thereof, and must report to the Medical Executive Committee any deviation from the following requirements at any time (e.g., other hospitals, surgery centers, or clinics).
- (j) The applicant must demonstrate their background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested.
- (k) The applicant must, on request, provide evidence of health conditions, that does not impair, with reasonable accommodation, the fulfillment of their Medical Staff responsibilities and the specific privileges requested by and granted to the applicant.

- (l) The applicant, if granted privileges, and who may have occasion to admit an inpatient must demonstrate their capability to provide continuous and timely care to the satisfaction of the Medical Executive Committee and the Board of Trustees.
- (m) The applicant must demonstrate current clinical competence within the last 24 months in the area in which they seek Clinical Privileges.
- (n) The applicant must request privileges for a service the Board has determined appropriate to provide at the hospital. The Board must also see a need for this service under its Medical Staff development plan.
- (o) The applicant must provide evidence of professional liability insurance appropriate to all privileges requested in an amount outlined in Section 10.9 of this chapter.
- (p) The applicant must provide documentation of current CPR, ACLS, PeRLS, BLS, PALS, etc., training if applicable to their specialty area and/or privileges.
- (q) The applicant must satisfy the Medical Center requirements for continuing medical education by meeting the Iowa Board of Medicine's continuing medical education requirements for licensure.
- (r) The applicant is determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions, to work cooperatively with others in the Medical Center setting, to participate in and properly discharge patients, and to commit to and cooperate with the Medical Staff in assisting the Medical Center in fulfilling its obligations related to patient care.
- (s) For specialties requiring EMTALA coverage refer to Section III, 3.4.

3.2-2 PARTICULAR QUALIFICATIONS

- (a) Physicians. An applicant for physician membership on the Medical Staff must hold a M.D. or D.O. degree issued by an accredited medical or osteopathic school approved by the Iowa Board of Medicine, and a valid, unrevoked, and unsuspended license to practice medicine issued to them by the Iowa Board of Medicine.
- (b) Dentists. An applicant for dental membership on the Medical Staff must hold a D.D.S. or D.M.D. degree issued by an accredited dental college approved by the Iowa Board of Dental Examiners, and a valid, unrevoked, and unsuspended license to practice dentistry issued to them by the Iowa Board of Dental Examiners.
- (c) Podiatrists. An applicant for podiatric membership on the Medical Staff must hold a DPM degree issued by an accredited podiatry college approved by the Iowa Board of Podiatry Examiners, and a valid, unrevoked, and unsuspended license to practice podiatry issued to them by the Iowa Board of Podiatry Examiners.
- (d) Psychologists. An applicant for psychology membership to admit/attend a patient and be a member of the Medical Staff must hold a PhD or PsyD issued by an institution approved by the Iowa Board of Psychology Examiners; a valid, unrevoked, and unsuspended license to practice psychology issued to them by the Iowa Board of Psychology Examiners and must be a certified health service provider in psychology pursuant to the Code of Iowa. The applicant shall be registered by the National Register of Health Service Providers in Psychology.

3.3 EFFECT OF OTHER AFFILIATIONS

No licensed independent practitioner shall be automatically entitled to Medical Staff membership or to exercise any particular Clinical Privileges because of present or past affiliations, memberships, privileges, licenses, or credentials in or with any organization, society, board, or practice setting.

3.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, gender, sexual orientation, or gender identity or expression, or on the basis of any other criterion unrelated to the delivery of quality patient care in the Medical Center setting, to professional qualifications, the Medical Center's purposes, needs and capabilities, or community needs.

3.5 MEDICAL ADMINISTRATIVE OFFICERS

A Medical Administrative Officer is a practitioner who is employed by or contracts with the Hospital, or otherwise serves pursuant to a contract in a capacity that includes administrative responsibilities and may also include clinical responsibilities. A Medical Administrative Officer must be a Medical Staff Member in good standing. The Medical Staff membership and Clinical Privileges of any medical administrative officer shall also be subject to the terms and conditions of their contract or agreement with the Medical Center. The contract or agreement shall be consistent with these Bylaws.

It shall further be the responsibility of all Medical Administrative Officers to provide in the agreements that they have with licensed independent practitioners or advanced practice providers, employees, subcontractors, and the like (hereinafter referred to as "subcontractors") that privileges made exclusive or semi-exclusive to the holder of a contract or agreement, are likewise subject to automatic termination upon:

- termination of the Medical Administrative Officer's contract or agreement with the Medical Center;
- termination by the Medical Administrative Officer of their employment of, association with, or partnership with the subcontractor.

Failure of a Medical Administrative Officer to include such provisions in their agreement with subcontractors shall not affect the Medical Center's right to deem or determine that the privileges of subcontractors have been automatically terminated in accordance with the provisions of this section.

3.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Each member of the Medical Staff and all practitioners holding privileges shall continuously comply with the provisions of these bylaws, Medical Staff and hospital manuals, rules, regulations, and policies. Members must:

- (a) Provide their patients with care at the generally recognized professional level of quality and efficiency established by the Medical Staff and the Medical Center.
- (b) Practice only within the scope of their privileges.
- (c) Retain responsibility within their area of professional competence for the continuous care and supervision of each patient in the Medical Center for whom they are providing services, or arrange for a suitable alternative to assure such care and supervision.
- (d) Abide by the Medical Staff Bylaws and all healthcare-related laws, mandates, and regulations required by the state and federal governments, and policies, procedures, and rules of the Medical Center.
- (e) Comply with all requirements set forth in the Medical Staff Governance and Structure and Rules and Regulations chapters of the Bylaws including but not limited to those requiring maintenance of professional liability insurance (Section 10.9) and refraining from unlawful fee-splitting (Section 10.4) (Governance and Structure Chapter, Section 8.6).
- (f) Participate in and collaborate with the peer review, risk management, and performance improvement activities of the Medical Staff and hospital as noted in the Bylaws.
- (g) Discharge such personal, Medical Staff, Department, Committee and Medical Center functions, including but not limited to, professional practice evaluation, patient care audit, utilization review, emergency service and back up functions, for which they are responsible by virtue of their Staff category assignment; appointment; election; utilization of APPs; or exercise of privileges, prerogatives, or other rights in the Medical Center.
- (h) According to Medical Staff and Medical Center policies, each practitioner shall prepare and complete in a timely fashion the required documentation for all patients to whom the practitioner provides care in the hospital, or within its facilities, clinical services, or departments in compliance with Section VI of the Rules and

Regulations Chapter.

- (i) Abide by the ethical principles of their profession.
- (j) Aid in educational programs for Medical Staff members, APPs, Medical Center personnel, patients, families, and the community upon request and as appropriate.
- (k) Cooperate with the Medical Staff in assisting the Medical Center in fulfilling its uncompensated or partially compensated patient care obligations.
- (l) Demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding of and sensitivity to diversity, and a responsible attitude toward patients, the profession, and society.
- (m) Submit the applicable Medical Staff dues or assessment fees.

3.7 DURATION OF APPOINTMENT

Initial appointments to the Medical Staff shall be for a period determined appropriate by the Medical Staff on a case-by-case basis through the process outlined in Section 1.4 of the Credentialing Policies chapter regarding the focused professional practice evaluation which is required of initial appointees. Reappointments shall be for a period of three years, unless otherwise determined in individual cases. No reappointment period will exceed three years.

3.8 FOCUSED PROFESSIONAL PRACTICE EVALUATION

3.8-1 FOR INITIAL APPOINTMENTS

Except as otherwise recommended by the Medical Executive Committee and approved by the Board of Trustees, all practitioners with privileges initially appointed to the Medical Staff shall complete a period of performance evaluation. This evaluation may include direct observation of the practitioner's performance, outcome review, statistical trending, and other screening criteria as may be designated by the departmental chair. The process for the Focused Professional Practice Evaluation is discussed in the Credentialing Policies chapter, Section 1.4.

3.9 LEAVE OF ABSENCE

3.9-1 LEAVE STATUS

A Medical Staff member may obtain a personal or medical leave of absence from the Medical Staff by submitting written notice to the Medical Executive Committee and the President stating the approximate period of time of the leave, which may not exceed two years or the practitioner's then-current term of appointment, whichever is shorter. Any absence from the Medical Staff for longer than six months shall require an individual to request a leave of absence.

During the period of the leave, the member's Clinical Privileges, prerogatives, and responsibilities shall be deemed inactive.

Any Medical Staff member who seeks to resume their hospital practice following a medical or personal leave shall be required to meet with the Credentials Committee or, for medical leaves of absence, obtain a written medical release from the attending physician releasing the licensed independent practitioner to resume privileges prior to resuming practice, for the purpose of ascertaining whether any restrictions on the individual's practice are indicated.

For a leave of absence of six months or greater, a focused professional practice evaluation and/or proctoring may be required by the Credentials Committee.

3.9-2 EXPIRATION OF LEAVE

At least 30 days prior to the expiration of the leave, the Medical Staff member shall request reinstatement of their privileges and prerogatives by submitting a written notice to that effect to the President and to the Medical Executive Committee. The Staff member shall submit a written summary of their relevant activities during the leave. The Medical Executive Committee shall recommend to the Board of Trustees whether to approve the member's request for reinstatement of their privileges and prerogatives and the Board shall make the final determination regarding reinstatement. Prior to reinstating a practitioner's Clinical Privileges following a leave of absence, the applicable background checking procedure set forth in Section 1.3 of the Credentialing Policies chapter shall be completed to ensure that the practitioner continues to meet the requirements set forth under such background investigation standards.

Failure, without good cause, to request reinstatement prior to the end of the two-year time limit (or prior to the expiration of the practitioner's then-current appointment term, whichever is shorter)

or to provide a requested summary of activities or meet with the Credentials Committee, if requested, or provide a medical release, shall be deemed to be a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A licensed independent practitioner whose membership, privileges and prerogatives are so terminated shall not be entitled to the procedural rights provided in Section IV of the Credentialing Policies chapter unless such termination would result in a report to the National Practitioner Data Bank. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

SECTION IV

CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Community Based, Privileges Only, and Emeritus.

4.2 ACTIVE MEDICAL STAFF

4.2-1 QUALIFICATIONS

The Active Medical Staff shall consist of licensed independent practitioners who:

- (a) Meet the qualifications set forth in Section 3.2. For initial appointment, the applicant shall also be American Board of Medical Specialties or American Osteopathic Medical Association or American Dental Association or American Podiatric Medicine Association Board or Association of State & Provincial Psychology Boards certified or is eligible to and will achieve board certification within six years of completion of training in the specialty in which privileges are requested, and maintain board certification as defined by the specialty board. Failure to achieve board certification within six years of completion of training in the specialty in which privileges are requested is deemed a voluntary resignation with no procedural rights under Section IV of the Credentialing Policies chapter.

A physician whose board certification expires, in the specialty in which they have privileges, will have two years (24 months) from the expiration date to recertify. Failure to recertify within two years of expiration is deemed a voluntary resignation. An individual may petition the Medical Executive Committee for special consideration.

If board certification expires within two years of retirement, recertification is not required.

- (b) Have completed the practitioner orientation program designed to welcome practitioners and familiarize them with the structure, policies, and practices of the Medical Center, as well as acquaint them with the various departments, services, and personnel.

- (c) Regularly admit patients to or otherwise regularly provide professional services for patients in the Medical Center, or as outpatients, as required on their respective privilege forms. Dentists, podiatrists, and doctorate-prepared clinical psychologists may admit and treat patients, but only co-admitting each patient with a physician member of the Medical Staff who has admitting privileges and who assumes, as required by Section 3.6 hereof, responsibility for care of the patient's medical problems.

4.2-2 PREROGATIVES

The prerogatives of an Active Medical Staff member shall be to:

- (a) Admit patients or provide services for patients consistent with their privileges, unless otherwise provided in the Medical Staff Governance and Structure or Rules and Regulations chapters.
- (b) Exercise such Clinical Privileges as are granted to them pursuant to Section II of the Credentialing Policies.
- (c) Hold office in the Medical Staff and in the Department and committees of which they are a member, and serve on committees, unless otherwise provided in this chapter.
- (d) Vote for Medical Staff officers, on Bylaws amendments, and on all matters presented at general and special meetings of the Medical Staff and of the Department and committees of which they are a member, unless otherwise provided in the Medical Staff Bylaws.

4.2-3 RESPONSIBILITIES

Each Active Medical Staff member shall:

- (a) Meet the basic responsibilities set forth in Section 3.6.
- (b) Actively participate in and regularly cooperate with the Medical Staff in assisting the Medical Center in fulfilling its obligations related to patient care, including but not limited to emergency service and on-call rotation, patient care audit, review, quality evaluation, and related monitoring activities required of and by the Medical Staff in supervising and proctoring initial appointees and APPs, and

in discharging such other functions as may be required from time to time.

4.3 COMMUNITY BASED PHYSICIANS

4.3-1 QUALIFICATIONS

Physicians in the Community Based (Admit/Consult and Refer) category shall consist of licensed independent practitioners who:

- (a) Meet the qualifications set forth in Section 3.2, except for requirements 3.2-1(p) regarding maintaining current CPR. Physicians in this category must maintain a medical practice in our service/market area.
- (b) Are assessed an initial credentialing fee and a recredentialing fee as determined by the Medical Staff.
- (c) Physicians in the Community Based category include one of the following:

Community Based Admit/Consult: These physicians write admitting orders and immediately refer the patients to the Hospitalist or other Medical Staff member. They may follow a patient's care within the Medical Center but do not order tests, consultations, drugs or therapies, or document in the medical record other than admitting orders and admitting History & Physical (H & P). May admit patients, provide specialty-specific consultations as requested, and complete electronic health record training. For initial appointment, the applicant shall also be American Board of Medical Specialties or American Osteopathic Medical Association or American Dental Association or American Podiatric Medicine Association Board certified or Association of State & Provincial Psychology Boards or is eligible to and will achieve board certification within six years of completion of training in the specialty in which privileges are requested and maintain board certification as defined by the specialty board. Failure to achieve board certification within six years of completion of training in the specialty in which privileges are requested is deemed a voluntary resignation with no procedural rights under Section IV of the Credentialing Policies chapter. A physician whose board certification expires, in the specialty in which they have privileges, will have two years (24 months) from the expiration date to recertify. Failure to recertify within two years of expiration is deemed a voluntary resignation. An individual may petition the Medical Executive Committee for special consideration. If board certification expires within two

years of retirement, recertification is not required.

Community Based Refer: This status is intended for primary care physicians only (unless valid exemption is made by the MEC); These physicians refer patients to Hospitalist/Specialist and may conduct social rounds. Community Based Refer physicians do not write orders in the electronic health record. Board certification and evidence of professional liability insurance are not required.

4.3-2 PREROGATIVES

Community Based staff members shall have the following prerogatives:

- (a) May attend meetings of the Medical Staff and the Department of which they are a member. A Community Based Staff member may not hold office in the Medical Staff or in the Department of which they are a member or serve on committees.
- (b) May not vote on any Medical Staff matter.

4.3-3 RESPONSIBILITIES

Each Community Based Staff member shall meet the basic responsibilities set forth in Section 3.6, as applicable.

4.4 EMERITUS STAFF

4.4-1 QUALIFICATIONS

The Emeritus Staff shall consist of physicians, dentists, podiatrists, and certified health service providers in psychology who have retired from active practice and, at the time of their retirement, were members in good standing of the Medical Staff for a period of at least two years, and who continue to adhere to appropriate professional and ethical standards.

4.4-2 PREROGATIVES

Emeritus staff members are not eligible to admit patients to the Medical Center or to exercise Clinical Privileges in the Medical Center, or to vote or hold office in the Medical Staff organization, but may serve on committees with or without voting rights at the discretion of the Medical Executive Committee.

4.5 PRIVILEGES ONLY PHYSICIANS

Privileges Only physicians shall consist of those physicians whose relationship with the Medical Center is strictly limited to providing services remotely, including via telemedicine, and therefore never physically provide

services to patients at the Medical Center. Privileges Only physicians do not have Medical Staff membership at the Medical Center. Instead, Privileges Only physicians only seek to be granted clinical privileges to provide services to patients of the Medical Center.

4.5-1 QUALIFICATIONS

- (a) In order to be eligible for appointment to the Privileges Only physician category, a physician must meet all eligibility requirements as stated in Section 3.2 of the Bylaws with the exception of those related to office location.

4.5-2 PREROGATIVES

- (a) Privileges Only physicians may exercise such clinical privileges as granted but will never have primary responsibility for any patient;
- (b) Privileges Only physicians may attend meetings of the Department to which they are appointed;
- (c) Due to the fact that Privileges Only physicians are not members of the Medical Staff, Privileges Only physicians may not serve as a Medical Staff officer, Department Chair, or member of any committee.

4.5-3 RESPONSIBILITIES

Each Privileges Only physician shall be responsible for meeting the responsibilities as set forth in Section 3.6, as applicable.

4.6 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other Sections of Governance and Structure, Rules and Regulations, or Credentialing Policies or by other policies of the Medical Center and Medical Staff. The prerogatives of dental, podiatric, and psychology staff members of the Medical Staff shall be limited to those for which they can demonstrate the possession of the requisite licensure, education, training, and experience.

SECTION V

OFFICERS

5.1 OFFICERS OF THE MEDICAL STAFF

5.1-1 IDENTIFICATION

The officers of the Medical Staff shall be Chief of Staff, Chief of Staff-Elect, Immediate Past Chief of Staff, and Secretary.

5.1-2 QUALIFICATIONS

Officers must be members in good standing of the Active Medical Staff who have completed at least two years of service on the Active Staff at the time of nomination and election, and must remain members in good standing as deemed and approved by the Medical Executive Committee during their term(s) of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

5.1-3 NOMINATIONS

- (a) The Medical Staff election year shall be the Medical Staff year ending in an odd number. A nominating committee shall be appointed by the Medical Executive Committee forty-five to ninety (45-90) days prior to the annual staff meeting to be held during the election year or at least forty-five (45) days prior to any special election. The nominating committee shall consist of: the current Chief of Staff, the Immediate Past Chief of Staff, and two other members of the Active Medical Staff appointed by the Chief. The nominating committee shall prepare a slate of candidates for the office of Chief-Elect and Secretary. The nominations of the committee shall be reported to the Medical Executive Committee at least thirty days (30) prior to the annual meeting in June and shall be circulated to the voting members at least twenty (20) days prior to the election.
- (b) Further nominations may be made for any office by any voting member of the Medical Staff. The name of the candidate must be submitted in writing to the Chair of the nominating committee, be endorsed by the signature of at least 10% of other members eligible to vote, and bear the candidate's written consent. These nominations shall be delivered to the Chair of the nominating committee as soon

as reasonably practicable, but at least ten (10) days prior to the date of election. For nominations made in this manner, the voting members of the Medical Staff shall be advised by notices delivered or mailed as soon as practicable, but at least five (5) days prior to the meeting.

5.1-4 ELECTION

The Chief of Staff-Elect and Secretary shall be elected by members of the Active Medical Staff at the annual meeting that falls during the election year. Voting shall be by use of an audience response system or voice vote. A nominee shall be elected upon receiving a simple majority of the valid votes cast by members. If no candidate receives a majority vote on the first ballot, a runoff election shall be held immediately thereafter between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee at its next meeting or a special meeting called for that purpose shall decide the election. This vote shall be by secret written ballot.

5.1-5 CHIEF OF STAFF AND IMMEDIATE PAST CHIEF OF STAFF

The Chief of Staff-Elect shall, upon completion of that term of office, immediately succeed to the office of Chief of Staff and then to the office of Immediate Past Chief of Staff.

5.1-6 TERM OF OFFICE

Each officer shall serve a two-year term, commencing on the first day of July of the Medical Staff year following their election. Each officer shall serve until the end of their term and until a successor is elected, unless they shall sooner resign or are removed from office.

5.1-7 REMOVAL OF ELECTED OFFICERS

Except as otherwise provided in these Bylaws, removal of a Medical Staff officer may be initiated by the Medical Executive Committee or by a petition signed by at least one-third of the members of the Medical Staff eligible to vote for officers. Removal shall be considered at a special meeting called for that purpose. Removal shall require a two-thirds vote of the Medical Staff members eligible to vote. The process for the vote will be defined by the Medical Executive Committee by a special meeting and/or mail ballot. If removal is by mail ballot, the voting shall be by secret

written mail ballot. The written mail ballots shall be sent to each voting member at least ten days before the voting date and the ballots shall be counted by the Secretary of the Medical Staff (except when that office is the subject of the balloting, in which case the Chief of Staff shall count the ballots). Removal shall be effective upon the approval of the Medical Center Board of Trustees.

If an officer ceases to be a member in good standing of the Active Medical Staff, or loses an employment relationship with the Medical Center, or suffers a loss or significant limitation of Clinical Privileges, that member shall be removed by the Medical Executive Committee.

5.1-8 VACANCIES IN ELECTED OFFICE

Vacancies occur on the death, disability, resignation, or removal of the officer, or that officer's failure to maintain membership in good standing on the Active Medical Staff. Vacancies, other than that of Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of Chief of Staff, the Chief of Staff-Elect shall serve out that remaining term and shall then serve as Chief of Staff the following term and shall immediately appoint an ad hoc nominating committee to decide within thirty (30) days upon nominees for the office of Chief of Staff-Elect. Those nominees shall be reported to the Medical Executive Committee and to the Medical Staff. A special election to fill the position shall occur at the next regular staff meeting.

5.2 CHIEF OF STAFF

The Chief of Staff is the individual responsible for the organization and conduct of the Medical Staff, with whom the Board of Trustees shall directly consult on all matters related to the quality of medical care provided to patients at the hospital and any other matters of mutual concern. The Chief of Staff:

- (a) Chairs the Medical Executive Committee;
- (b) Presides at Medical Staff meetings;
- (c) Appoints chairs and members of Medical Staff committees, and Medical Staff representatives to hospital committees, subject to Medical Executive Committee ratification, unless otherwise stipulated in these Bylaws;

- (d) Serves as an ex-officio member of all other staff committees without vote, unless their membership in a particular committee is required by these Bylaws;
- (e) Enforces the Medical Staff Governance and Structure, Rules and Regulations, and Credentialing Policies, implement sanctions when indicated, and promote compliance with procedural safeguards when corrective action has been requested or initiated;
- (f) Represents the Medical Staff at Board meetings and communicates with Board members on behalf of the Medical Staff;
- (g) Represents the Medical Staff, or designate a Medical Staff representative on any physician or Medical Staff council, taskforce, or panel organized by the hospital administration;
- (h) Communicates regularly with the Medical Staff and is responsive to individual members' complaints, concerns, and requests;
- (i) Assists and supports the Department Chair of each clinical department in any disciplinary or corrective action plans needed;
- (j) Serves as Medical Staff spokesperson for the hospital;
- (k) Fulfills such other responsibilities assigned by the Medical Staff or Medical Executive Committee, stipulated elsewhere in the Bylaws, or as usually pertain to the office of Chief of Staff

5.3 CHIEF OF STAFF-ELECT

The Chief of Staff-Elect:

- (a) Assumes the office of Chief of Staff following the conclusion of the term of their predecessor or if the Chief fails to serve for any reason;
- (b) Assumes the duties of the Chief of Staff when they are temporarily unavailable;
- (c) Is a member of the Medical Executive Committee, Patient Care Review Committee, and chairs the Credentials Committee;
- (d) Fulfills such other responsibilities assigned by the Medical Staff or Medical Executive Committee, stipulated elsewhere in the Bylaws, or as usually pertain to the office of Chief of Staff-Elect.

5.4 IMMEDIATE PAST CHIEF OF STAFF

The Immediate Past Chief of Staff:

- (a) Assumes the duties of the Chief of Staff when both the Chief of Staff and Chief of Staff-Elect are unavailable;
- (b) Is a member of the Medical Executive Committee;
- (c) Chairs the Bylaws Committee;
- (d) Fulfills such other responsibilities assigned by the Medical Staff or Medical Executive Committee, stipulated elsewhere in the Bylaws, or as usually pertain to the office of Immediate Past Chief of Staff.

5.5 SECRETARY

The Secretary shall:

- (a) Ensure a roster of members is maintained;
- (b) Ensure that minutes of Medical Staff meetings and Medical Executive Committee meetings are thorough and accurate;
- (c) Serve as a member of the Credentials Committee and Medical Executive Committee;
- (d) Fulfill such other responsibilities assigned by the Medical Staff or Medical Executive Committee, stipulated elsewhere in the Bylaws, or as usually pertain to the office of Secretary.

SECTION VI

CLINICAL DEPARTMENTS

6.1 ORGANIZATION OF DEPARTMENTS

The Medical Staff shall be divided into clinical departments. Each Department shall be organized as a separate component of the Medical Staff and shall have a chair whose selection and responsibilities are set forth in Section 6.3. When appropriate, the Medical Executive Committee may recommend to the Medical Staff and Board of Trustees the designation, creation, elimination, modification or combination of Departments.

6.2 ASSIGNMENT TO DEPARTMENTS

Each member shall be assigned membership in at least one Department.

6.3 DEPARTMENT CHAIRS

6.3-1 QUALIFICATIONS

Each Department Chair shall be a member of the Active Medical Staff and possess demonstrated ability in at least one of the clinical areas of the Department. The chair of each department should be certified by an appropriate specialty board. Department Chairs may seek the expertise of members of their department in fulfilling the duties of the Department Chair.

6.3-2 SELECTION

The Department Chair shall be appointed by the Chief of Staff, who shall consult with the Department members regarding the appointment. Selection of all Department Chairs shall be subject to approval of the Medical Executive Committee.

6.3-3 TERM OF OFFICE

Each Department Chair shall serve a two-year term that coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose

their Medical Staff membership or Clinical Privileges in that Department. Department officers shall be eligible to succeed themselves.

6.3-4 REMOVAL

Removal of a Department Chair from office may be initiated by the Medical Executive Committee or by written request from 20% of the members of that Department eligible to vote. The removal may be affected by a majority vote of the Medical Executive Committee and a majority vote of the Department members eligible to vote on Department matters. Voting may be by secret mail ballot according to procedures established by the Medical Staff. Such removal shall be effective upon the approval of the Medical Center Board of Trustees.

If a Department Chair ceases to be a member in good standing of the Active Medical Staff or loses a contract or employment relationship with the Medical Center, or suffers a loss or significant limitation of Clinical Privileges, that member shall be removed as Department Chair by the Medical Executive Committee.

6.3-5 DUTIES

Each Department Chair shall have the following authority and responsibilities:

- (a) Serve on the Medical Executive Committee (MEC) and give guidance on the overall medical policies of the Medical Staff and Medical Center;
- (b) Reports to the Medical Executive Committee and the general Medical Staff on department's activities. Reports include follow-up of quality initiatives, patient satisfaction, current trends, and concerns of department members.
- (c) Reports, whenever necessary or requested, to the Chief of Staff and/or hospital administration on matters of immediacy, especially where action to coordinate clinical services to maintain quality or to ensure patient safety is an issue.
- (d) Implement actions taken by the Medical Executive Committee within their Department;
- (e) Ongoing monitoring of the professional performance of all individuals who have Clinical Privileges in the department;

- (f) Review and recommend to the Medical Staff the criteria for Clinical Privileges in the department;
- (g) Review and recommend Clinical Privileges for each member of the department;
- (h) Participation in determination of the qualifications and competence of department personnel who are not physician practitioners and who provide patient care services;
- (i) Drive the continual assessment and improvement of the quality of care and services provided;
- (j) Involvement in department and hospital committees, as appropriate;
- (k) Support and contribute to hospital patient satisfaction initiatives including: reviewing physician-specific report cards, presenting data at meetings, assisting in the development of action plans for improvement;
- (l) Involvement in the orientation and continuing education of all members in the department;
- (m) Recommend equipment and resources needed by the department;
- (n) Recommend actions to the hospital administration regarding off-site sources for needed patient care services not provided by the department or hospital;
- (o) Participation in the development of new programs and outpatient projects for services not provided by the department or hospital;
- (p) Responsible for all administratively related activities of the department which include, but are not limited to: meeting agenda preparation, conducting meetings, minutes review and correction, assigning task force members, etc.
- (q) Development and implementation of policies and procedures;
- (r) Coordination and integration of interdepartmental and intradepartmental services;

- (s) Represents the department in recommending space and other resources needed by the department or service to perform Clinical Privileges;
- (t) Perform other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff, the Medical Executive Committee, or the Board of Trustees.

SECTION VII

MEDICAL STAFF COMMITTEES

7.1 DESIGNATION

The committees of this chapter shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the Chair and members of all committees shall be appointed by, and may be removed by, the Chief of Staff, after consultation with and approval by the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee, including providing summary reports after their regularly scheduled meetings.

All Medical Staff Committees may conduct peer review in their meetings. Peer review records are privileged and confidential, are not subject to discovery, subpoena, or other means of legal compulsion for release to a person other than an affected licensee or a peer review committee, and are not admissible in evidence in a judicial or administrative proceeding brought by a licensee who is the subject of a peer review record and whose competence is at issue. A person shall not be liable as a result of filing a report or complaint with a peer review committee or providing information to such a committee, or for disclosure of privileged matter to a peer review committee. Persons making these reports and persons participating in resulting proceedings related to these reports shall be immune from civil liability with respect to the making of the report or participation in resulting proceedings. (Iowa Code 147.135) This applies to all Medical Staff committees.

7.2 GENERAL PROVISIONS

Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to:

- (a) a named committee, but no such committee exists, the Medical Executive Committee shall perform such function or receive such report or recommendation, or shall assign the functions of this committee to a new or existing committee of the Medical Staff, or to the staff as a whole.
- (b) the Medical Executive Committee, but a standing or special committee has been formed to perform the functions, the

committee so formed shall act in accordance with the authority delegated to it.

7.2-1 TERMS OF THE COMMITTEE MEMBERS

Unless otherwise specified, a committee member's term shall be two years and the member shall serve until the end of this period or until a successor is appointed, unless the member shall sooner resign or be removed from the committee.

7.2-2 VOTING

Unless otherwise specified, the only voting members of committees shall be members of the Active Medical Staff.

7.2-3 REMOVAL

Unless otherwise provided herein a member of a committee ceases to be a member in good standing of the Medical Staff, or loses an employment or contract relationship with the Medical Center, suffers a loss or significant limitation of Clinical Privileges, or if any other good cause exists, that member may be removed from the committee by the Medical Executive Committee.

The removal of any committee member who is automatically assigned to a committee because they are a general officer or other official shall be governed by the provisions pertaining to removal of those officers or officials.

7.2-4 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the manner of original appointment to the committee; provided, however, that if an individual obtains membership by virtue of these Bylaws and is removed for cause, a successor may be selected by the Medical Executive Committee by the Medical Executive Committee.

7.3 MEDICAL EXECUTIVE COMMITTEE

7.3-1 COMPOSITION

The Medical Executive Committee shall consist of physicians and may include other licensed independent practitioners. The majority of voting Medical Executive Committee members shall be fully licensed doctors of medicine or osteopathy actively practicing in the Medical Center. All members of the Medical Staff of any discipline or specialty are eligible for membership on the Medical Executive Committee as long as they are one of the following:

- (a) The Chief of Staff, Chief of Staff-Elect, and Secretary who shall serve as Chair, Vice-Chair and Secretary of the Medical Executive Committee, respectively;
- (b) The immediate Past Chief of Staff;
- (c) The Department Chairs;
- (d) The President of the Medical Center or his or her designee attends each Medical Staff executive committee meeting on an ex-officio basis, without a vote;
- (e) The Chairs of certain committees, to be designated by the Chief of Staff subject to approval by the majority vote of the remaining Medical Executive Committee members at a meeting of the Medical Executive Committee at which a quorum is present.

7.3-2 DUTIES

The Medical Staff has delegated the following authority to the Medical Executive Committee:

- (a) Represent and act on behalf of the organized Medical Staff between Medical Staff meetings;
- (b) Recommend action to the Board of Trustees on Medical Staff membership, the organized Medical Staff's structure, the process used to review credentials and delineate privileges, the delineation of privileges for each practitioner privileged through the Medical Staff process, and the committee's review of and actions on reports of Medical Staff committees, departments, and other assigned activity groups;

- (c) Coordinate and implement the professional and organizational activities and policies of the Medical Staff. Participate in the development of all Medical Staff policy, practice and planning;
- (d) Recommend revisions to the Medical Staff Documents to the Board of Trustees pursuant to these Bylaws;
- (e) Receive and act on reports and recommendations from Medical Staff Departments, committees and other groups appointed pursuant to these Bylaws;
- (f) Provide liaison between the Medical Staff and the Board of Trustees and its designees;
- (g) Recommend action to the Board of Trustees on matters of a medical-administrative nature;
- (h) Participate in defining the structure of the Medical Staff, the mechanism to review credentials and delineate individual Clinical Privileges, the organization of quality improvement activities and mechanisms of the Medical Staff, termination of Medical Staff membership and fair hearing procedures, and other matters relevant to the operation of an organized Medical Staff;
- (i) Evaluate the medical care provided to patients in the Medical Center;
- (j) Review the qualifications, credentials, performance and professional competence and character of applicants and staff members and of APPs to the extent required by these Bylaws and make recommendations to the Board of Trustees regarding staff appointments and reappointments, Clinical Privileges, and corrective action. The Medical Executive Committee requests evaluations of practitioners privileged through the Medical Staff process in instances where there is doubt about an applicant's ability to perform the privileges requested;
- (k) Take reasonable steps to assure ethical conduct and competent clinical performance on the part of all members and APPs, to the extent required by the documents specified in subsection (j) above, including initiation of and participation in corrective or review measures when warranted;

- (l) Take reasonable steps to develop continuing education activities and programs for the Medical Staff;
- (m) Report to the Medical Staff at each regular staff meeting;
- (n) Assure that the Medical Staff is informed about the accreditation program and status of Medical Center, and assist in obtaining and maintaining accreditation;
- (o) Develop and maintain methods for the protection and care of patients and others in the event of internal or external disaster;
- (p) Appoint special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;
- (q) Review the quality and appropriateness of services provided by contract physicians; and
- (r) Perform other functions as may be assigned to it by these Bylaws or the Medical Staff.

7.3-3 TERM OF MEMBERS

Members of the Medical Executive Committee shall serve two-year terms, which shall run concurrently with the terms of the Officers. Members may serve consecutive terms.

7.3-4 REMOVAL

If a member of the Medical Executive Committee ceases to be a member in good standing of the Medical Staff or loses an employment or contract relationship with the Medical Center, suffers a loss or significant limitation of Clinical Privileges, or if any other good cause exists, that member may be removed from the Medical Executive Committee with a majority vote of the Medical Executive Committee members present and voting.

7.3-5 MEETINGS

The Medical Executive Committee shall meet monthly, no fewer than 10 times per year, and shall maintain a record of its proceedings and actions.

7.3-6 DELEGATION AND REMOVAL OF AUTHORITY

The Medical Staff may delegate additional authority to the Medical Executive Committee, or may remove authority previously delegated, following the process set forth in these Bylaws for amending these Bylaws.

7.4 BYLAWS COMMITTEE

7.4-1 COMPOSITION

The Bylaws Committee shall consist of at least five (5) members of the Medical Staff, including at least the Chief of Staff-Elect and Immediate Past Chief of Staff, and one member of the Board of Trustees and the President or their designee. The Past Chief of Staff shall serve as Chair.

7.4-2 DUTIES

The Bylaws Committee shall:

- (a) Review the Medical Staff Bylaws and forms promulgated by the Medical Staff, its Departments at least biennially
- (b) Recommend to the Medical Executive Committee changes in these documents;
- (c) Receive and evaluate for recommendation to the Medical Executive Committee suggestions for modification of the items specified in subdivision (a); and
- (d) Receive and evaluate for recommendation from the Medical Staff and its committees' recommendations for changes in the Medical Center's corporate bylaws to be submitted to the Board of Trustees.

7.4-3 MEETINGS

The Bylaws Committee shall meet as often as necessary at the call of its Chair, but at least biennially. It shall maintain a record of its proceedings and shall report on its activities and recommendations to the Medical Executive Committee.

7.5 CREDENTIALS COMMITTEE

7.5-1 COMPOSITION

The Credentials Committee shall consist of not less than five members of the Active Medical staff selected on a basis that will insure, insofar as feasible, representation of major clinical specialties, and the president and his or her designee on an ex-officio basis without a vote. The Chair shall be the Chief of Staff Elect.

7.5-2 DUTIES

The Credentials Committee shall:

- (a) Review and evaluate the qualifications of each person applying for initial appointment, reappointment, or modification of Clinical Privileges, and, in this regard, obtain and consider the recommendations of the appropriate Committees or Departments.
- (b) Submit reports pursuant to the Credentialing Policies chapter regarding the qualifications of each person applying for membership or particular Clinical Privileges including recommendations for appointment, membership category, Clinical Privileges, and special conditions.
- (c) Investigate, review, and report on matters referred by the Chief of Staff or Medical Executive Committee regarding the qualifications, conduct, professional character, or competence of any applicant, Medical Staff member, or APP.
- (d) Submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.

7.5-3 MEETINGS

The Credentials Committee shall meet as often as necessary at the call of the Chair. The Committee shall maintain a record of its procedures and actions and shall report to the Medical Executive Committee.

7.6 INFECTION PREVENTION COMMITTEE

7.6-1 COMPOSITION

The Infection Prevention Committee shall consist of an Infectious Disease Specialist (IDS) (or Pathologist when an IDS is not available) and at least four other members of the Medical Staff. Additional voting members include representatives from Quality Management, Nursing Service, the President, Chief Nursing Officer, Microbiology, and an Infection Control representative. It may include other members from relevant hospital services such as home care, public health, the operating room/sterile processing, facilities management, pharmacy, and Environmental Services. The chair shall be appointed by the committee.

7.6-2 DUTIES

The Infection Prevention Committee shall:

- (a) Develop a hospital-wide infection control program and maintain surveillance over the program including written policies defining special indications for isolation requirements, hospital-wide preventative, surveillance, and control policies and procedures;
- (b) Develop a system for reporting, identifying, and analyzing healthcare associated infections;
- (c) Develop and implement preventative and corrective programs designed to minimize infection hazards;
- (d) Act on recommendations relating to infection control received from the Chief of Staff, the Medical Executive Committee, Departments, and other committees; and
- (e) Review sensitivities of organisms specific to the facility.
- (f) Other duties as assigned in Infection Prevention Policy ICP004.

7.6-3 MEETINGS

Infection Prevention Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record

of its proceedings and shall report on its activities and recommendations to the Medical Executive Committee.

7.7 PATIENT CARE REVIEW COMMITTEE

7.7-1 COMPOSITION

The Patient Care Review Committee shall consist of Medical Staff Department Chairs and Medical Directors representing various departments, the Chief of Staff Elect of the Medical Staff, and an administrative representative. Additional non-voting members include representatives from Quality Management. The chair shall be the Quality Medical Director.

7.7-2 DUTIES

The Patient Care Review Committee oversees the quality of patient care, treatment, and services provided by practitioners privileged through the Medical Staff process.

The Committee shall:

- (a) Adopt, subject to the Medical Executive Committee and Medical Center Board of Trustees approval, a quality improvement plan for maintaining quality patient care within the Medical Center. This plan may include mechanisms to:
 - (i) establish systems to identify potential problems in patient care through the use of objective criteria in measurement of actual practice against these criteria;
 - (ii) set priorities for action on problem correction;
 - (iii) refer problems for assessment and corrective action to appropriate Departments or Committees;
 - (iv) monitor the results of quality improvement activities throughout the Medical Center;
- (b) Conduct peer review by examining the work of peers and determine whether the practitioner(s) under review has met accepted standards of care in rendering medical services.
- (c) Establish and approve a utilization management plan to be approved by the Medical Executive Committee.

- (d) Conduct utilization management studies designed to evaluate the appropriateness of admissions to the Medical Center, length of stay, discharge practices, use of medical and Medical Center services, including over- and under-utilization, and related factors that contribute to the effective utilization of services.
- (e) Measure, assess and improve the Medical Center's performance to improve patient safety. This is accomplished in part by:
 - (i) utilization of the Accreditation Council for Graduate Medical Education (ACGME) Core Competencies (patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice);
 - (ii) assessment of appropriateness of clinical practice patterns;
 - (iii) assessment of significant departures from established patterns of clinical practice;
 - (iv) the focused professional practice evaluation (FPPE);
 - (v) the ongoing professional practice evaluation (OPPE);
 - (vi) perform operative and other procedure(s) review and blood/blood product utilization review (including blood transfusion reactions).
 - (vii) perform other review functions including, but not limited to, medical histories and physical examinations, mortality, autopsy, restraint/seclusion utilization, pain management, moderate/deep sedation, variance/indicator monitoring, patient grievances, and quality indicator monitors, as defined by the Quality and Patient Safety Council.
 - (viii) maintain a record of all actions taken and submit periodic reports to the Medical Executive Committee.

- (f) Develop, evaluate, and periodically revise and approve risk management policies and procedures relating to all phases of the Medical Center's activities.
- (g) Makes recommendations to Medical Executive Committee, Departments, and other Committees regarding improvement actions from professional practice evaluation activities.
- (h) Review and evaluate medical records, or a representative sample, to determine whether:
 - (i) they properly describe the condition, diagnosis, and progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided and those results, and adequate identification of individuals responsible for orders given and treatment provided;
 - (ii) they are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the hospital; and
 - (iii) special justification for the use of restraint or seclusion follows State law and the regulations of the hospital's accreditation organization.

7.7-3 MEETINGS

The Patient Care Review Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of its proceedings and shall report on its activities and recommendations to the Medical Executive Committee.

7.7-4 PROFESSIONAL PRACTICE EVALUATION

Many of the activities of the Patient Care Review Committee constitute confidential professional practice evaluation. When conducting professional practice evaluation activities, the Patient Care Review Committee is acting as an agent of the Medical Staff and may engage individuals from inside or outside the Medical Center to assist the committee in its professional practice evaluation activities.

7.8 PHARMACY AND THERAPEUTICS COMMITTEE

7.8-1 COMPOSITION

The Pharmacy and Therapeutics Committee shall consist of a minimum of 5 representatives from the Medical Staff with a minimum of 3 required for quorum. Non-voting members include a representative from pharmacy services, a representative from quality management, and a representative from the nursing service. The chair is appointed by the committee.

7.8-2 DUTIES

The Pharmacy and Therapeutics Committee shall:

- (a) Provide oversight of the medication management process at Mary Greeley Medical Center with regard to regulatory compliance.
- (b) Assist in formulating professional practices and policies for the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to drugs and diagnostic testing materials in the Medical Center, including antibiotic usage;
- (c) Develop and periodically review a formulary or drug list for use in the Medical Center;
- (d) Evaluate clinical data concerning new drugs or preparations requested for use in the Medical Center;
- (e) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;
- (f) Review all significant untoward drug reactions.

7.8-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of its proceedings and shall report on its activities and recommendations to the Medical Executive Committee.

7.9 INSTITUTIONAL REVIEW BOARD

The Institutional Review Board (IRB) shall be responsible for protecting the rights and welfare of human subjects through the review and approval of research projects.

7.10 ETHICS COMMITTEE

7.10-1 COMPOSITION

The Ethics Committee shall consist of physicians and other Medical Center staff members and non-staff members who are voting members, including social workers, representatives from nursing and Quality Management, clergy, ethicists, attorneys, and administrators. A minimum of three physicians must be present at a meeting to constitute a quorum. The chair is appointed by the committee.

7.10-2 DUTIES

The Ethics Committee shall:

- (a) Participate in development of guidelines for consideration of cases having ethical implications;
- (b) Develop and implement procedures for the review of these cases;
- (c) Develop and/or review of institutional policies regarding care and treatment of such cases;
- (d) Review retrospectively cases for evaluation of ethical policies;
- (e) Consult with concerned parties to facilitate communication and aid in conflict resolution; and
- (f) Participate in educational programs for the Medical Center practitioners and staff on ethical matters.

7.10-3 MEETINGS

The Ethics Committee shall meet as often as necessary at the call of its Chair but at least annually. It shall maintain a record of its activities and report to the Medical Executive Committee and the Board; however, any individual patient or physician identifiers shall be eliminated to the extent possible.

7.11 CANCER COMMITTEE

7.11-1 COMPOSITION

The Cancer Committee shall be a multi-disciplinary committee composed of representatives from surgery, medical oncology, diagnostic radiology, radiation oncology, pathology, cancer liaison physician, cancer program administrator, palliative care practitioner, and representatives of professional/technical services as appropriate. The Chair is appointed by the committee.

7.11-2 DUTIES

The Cancer Committee:

- (a) Annually establishes, implements, and monitors at least one clinical and one programmatic goal related to cancer care.
- (b) Promotes a coordinated, multi-disciplinary approach to patient management.
- (c) Annually monitors and evaluates the cancer case conference frequency, format, case presentation, and attendance requirements.
- (d) Annually monitors and evaluates effectiveness of community outreach activities.
- (e) Measures quality improvement outcome studies and complies with MGMC Quality Management Plan.
- (f) Promotes cancer related clinical trials.
- (g) Annually evaluates the quality of Cancer Registry data and activity.
- (h) Annually offers at least one cancer-related educational activity focused on staging in clinical practice guidelines.

7.11-3 MEETINGS

The Cancer Committee shall meet at least quarterly and shall keep a record of its proceedings.

7.12 BREAST PROGRAM LEADERSHIP COMMITTEE

7.12-1 PURPOSE

The Breast Program Leadership Committee (BPLC) (Professional Advisory Council) is responsible for goal setting, planning, initiating cancer policies, protocols, and activities adopted by the breast program. Policies and procedures are aligned with the national best practice standards. The Chair is appointed by the committee.

7.12-2 COMPOSITION

The BPLC shall consist of board-certified representatives from clinical specialties of surgery, medical oncology, radiation oncology, diagnostic radiology, pathology, and other appointees as deemed necessary by the Breast Program Director. The committee also includes a representative of genetics, nursing navigation, radiological technologist, cancer registry, marketing, and quality assurance.

7.12-3 DUTIES

Key elements of the Breast Program Leadership Committee are as follows. A full description of committee duties is defined in the breast program Scope of Services.

- (a) Assure compliance and review annual audits including but not limited to the following:
- Interdisciplinary Breast Cancer Conference Activity
 - Breast Conservation Rate
 - Sentinel Lymph Node Biopsy Rate
 - Breast Cancer Staging
 - Reconstructive Surgery Referral Rate
 - Clinical Trial Accrual
 - Quality and Outcomes
 - Quality Improvement

- (b) Identify and implement the scope of clinical services needed to provide quality breast care to patients.
- (c) Collaborate with physicians managing breast cancer patients to assure an interdisciplinary approach to patient care.
- (d) Assure a patient navigation process is in place to guide the patient and family through the complex continuum of care following diagnosis of a breast abnormality.
- (e) Monitor physician use of the American Joint Committee on Cancer (AJCC) staging in treatment planning for breast cancer patients.
- (f) Monitor and assure that the College of American Pathologists (CAP) guidelines are followed for all breast cancer reporting including Ki-67, estrogen and progesterone receptors and Her2 Status of all invasive breast cancers and to assure that outside slides are reviewed and reported by WRBCC pathologists.
- (g) Assure that radiation oncology services are performed by physicians' board certified in radiation therapy and monitor that a quality assurance program is in place, and that the breast cancer quality measures developed by the National Quality Forum (NQF) for radiation therapy are adopted.
- (h) Assure that medical oncology services are performed by physicians' board certified in oncology and monitor that a quality assurance program is in place, and that the breast cancer quality measures developed by the National Quality Forum (NQF) for medical oncology are adopted.
- (i) Promote advancement in prevention, early diagnosis, and treatment through the provision of clinical trial information and patient accrual to breast cancer related clinical trials and research protocols.
- (j) Encourage education, prevention, and early detection programs as part of the Breast Center's community outreach efforts.

7.12-4 MEETINGS

The BPLC shall meet at least quarterly and shall keep a record of its proceedings.

7.13 EMERGENCY MEDICINE COMMITTEE

7.13-1 COMPOSITION

The Emergency Medicine Committee shall be an interdisciplinary committee composed of representatives from Emergency Medicine and representatives of professional and technical services as appropriate. The chair of the committee is the Emergency Medicine Department Chair.

7.13-2 PURPOSE

The purpose of the Emergency Medicine Committee is to ensure that the MGMC Emergency Department (ED) provides quality, appropriate care to individuals presenting to the ED, and that the ED is in compliance with regulatory requirements.

7.13-3 DUTIES

The Emergency Medicine Committee:

- (a) Develops and evaluates the annual goals and objectives for Emergency Medicine Department.
- (b) Promotes an evidence based, coordinated, multi-disciplinary approach to patient management.
- (c) Monitors quality of care and patient satisfaction.
- (d) Monitors quality improvement and compliance with MGMC Quality Management Plan measures that pertain to the ED.
- (e) Reviews processes and implements change related to patient flow through the ED.
- (f) Monitors compliance with regulatory requirements.

7.13-4 MEETINGS

The Emergency Medicine Committee shall meet at least quarterly and shall keep a record of its proceedings.

7.14 CONTINUING MEDICAL EDUCATION COMMITTEE

7.14-1 COMPOSITION

The Continuing Medical Education Committee shall consist of at least five (5) members of the Medical Staff representing various specialties, and representatives from Pharmacy, Quality Management, Nursing Service, Media Services, and Administration. The chair is appointed by the committee.

7.14-2 DUTIES

The Continuing Medical Education Committee shall:

- (a) Provide learning activities with content that:
 - promotes improvements of quality in healthcare;
 - is valid, reliable, and accurate;
 - offers balanced presentations that are free of commercial bias for or against a product/service;
 - is vetted through a process that resolves any conflicts of interest of planners and faculty;
 - is driven and based on learning needs, not commercial interest;
 - addresses the stated objectives or purpose;
 - is evaluated for its effectiveness in meeting the identified educational need.
- (b) Provide a learning environment that:
 - supports learners' ability to meet their individual needs;
 - respects and attends to any special needs of the learners;
 - respects the diversity of the groups of learners;
 - is free of promotional and/or commercial activities.
- (c) Provide disclosure of:
 - relevant financial relationships planners or faculty have with commercial interests related to the content of the activity;
 - commercial support of the activity.
- (d) Strive to maintain ACCME/IMS accreditation standards.

7.14-3 MEETINGS

The Continuing Medical Education shall meet monthly, no fewer than 9 times per year, and shall maintain a record of its proceedings.

SECTION VIII

MEDICAL STAFF MEETINGS

8.1 MEETINGS

8.1-1 ANNUAL MEETING

The Annual Meeting of the Medical Staff shall be the last regular meeting before the end of the Medical Center's fiscal year. The Chief of Staff, or such other officers, Department heads, or Committee Chairs that the Chief of Staff or Medical Executive Committee designates, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the members. Notice of this meeting shall be given to the members at least thirty days prior to the meeting. The election of officers and committee members shall take place at this meeting on a biennial basis, as required by the Bylaws. The Chief of Staff shall report on actions taken by the Medical Executive Committee during the preceding year and on other matters believed to be of interest and value to the membership.

8.1-2 REGULAR MEETINGS

Regular meetings of the members shall be held at least quarterly, except that the Annual Meeting shall constitute the regular meeting during the quarter in which it occurs. The Medical Staff shall, by standing resolution, designate the date, place, and time of regular meetings.

8.1-3 AGENDA

The order of business at a regular meeting shall be determined by the Chief of Staff and Medical Executive Committee. The agenda shall include, at a minimum:

- (a) Acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;
- (b) Administrative reports from the Chief of Staff, the Departments, and committees;
- (c) Election of officers when required by the Bylaws;
- (d) Provide reports of Medical Staff activities from departments and committees;

- (e) Old business;
- (f) New business.

8.1-4 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee or shall be called upon the request 10% of the members of the Active Staff. The Medical Executive Committee, upon the written request of the Board of Trustees, shall call a special meeting of the Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within 30 days after receipt of this request. No later than 72 hours prior to the meeting, notice shall be disseminated to the members of the staff that includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice 72 hours prior to calling the meeting.

8.2 COMMITTEE AND DEPARTMENT MEETINGS

8.2-1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the Chairs of Committees, and Departments may establish the dates of regular meetings. The Chair shall make every reasonable effort to ensure that the meeting dates are disseminated to members with adequate notice.

8.2-2 SPECIAL MEETINGS

A special meeting of any committee or department may be called by, or at the request of its Chair, the Medical Executive Committee, the Chief of Staff or by a written request of 20% of the current members of the committee or department.

8.3 QUORUM

8.3-1 MEDICAL STAFF MEETINGS

The presence of at least 25% of the total membership of the Active Staff at any regular or special meeting shall constitute a quorum. Physicians must be physically present at the meetings or as approved in a virtual environment.

8.3-2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of 50% of the voting members shall be required for Medical Executive, Credentials, and Patient Care Review Committee meetings. For all other committees and departments, a quorum shall consist of the number of members present with no less than three physicians. Physicians may participate in departmental/committee meetings without physical attendance via conference or video call.

8.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such a meeting. Committee action may be conducted by telephone conference which shall be deemed to constitute a meeting for the matters then discussed. Action may be taken without a meeting by a Department Committee or the Medical Executive Committee by a written description of the action so taken that is signed by at least two-thirds of the members entitled to vote.

8.5 MINUTES

Except as otherwise specified, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on each matter. A copy of the minutes shall be signed by the presiding officer. A summary of the meeting minutes are forwarded to the Medical Executive Committee each month. Each Committee and Department shall maintain a permanent file of the minutes of each meeting.

8.6 ATTENDANCE REQUIREMENTS

8.6-1 REGULAR ATTENDANCE

Each member of the Active staff during the term of appointment who are required to attend meetings under Section III and IV should attend at least 50 percent of all meetings of each Department and Committee to which they have been assigned. Each member of the Community Based staff who qualifies under criteria applicable to Community Based members should attend such other meetings as may be determined by the Medical Executive Committee.

Attendance at 50% of the quarterly and annual Medical Staff meetings is required for members of the Active staff. If a practitioner fails to attend 50% of the quarterly meetings annually, the Medical Executive Committee will be informed and will determine if a letter will be placed in their file. The letter would be under professional practice evaluation protection. Members of the Community Based staff and APP staff are strongly encouraged to attend for their benefit and the benefit to the Medical Staff as a whole.

8.6-2 SPECIAL APPEARANCE

At the discretion of the Chair or presiding officer, when a member's clinical practice or conduct is scheduled for discussion at a regular Department, or Committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting, a statement of the issue involved, and that the member's appearance is mandatory. If a member fails to appear at any meeting for which they were given this notice, unless excused by the Medical Executive Committee on showing of good cause, all or such portion of the member's Clinical Privileges will be automatically suspended as directed by the Medical Executive Committee. This suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee as provided in Section 3.4-4 of the Credentialing Policies.

8.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to accepted parliamentary procedure; however, technical or nonsubstantive departures from these rules shall not invalidate an action taken at a meeting.

SECTION IX

CONFIDENTIALITY, IMMUNITY, AND RELEASES

9.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising Clinical Privileges within this Medical Center, an applicant:

- (a) Authorizes representatives of the Medical Center and the Medical Staff to solicit, provide, and act on information bearing, or reasonably believed to bear, on the applicant's professional ability and qualifications;
- (b) Authorizes persons and organizations to provide information concerning the applicant to the Medical Staff and Medical Center;
- (c) Authorizes the Medical Center to conduct a background check;
- (d) Agrees to be bound by the provisions of this Section and to waive all legal claims against any representative of the Medical Staff or the Medical Center who acts in accordance with the provisions of this Section; and
- (e) Acknowledges that the provisions of this Section are expressed conditions to an application for Medical Staff membership or the continuation of membership, and to the application for Clinical Privileges or to the continued exercise of Clinical Privileges at this Medical Center.

9.2 CONFIDENTIALITY OF INFORMATION

9.2-1 GENERAL

Medical Staff, Department, or Committee minutes, files and records, including information regarding any members or applicants to this Medical Staff or to any APP collected or prepared for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research, shall be confidential to the fullest extent permitted by law. Dissemination of this information and these records shall only be made when expressly permitted by law, pursuant to officially adopted policies of the Medical Staff or, if no officially adopted policy exists, only with the express approval of the Medical Executive Committee, or its designee. This confidentiality shall also extend to information of like kind that may be provided by third parties. The information

shall be part of Medical Staff Committee files and shall not become part of any particular patient's file or of the general Medical Center records.

9.2-2 BREACH OF CONFIDENTIALITY

Any breach of confidentiality of the discussions or deliberations of Medical Staff Departments, or Committees, except in conjunction with other Medical Center, professional society, or licensing authority, is outside the appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Medical Center. If determined that a breach occurred, the Medical Executive Committee shall undertake corrective action as it deems appropriate.

9.3 IMMUNITY FROM LIABILITY FOR ACTIONS TAKEN AND INFORMATION PROVIDED

Each representative of the Medical Staff and Medical Center, including all committee members, acting pursuant to these Bylaws shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken, or statements or recommendations made within the scope of their duties, or for providing information concerning any person who is or has been an applicant to or member of the staff, or who did or does, exercise Clinical Privileges or provide services at this Medical Center. (Pursuant to Iowa Code.)

9.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity of this Section shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility or organization's activities concerning, but not limited to:

- (a) Applications for appointment, reappointment, Clinical Privileges and prerogatives, and periodic reappraisals of members' status, privileges, and/or prerogatives;
- (b) Corrective action;
- (c) Hearings and appellate reviews;
- (d) Utilization reviews;

- (e) Other Department, Committee or Medical Staff activities related to monitoring or maintaining quality patient care and other appropriate professional conduct; and
- (f) Professional practice evaluation organizations and similar reports.

9.5 RELEASES

The Medical Center may request that an applicant or member execute general and specific releases in accordance with the express provisions and general intent of this Section. However, execution of these releases is not requisite to the effectiveness of this Section.

SECTION X

GENERAL PROVISIONS

10.1 RULES AND REGULATIONS AND CREDENTIALING POLICIES

The Medical Staff shall initiate and adopt the Credentialing Policies and such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise the Rules and Regulations and Credentialing Policies to comply with current Medical Staff practice. Recommended changes to the Rules and Regulations and Credentialing Policies chapters shall be submitted to the Medical Executive Committee for review and evaluation before consideration by the Medical Staff as a whole under review or approval mechanisms that the Medical Staff shall establish. If adopted, the Rules and Regulations and Credentialing Policies shall become effective following approval by the Board of Trustees. Applicants to and members of the Medical Staff shall be subject to and governed by the Rules and Regulations and Credentialing Policies. If a conflict arises between the Governance and Structure and the Rules and Regulations or Credentialing Policies, the Governance and Structure shall prevail.

10.1-1 DEPARTMENTAL GUIDELINES

Each Department shall initiate and adopt guidelines in the manner set forth in Chapter IV, Adoption and Amendment of Medical Staff Bylaws. If a conflict arises between Departmental guidelines and these Bylaws, those of the latter shall prevail.

10.2 AUTHORITY TO ACT

Action of the Medical Staff in relation to any person other than the members thereof shall be expressed only through the Chief of Staff or the Medical Executive Committee or his, her, or its designee, and they shall first confer with the President. Any member or members who act in the name of this Medical Staff without following this procedure shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate; however, this provision shall not apply if the action involves the President. In that situation, the Chief of Staff or Medical Executive Committee may confer directly with the Board of Trustees.

10.3 DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, subject to the approval the Medical Staff and

the Board of Trustees, and to determine the manner of expenditure of such funds received. Application fees within two years of a resignation and/or voluntary relinquishment of privileges will be assessed as established by the Medical Executive Committee. A failure to pay such dues or assessments shall result in those actions specified in Section 3.4 of the Credentialing Policies chapter.

10.4 DIVISION OF FEES

Any unlawful division of fees, or "fee-splitting", by members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff. It shall be understood, however, that a compensation arrangement involving payment by a group practice of the salary of a physician member of the group practice is not an unlawful division of fees.

10.5 MEDICAL STAFF CREDENTIALS FILES

10.5-1 INSERTION OF ADVERSE INFORMATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members, pursuant to Section 3.2-1 of the Credentialing Policies chapter. When adverse information is presented for insertion in the Medical Staff member's credentials file, the respective Department Chair, Chief of Staff, and the President shall review this request.

After this review, a decision will be made by the Credentials Committee to:

- (a) Not insert the information;
- (b) Insert the information with a notation that no further review is warranted; or
- (c) Insert the information and include review/consideration for further follow-up.

Adverse information placed in a credentials file will be reported to the practitioner.

The process for review and action of unacceptable behavior is outlined in Section 9.3 of the Rules and Regulations Chapter, Professionalism Policy.

10.5-2 REVIEW OF ADVERSE INFORMATION AT THE TIME OF REAPPRAISAL AND REAPPOINTMENT

Prior to recommendation on reappointment, the Credentials Committee, as part of its reappraisal function, shall review any adverse information in the credentials file pertaining to a member. Following this review, the Credentials Committee shall determine whether documentation in the file warrants further action.

- (a) If it does not appear that an investigation and/or adverse action on reappointment is warranted because of the adverse information (for whatever reason, including that the matter was already addressed through the progressive discipline policy under Section 9.3 of the Rules and Regulations chapter or under the Corrective Action or Fair Hearing procedure under Sections III and/or IV of the Credentialing Policies chapter), the Credentials Committee shall so inform the Medical Executive Committee;
- (b) If an investigation and/or adverse action on reappointment is warranted, the Credentials Committee shall so inform the Medical Executive Committee.

Not later than sixty (60) days following final action on reappointment, the Medical Executive Committee shall, except as provided in this Section:

- (a) Initiate a request for corrective action, based on such adverse information and on the Credentials Committee's recommendation relating thereto; or
- (b) Cause the substance of such adverse information to be summarized and disclosed to the member.

The member shall have the right to respond thereto in writing, and the Medical Executive Committee may elect to remove the adverse information on the basis of such response.

If the adverse information is not used as the basis for a request for corrective action or disclosed to the member as provided in this Section, it shall be removed from the file and discarded, unless the Medical Executive Committee, by a majority vote, determines that the information is required for continuing evaluation of the member.

10.5-3 CONFIDENTIALITY

The records of the Medical Staff and its Committees responsible for the evaluation and improvement of the quality of patient care provided in the Medical Center shall be maintained as confidential. Access to such records shall be limited to duly appointed officers and Committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities, subject to the requirement that confidentiality be maintained. Information shall be disclosed or available to the Board of Trustees of the Medical Center or its designee to allow the Board of Trustees to discharge its lawful obligations and responsibilities and shall be maintained as confidential. Members of the Medical Staff serving on Medical Staff committees are requested to sign a confidentiality agreement to signify their commitment to the confidentiality of all patient information and professional practice evaluation activities.

Information in the credentials file of any member may be disclosed with the member's consent, to any authorized Medical Staff or Medical Center, or to any professional licensing board. However, any disclosure without the member's consent outside of the Medical Staff or the Medical Center shall require the authorization of the Chief of Staff, the concerned Department Chair, and the President following consultation with legal counsel.

10.5-4 MEMBER'S ACCESS TO FILE

A Medical Staff member shall be granted access to their application or reappointment credentials file, subject to the following provisions:

- (a) Timely notice of this request shall be made by the member to the Chief of Staff, or their designee;
- (b) The member may review, and receive a copy of, their application and other documents provided by or addressed personally to the member. A written summary of all other information, including, but not limited to materials such as professional practice evaluation, committee findings, letters of reference, proctoring reports, and complaints, shall be prepared for the member if requested in writing. This summary shall disclose the substance, but not the sources, of the information summarized;

- (c) The review by the member shall take place during normal working hours, in the presence of an officer or designee of the Medical Staff or Medical Center administration.

10.5-5 CORRECTIONS, DELETIONS AND ADDITIONS TO THE CREDENTIALS FILE

- (a) When a member has reviewed their file as provided under Section 10.5-4, they may request, in writing, that the Chief of Staff make a correction or deletion of information in their credentials file. The request shall include a statement of the basis for the action requested.
- (b) The Chief of Staff shall review such a request within 60 days and shall recommend to the Medical Executive Committee after such review, whether or not to make the correction or deletion requested. The Medical Executive Committee then, by a majority vote, shall either ratify or initiate action contrary to this recommendation.
- (c) The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.
- (d) A member shall have the right to add to their own credentials file a statement responding to any information contained in the file, regardless of any action taken pursuant to this Section.

10.6 CONSTRUCTION OF TERMS AND HEADINGS

The captions and headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

10.7 NOTICES

“Notice” refers to a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified, or registered mail, return receipt requested, addressed to the required addressee at the address that appears in the records of the Medical Center.

Current Chief of Staff
Administration
Mary Greeley Medical Center
1111 Duff Avenue
Ames, Iowa 50010

10.8 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, Department Chairs, or the Medical Executive Committee shall, at least 20 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

10.9 PROFESSIONAL LIABILITY INSURANCE

Each practitioner, with the exception of Community Based Refer practitioners, granted Clinical Privileges at the Medical Center shall maintain in force professional liability insurance coverage with an insurance carrier licensed or approved to do business in the State of Iowa, in an amount of \$1M/\$3M as determined by the Medical Center Board of Trustees. This amount is subject to change at the discretion of the Board of Trustees. Any such change would be communicated to the Medical Staff. A plan of self-insurance, appropriately secured and supplemented as necessary by an excess liability insurance policy with an approved insurer, may be acceptable, but must be submitted to and approved in writing by the President. Each practitioner shall give evidence in writing of their insurance coverage or self-funded plan to the Credentials Committee and the President as a precondition to acceptance as a member of the Medical Staff and annually thereafter. The written evidence shall be a certificate of coverage issued by the insurance carrier indicating the amount of coverage, or details of the self-insurance plan with documentation of security and excess liability insurance coverage as appropriate. Each member shall report to the Credentials Committee and the President any reduction, restriction, cancellation, or termination of the required professional liability insurance coverage or change in insurance carrier or self-insurance plan within ten (10) days of receipt of notification or decision regarding such action from the insurance carrier or plan administrator.

10.10 CONFLICT RESOLUTION IN THE EVENT OF CONFLICT BETWEEN MEDICAL STAFF LEADERSHIP AND MEDICAL CENTER ADMINISTRATION (OR THE BOARD OF TRUSTEES)

Mary Greeley Medical Center recognizes that unmanaged or unresolved conflict among leadership groups is detrimental to the organization and may ultimately compromise the quality and safety of care provided within the organization. Therefore, the administrative leadership, the organized Medical Staff, and members of the Board of Trustees have developed an ongoing process for managing conflict that may arise among leadership of the Medical Center. This process has been approved by the Board of Trustees.

Individuals who help implement this process are judged to be competent and skilled in conflict management. The conflict management process is designed to be objective, information driven, and responsive in identifying and resolving conflict as early as possible in order to protect the safety and quality of care provided by the organization. This process is implemented whenever a conflict arises that, if not managed, could adversely affect patient safety or the quality of care provided within the Medical Center. The Board of Trustees reserves the ultimate authority to make decisions on behalf of the organization.

When a conflict arises between Medical Staff leadership and Medical Center leadership (and/or the Board of Trustees), the Medical Staff officers shall meet with the Board of Trustees and administrative leadership, or a designated committee of the Board and leadership, and seek to resolve the conflict through informal discussions.

If these informal discussions fail to resolve the conflict, the Chief of Staff, the chairperson of the Board, or the President, may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with establishment of a Joint Conference Committee including three officers of the Medical Staff, an at-large Medical Executive Committee member, the chair and secretary of the Board of Trustees or other designees of the Board, and the President or their designee. This process will begin within 30 days of the initiation of the formal conflict resolution process.

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee, leadership, and the Board within 30 days of the initial meeting, the Medical Staff, leadership, and the Board shall enter into mediation facilitated by an outside party. The third-party mediator shall be selected together by the Medical Executive Committee, the Board, and leadership.

The Medical Executive Committee, leadership, and Board shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Board, leadership, and the Medical Executive Committee shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee, leadership, and the Board.

If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee, leadership, and Board cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

In addition to the formal conflict resolution process herein described, the Chair of the Board or the Chief of Staff may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Board of Trustees, or Administration.

CHAPTER TWO
RULES AND REGULATIONS

SECTION I

ADMISSION OF PATIENTS

1.1 TYPES OF PATIENTS

Patients are admitted to Mary Greeley Medical Center without regard to age, race, color, national origin, ethnicity, religion, culture, language, disability, socioeconomic status, gender, sexual orientation, and gender identity or expression. Admission of any patient is contingent upon availability of room, staff, and patient care within MGMC's scope of services.

Definition of admission: A patient with inpatient admission orders.

1.2 ROLE AND RESPONSIBILITY OF ATTENDING PRACTITIONER

The attending practitioner shall be designated according to the following procedure:

1. The admitting practitioner is the attending practitioner until another practitioner is designated as attending and accepts the care of the patient. Refer to 2.2.
2. The attending practitioner shall be responsible for the overall care of the patient.
3. The designated attending practitioner during the first twenty-four (24) hours of hospitalization is responsible to ensure a history and physical is completed within twenty-four (24) hours of admission.
4. The attending practitioner at time of discharge will be responsible to ensure that the discharge summary which includes the diagnoses and procedure upon discharge are documented.
5. The final summary of care for patients who leave Against Medical Advice (AMA) prior to being physically seen by the oncoming attending practitioner must be completed by the last listed attending practitioner who saw the patient. When no practitioner has seen the patient, the responsibility of noting in the patient's medical record the circumstances upon which the patient left AMA must be documented by the last listed attending practitioner.

1.3 ADMITTING PREROGATIVES

1.3-1 GENERALLY

Only a member in good standing of the Active, or the Community Based (Admit and/or Consult) category of the Medical Staff, or Advanced Practice Provider Staff category may admit patients or accept transfers to the Medical Center to the extent allowed by Iowa code, subject to the admitting policies of the Medical Center in effect. Community Based-Refer providers must contact an Active member of the Medical Staff to admit inpatients and outpatients to the Medical Center. A Community Based-Refer provider may order non-invasive outpatient tests. A member "in good standing" is one who has had no adverse professional review action taken, including no involuntary limitation, restriction, suspension, revocation, denial, or non-renewal of the practitioner's staff membership and/or Clinical Privileges. Names of members not in good standing are provided to the admitting office by the President or his designee.

1.3-2 PRIORITIES WHEN RESOURCES ARE STRAINED

At times of full Medical Center occupancy or shortage of hospital beds or other facilities, as determined by the President or their designee, priorities for access to beds, services or facilities for patients are as follows:

- (1) Emergency (life threatening)
- (2) Urgent (serious, but not life threatening)
- (3) Elective

When two or more licensed independent practitioners with patients of the same priority status have made a reservation for an elective admission and all such reservations cannot be accommodated, priority is determined by the order in which the reservations were received.

1.3-3 LIMITATIONS FOR NON-MD OR NON-DO AND ADVANCED PRACTICE PROVIDER STAFF

Non-MD or non-DO staff and Advanced Practice Provider Staff may admit patients to the Medical Center, but a Doctor of Medicine

or Osteopathy (MD or DO) must be co-admitting or collaborating in the care as defined by the Clinical Privileges of the non-MD, non-DO, and/or Advanced Practice Provider staff.

1.3-4 DIRECT ADMISSIONS

A patient may be directly admitted to a specific unit once the physician or their designee telephones the House Supervisor for bed assignment. A representative from Admissions will complete the admission documentation with the patient when the patient is settled in their room. If deemed stable by the admitting physician, the patient may be directed to hospital registration. Behavioral Health patients are managed directly by Behavioral Health staff or providers.

1.4 ADMISSION INFORMATION

Except in an emergency, a patient will not be admitted to the Medical Center until an admitting diagnosis or valid reason for admission and admitting and initial treatment orders are provided by the practitioner requesting admission. Other required documentation or information specific to the type of admission involved is detailed in Section VI. If applicable, the admitting practitioner is also responsible for providing in the medical record the following information concerning a patient to be admitted: any source of communicable disease or significant infection; behavioral characteristics that would disturb or endanger others; and need for protecting the patient from self-harm.

1.5 EVALUATION BEFORE ADMISSION

All patients should be seen and evaluated by a qualified provider with admitting privileges prior to admission, except in the case of obstetrical patients in active labor, newborns, or in the case of a transfer patient, who will be seen upon arrival.

1.6 UNATTACHED PATIENTS

Active staff members will be assigned, commensurate with delineated Clinical Privileges, to attend unattached patients according to the on-call schedule, except as assigned to the Hospitalist, without regard to payment source.

1.7 CARING FOR A FAMILY MEMBER

It is recommended that physicians not be clinically involved in the care of a family member unless the required care is unavoidable. Family members include grandparents, parents, siblings, spouse, significant others, in-laws, children, and grandchildren.

This policy is in effect for the following potential conflicts:

Patient conflicts

- a. Compromise of patient autonomy if the patient prefers another provider or wants a second opinion for fear of offending the provider family member;
- b. Compromise of patient autonomy if patient wishes to refuse or alter care;
- c. Patient may avoid discussing sensitive issues or refuse intimate parts of physical examination;
- d. Possibility of family tensions if medical outcome is poor.

Provider conflicts

- a. Compromise of provider objectivity;
- b. Personal feelings may lead to undertreatment or overtreatment;
- c. Provider may avoid sensitive issues or intimate parts of the physical examination;
- d. Provider may feel obligated to treat or prescribe controlled substances for family members even if they feel uncomfortable;
- e. Insurance billing for family members creates a conflict of interest;
- f. Possibility of blurring distinction between family support and professional obligations.

SECTION II

GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

2.1 GENERALLY

A member of the Medical Staff shall be responsible for the coordination of medical care, treatment, and services among the practitioners involved of each patient in the Medical Center, for the prompt completion and accuracy of those portions of the medical record for which they are responsible, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner, if any, and to relatives of the patient authorized to receive such reports. Primary licensed independent practitioner responsibility for these matters belongs to the attending practitioner except when transfer of responsibility is affected pursuant to Section 2.2.

2.2 TRANSFER OF RESPONSIBILITY

The admitting provider will designate the attending provider in the medical record. When primary responsibility for a patient's care is transferred from the current attending practitioner to another staff member, it requires physician-to-physician communication of the transfer of care. Communication to the unit staff should be documented in the medical record.

2.3 CONTINUOUS CARE

Practitioners must assure continuous professional care for their patients in the Medical Center by being personally available or designating a qualified alternate licensed independent practitioner with whom prior arrangements have been made and who has the requisite Clinical Privileges at this Medical Center to care for the patient. Each hospitalized acute care patient shall be seen by their attending practitioner or designee within 24 hours of admission and every day, including daily progress note documentation in the patient record. "Being personally available" means that the practitioner or their designee is able to respond timely to emergency calls, appropriate for the situation/procedure performed as determined by the Board-Certified specialty under which the practitioner is granted privileges. There may be situations that require emergency transfer.

If the attending practitioner is unavailable, in case of an emergency or routine medical need, the practitioner must notify the nursing unit(s) and House Supervisor of the name of the alternate licensed independent practitioner who will be assuming responsibility for the care of the patient during their absence. If the staff member fails to make the required designation, the President, the Chief of Staff, or the applicable Department

Chair has the authority to call any member of the staff with the requisite Clinical Privileges to assume care. Failure of a practitioner to meet these requirements for continuous care may result in loss of Medical Staff membership or such other disciplinary action as the Medical Executive Committee or Board of Trustees deems appropriate.

2.4 POLICY CONCERNING IMMEDIATE QUESTIONS OF CARE

If a nurse or other health care professional involved in the care of a patient has reason to doubt or question whether the care provided is in the best interest of that patient or the appropriate consultation is needed and has not been obtained, such individual shall promptly bring the matter to the attention of the patient's attending physician. If the attending physician is not available, or if the doubt or question has not been resolved by the attending physician, the health care professional shall bring the matter to their Supervisor or the House Manager. The Supervisor/House Manager may contact the consultant on call if warranted.

2.5 CONSULTATIONS

2.5-1 RESPONSIBILITY

The good conduct of medical practice includes the proper and timely use of consultation.

If a department has fewer than four physicians, the specialty may opt to provide less than 24-hour, 7 days a week consult coverage. Departments of fewer than four full-time equivalent physicians should provide non-EMTALA consult coverage the equivalent of 7 days per month per FTE in the department. A monthly non-EMTALA consult schedule for the department must be provided to the hospital.

If the attending practitioner disagrees with the necessity for consultation, the matter can be brought immediately to the Chief of Staff or the applicable Department Chair for final decision and direction.

There may be situations in which a consultation is required. In these cases, the patient must actually be seen by the consulting physician as ordered. These situations are department-specific and are defined in the departmental policies and procedures.

2.5-2 QUALIFICATIONS OF CONSULTANT

A consultant must have demonstrated the skill and judgment requisite to evaluation and treatment of the condition or problem presented and have been granted the appropriate level of Clinical

Privileges.

2.5-3 COMMUNICATION AND DOCUMENTATION

- (a) Request By Licensed Independent Practitioner: Patient care is best served by direct communication between the requesting practitioner and the consultant/designee and should be documented in the medical record.
- (b) Report by Consultant: The consultant reports and documents their findings, impressions, and recommendations within 24 hours to the requesting practitioner. In addition, such report shall become part of the patients' medical record within 24 hours of the consultation.
- (c) Licensed Independent Practitioner's Response to Consultation: In the case of elective consultation, the requesting practitioner may utilize the consultant report in any manner that they judge to be in the patient's best interest. In cases of required consultation when the practitioner does not agree with the consultant, they shall either seek the opinion of a second consultant or refer the matter to the applicable Department Chair for final advice.

2.6 PHYSICIAN SUPERVISION OF DEPENDENT ADVANCED PRACTICE PROVIDERS

All licensed dependent APPs as defined by the Iowa Code practicing in the Medical Center must be supervised by a physician(s) currently appointed to the Medical Staff of this Medical Center. The physician must:

- assume responsibility for supervision or monitoring of the PA's practice as stated in the Rules and Regulations chapter and Advanced Practice Provider Manual;
- be continuously available or provide an alternate to provide consultation when requested or to intervene when necessary;
- assume total responsibility of the care of any patient when requested by the APP or in the interest of patient care;
- co-sign entries in the medical record as defined by the APP's privilege delineation.

Non-MD and non-DO staff and Advanced Practice Providers may treat patients under the conditions provided in Section 1.3-3 of this chapter and the Advanced Practice Providers Manual.

2.7 STUDENTS

2.7-1 Medical Students

Students who are currently enrolled in an accredited allopathic or osteopathic medical, dental, or podiatric school, residency, internship program, or an accredited physician assistant training program or nurse practitioner training program may be granted permission to observe, assess, and/or treat patients in the Medical Center under the direction and supervision of a member of the Active Medical Staff/APP Staff.

An affiliation agreement with the accredited school is required prior to scheduling a medical student observation/rotation. It is the responsibility of the clinic/supervising practitioner to complete the agreement process and submit a copy to MGMC with the student's rotation/observation request.

If a member of the Active Medical Staff/APP Staff wishes to supervise a student to assess or treat patients in the Medical Center, the following documentation is required to be sent to the President of the Medical Center:

- (a) current enrollment
- (b) Iowa license if applicable
- (c) current liability insurance
- (d) curriculum vitae
- (e) dates the individual plans to be in the facility
- (f) name of the supervising Active Medical Staff/APP Staff member(s)
- (g) description of privileges they wish to exercise, developed by the supervising practitioner and student. Students should only perform privileges within the scope of their education.

Privileges other than observation must be approved in advance by the Chair of the Department and the President, or their designees.

The student is required to report to the Human Resources Department to sign a confidentiality statement and receive a name badge.

The following guidelines shall apply to the student working with staff practitioners in the hospital. The student:

- (a) Must be covered by liability insurance provided through their medical school.
- (b) Must only work with practitioners who have agreed to be a supervising practitioner.
- (c) Must wear identifying insignia.

The staff practitioner:

- (a) Shall insure that patients are fully informed to consent to

- participation of the student in their care.
- (b) Must be immediately available during any patient care activity.
- (c) Must provide direct supervision during any procedures.

The Medical Staff designee will notify all clinical areas in the hospital of the scheduled student experience.

If the request is for observation or job shadow only and involves less than one week, the student must complete a Job Shadow Observation Agreement with MGMC Human Resources (HR). The student will check in with HR on their first day to receive a name badge and complete any other necessary paperwork. Permission is at the discretion of the supervising practitioner, who will notify the department director of the scheduled observation.

Non-Mary Greeley Medical Center physicians may be granted permission to observe procedures at the Medical Center. Permission is at the discretion of the physician being observed and the department director.

2.7-2 Non-Medical Students

Non-medical students (e.g. Master of Science in Nursing) who are currently enrolled in an accredited school may be granted permission to observe, assess, and/or treat patients in the Medical Center under the direction and supervision of qualified individuals as defined by the educational institution. These rotations will be processed through the Human Resources Department. An affiliation agreement with the accredited school is required prior to scheduling a non-medical student observation/rotation. An affiliation agreement must be completed.

2.8 NON-MEDICAL OBSERVERS (DOES NOT INCLUDE VENDORS REQUESTED BY THE PHYSICIAN FOR TECHNICAL SUPPORT)

Non-medical individuals may request permission to observe hospital functions, non-specific patient care, or a specific patient procedure. If the observation request pertains to hospital operations or non-specific patient care, the request must be approved in advance by the President and the Department Director or Clinical Supervisor, or their designees, who shall be responsible for verifying that patients do not object to the observation. If the observation request pertains to a specific patient or procedure, the request must be approved in advance by both the patient's attending physician and the Department Director or Clinical Supervisor, and it shall be the responsibility of the physician, or their designee, to verify and document that the patient does not object to the observation. Family members of the patient may not observe in the Operating Room, with the exception of family members on Birthways during a delivery. Non-medical students who wish to observe in the Medical Center shall follow the Human Resources policy.

2.9 VENDORS REQUESTED BY PHYSICIAN FOR TECHNICAL SUPPORT

All vendors will adhere to the guidelines of Administrative Policy GEN058, including confidentiality. Vendors will not be present in the procedure/operating room unless technical support of the staff and/or proceduralist/surgeon is requested and approved by the surgeon and Director of Surgical Services.

2.10 PERFORMANCE OF ABORTIONS

Chapter 146 of the Code of Iowa provides that an individual who may lawfully perform, assist, or participate in medical procedures which will result in an abortion shall not be required against that individual's religious beliefs or moral convictions to perform, assist, or participate in such procedures. Chapter 146 also provides that no individual shall be required against their religious beliefs or moral convictions to perform, assist, or participate in an abortion procedure. For the purposes of Chapter 146, "abortion" means the termination of a human pregnancy with the intent other than to produce a live birth or to remove a dead fetus.

As required by law, no individual shall be discriminated against in any way, including but not limited to employment, promotion, advancement, transfer, licensing, education, training, or the granting of hospital privileges or staff appointments, because of the individual's participation in or refusal to participate in recommending, performing, or assisting in an abortion procedure.

2.11 DISASTER PLAN

In the event of an officially declared disaster, whether it is local, state, or national, all available physicians on the Medical Staff shall make every effort to respond if needed and shall carry out assignments made by the physician in charge. The Medical Director of Emergency Services, the President, and the Chief of Staff or their designees will work as a team to coordinate activities and directions. In case of evacuation of patients from one section of the Medical Center to another or evacuation from the premises, they will authorize the movement of patients. All policies concerning patient care will be a joint responsibility of these individuals and, in their absence, of the administrative and Medical Staff members next in line of authority. All practitioners on the Medical Staff of the Medical Center specifically agree to relinquish direction of the professional care of their patients to these individuals in cases of such emergency.

2.12 CREDENTIALING VOLUNTEERS IN THE EVENT OF DISASTER

Volunteer licensed physicians who do not possess Medical Staff privileges at Mary Greeley Medical Center may practice at this hospital during a

“disaster” (defined as any officially declared disaster, whether it is local, state, or national). See Section 2.7 of the Credentialing Policies chapter.

SECTION III

TRANSFER OF PATIENTS

3.1 INTERNAL TRANSFER

Internal patient transfer priorities are as follows:

- (a) Emergency patient to an available and appropriate patient bed;
- (b) From intensive care unit to any general care room;
- (c) From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.

3.2 TRANSFERS TO MEDICAL CENTER

Transfers to the Medical Center from another facility must be accepted if the nature of the medical problem is emergent as defined by the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended (EMTALA) and if it is within the scope of care routinely provided at the Medical Center. Federal law currently defines an "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in

- (a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (b) Serious impairment to bodily functions;
- (c) Serious dysfunction of any bodily organ or part.

Or with respect to a pregnant woman who is having contractions

- (d) That there is inadequate time to affect a safe transfer to another hospital before delivery; or
- (e) That transfer may pose a threat to the health or safety of the woman or the unborn child.

The ED physician, Hospitalist and/or Specialist on-call have the responsibility to accept patients in transfer from another facility when contacted directly by the transferring physician and after determining that the Medical Center has the clinical capabilities to properly care for the patient.

When a call requesting a patient transfer to MGMC is received, the House Supervisor will verify the Medical Center's capacity by ensuring there is bed availability and adequate staffing resources. If the Medical Center has the capacity to accept a transfer patient, the House Supervisor will contact

the Specialist and/or Hospitalist to coordinate a three-way call with the transferring physician. If the patient is accepted, the House Supervisor will then make transfer arrangements.

If the accepting physician should need additional medical support, they should consult directly with the necessary physicians.

If the accepting physician determines that the patient's medical condition exceeds the capabilities of the Medical Center, they will suggest alternative referral sites to the transferring physician. The accepting physician may want to collaborate with other clinicians as appropriate for the case.

If a patient is transferred to the Medical Center and the receiving staff reasonably believes that the general transfer requirements of EMTALA (specified in Section 3.3-1 of this section) were not met by the transferring hospital, federal law requires that the improper transfer must be reported to the Iowa Division of Inspections and Appeals.

Advanced Practice Providers may not independently accept patient transfers from other medical facilities without the prerequisite privileges.

3.3 TRANSFER TO ANOTHER FACILITY

3.3-1 GENERAL REQUIREMENTS

Federal law requires that a patient shall be transferred to another medical care facility when:

- the patient is considered sufficiently stabilized for transport;
- arrangements have been made for admission with the receiving facility and receiving physician and their consent to receive the patient has been documented;
- the patient's informed written consent and the physician's certification have been obtained;
- the order is received of the attending practitioner or their designee; and
- the patient's emergency medical condition has not been stabilized but the patient (or a legally responsible person acting on the patient's behalf), after being informed of the hospital's obligation to provide further examination and treatment and of the risk of transfer, requests a transfer to another medical facility.

If the patient is unconscious or unable to provide a signed consent, and there is no next of kin available, the physician will decide what treatment is in the best interest of the patient. All pertinent medical information necessary to ensure continuity of care must accompany the patient.

In compliance with EMTALA requirements, if applicable, the name and address of any physician who failed to appear within a reasonable time when called to provide necessary stabilizing treatment shall also be documented and accompany the transfer.

3.3-2 DEMANDED BY EMERGENCY OR CRITICALLY ILL PATIENT

A transfer demanded by an emergency or critically ill patient, or the patient's family, is not permitted until a physician has explained to the patient or their family the full disclosure of risks and benefits specific to the patient's condition and generally not until a physician has determined that the condition is sufficiently stabilized for, and so documented, safe transport. In each such case, the appropriate release forms are to be executed. If the patient or the patient's authorized representative refuses to sign the release, a completed form without the patient's signature and a note with details that the patient was given complete explanation of the hospital's duties under COBRA must be included in the patient's medical record.

The patient requiring services not available at this facility will be transferred from the Medical Center to another facility after being examined shortly before transfer by the attending physician or their designee. The patient should be rendered as stable as reasonably possible for transfer. Orders should be given by the transferring physician to the EMT/Paramedic for treatment of any anticipated medical problems that may occur during the transfer.

3.3-3 MEDICAL SCREENING

Providers authorized to perform medical screening exams to determine if an emergency medical condition exists, are as follows:

(a) Emergency Department

Practitioners: Any physician Medical Staff member or physician assistant or advanced practice nurse with appropriate privileges providing emergency services is authorized to perform medical screening examinations in any location on the Medical Center premises.

Registered Nurses: Any registered nurse employed by the Medical Center who has completed the competency orientation checklist for Emergency Services is authorized to perform a nursing assessment to determine the need for a medical screening examination for individuals presenting as a sexual assault victim. Upon completion of the assessment, the registered nurse will describe the results to the appropriate physician and/or advanced practice provider, who will then

determine if the individual is in an emergency medical condition and will give orders of any further treatment outside of the sexual assault forensic examination.

(b) Mobile Intensive Care Services

Practitioners: Any Emergency Department practitioner is authorized to perform medical screening examinations, whether in person or through medical control via radio contact with the paramedics.

Paramedics: Any Paramedic Specialist employed by the Medical Center who has completed the competency-based orientation checklist for the Mobile Intensive Care Service, is authorized to perform a pre-hospital assessment which may form the basis of a medical screening examination.

Paramedics operate under standing protocols approved by the Medical Director. Paramedics may contact the on-duty Emergency Department physician for further orders/discussion.

(c) Birthways

Physicians: Any physician Medical Staff member with appropriate obstetrical privileges is authorized to perform medical screening examinations on the Birthways unit.

Midwives: Any midwife with appropriate obstetrical privileges is authorized to perform medical screening examinations on the Birthways unit.

Registered Nurses: Any registered nurse employed by the Medical Center who has completed the competency orientation checklist for Labor and Delivery is authorized to perform a nursing assessment which will form the basis for a medical screening examination. Upon completion of the nursing assessment, the registered nurse will describe the results to the appropriate physician or midwife who will determine whether the individual is in an emergency medical condition and will give orders for any further treatment.

(d) Psychiatric Services

Physicians/APPs: Any physician Medical Staff member or Advanced Practice Provider member with appropriate psychiatric privileges is authorized to perform medical screening examinations in the psychiatric unit.

Registered Nurses: Any registered nurse employed by the Medical Center who has completed the competency orientation checklist for psychiatric services is authorized to perform a nursing assessment of a psychiatric or substance abuse patient which will form the basis for a medical screening examination. Upon completion of the nursing assessment, the registered nurse will describe the results to the appropriate practitioner who will determine whether the individual is in an emergency medical condition and will give orders for any further treatment.

3.4 PHYSICIANS ON-CALL

3.4-1 GENERAL REQUIREMENTS

A Doctor of Medicine or Osteopathy is on duty at all times. Physicians on call to the ED for their specialty must respond to the ED as requested and personally evaluate the patient and may assist the ED physician with the appropriate treatment plan or disposition within 30 minutes after notification for emergent conditions as deemed emergent by the ED physician and within 60 minutes for non-emergent conditions. If an on-call consultant anticipates being unable to provide timely consultation, they will designate a substitute from their own department or a provider with like privileges and notify the ED nursing staff accordingly. See Section 2.5 in the Credentialing Policies Chapter.

The ED Medical Director will be notified if an on-call physician cannot be reached, failed to respond, or refused to accept the patient. If the patient must be transferred to another facility because of the on-call physician's inability to be reached, failure to respond, or inappropriate refusal to accept the patient (based on capability and capacity), then the EMTALA Transfer Form will be completed and sent with the patient to the receiving facility with the on-call physician's name and address. The ED personnel will complete a variance report.

Elective Procedures: On-call physicians are permitted to schedule elective procedures concomitantly while on-call. The on-call physician will not be considered unavailable due to the elective procedure, however, until initiation of anesthesia for the patient in the surgical suite.

Under circumstances in which all members of a consulting department are performing elective procedures in surgery or involved with other emergent conditions, the consultant on-call will be contacted for further instructions.

Simultaneous Call: On-call primary care physicians (Internal Medicine, Pediatrics, Hospitalists) are prohibited from serving on call at other hospitals while serving on-call at the Medical Center. On-call physicians from other specialties are permitted to serve on-call simultaneously at a hospital other than the Medical Center.

3.4-2 EMTALA PHYSICIAN CALL ROSTER

A roster of physicians regularly utilized in the treatment of patients with emergency medical conditions will be maintained in the Emergency Department and via Epic on-call. A department is determined by the specialty under which a practitioner is granted privileges. Providing on-call scheduling will be the responsibility of each department on the list noted below in coordination with hospital administration.

The physician will notify the hospital of any changes to the on-call schedule. If the physician responsible for treatment of an established patient is unavailable for any reason, the patient will be considered unattached and the physician on-call in the relevant specialty will be contacted.

If a specialty has fewer than four full time equivalent physicians, the specialty may opt to provide less than 24-hour, 7 days a week on-call coverage. However, departments of fewer than four full-time equivalent physicians on the on-call roster should provide call coverage the equivalent of 1 week per month per FTE in the department. A monthly EMTALA call schedule for the specialty must be provided to the hospital.

EMTALA PHYSICIANS ON-CALL ROSTER:

Anesthesiology	Ophthalmology
Cardiology	Gastroenterology
Orthopedic Surgery	General Surgery
Otolaryngology	Nephrology/Tele-Nephrology
Pediatrics/Peds Hospitalists	Tele-Neurology
Psychiatry/Tele-Psychiatry	Obstetrics & Gynecology
Radiology	Oncology
Urology	Internal Medicine/Hospitalist
Pulmonology	Podiatry

3.5 EMERGENCY DEPARTMENT INPATIENT ADMISSIONS

For inpatient admissions from the Emergency Department (ED), the ED physician will call the admitting physician to discuss admission and determine the appropriate unit. If the patient admission is approved, the ED physician will write holding orders, as appropriate, and make a bed request in the electronic health record (EHR). The unit will page the

admitting physician, who shall see the patient.

SECTION IV

DISCHARGE OF PATIENTS

4.1 REQUIRED ORDER

A patient may be discharged only on the order of the physician or their designee. The attending physician or their designee is responsible for documenting the principal diagnosis, secondary diagnoses, co-morbidities, complications, principal procedures, additional procedures, and medication reconciliation.

4.2 LEAVING AGAINST MEDICAL ADVICE

If a patient desires to leave the Medical Center against the advice of the attending practitioner or without proper discharge, the attending practitioner shall be notified and the patient will be requested to sign the appropriate release form, attested by the patient or their legal representative and witnessed by a competent third party. If possible, the attending physician should talk to the patient before the patient leaves to provide informed consent. If a patient leaves the Medical Center against the advice of the attending practitioner or without proper discharge, a notation of the incident must be made in the patient's medical record.

4.3 DISCHARGE OF MINOR PATIENT

Any individual who cannot legally consent to their own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, they shall so state in writing, and the statement must be made a part of the patient's medical record.

SECTION V

ORDERS

5.1 GENERAL REQUIREMENTS

All orders/requisitions for diagnostic tests and treatment procedures to be performed on an inpatient or outpatient must be ordered by a member of the Medical Staff or APP Staff within their scope and documented in the electronic medical record unless the order falls into the exception categories. All handwritten orders/requisitions must be written clearly, completely, legibly, in ink, and dated, timed, and signed by the practitioner responsible for them. Orders which are illegible or improperly written/entered will not be carried out until rewritten/re-entered or understood by the person who is to execute the order. Orders for diagnostic tests which necessitate the administration of test substances or medications will be considered to include the order for administration. All medication orders shall specify the route of administration.

Orders for admission into hospice and initial treatment orders into hospice may be provided by an Iowa licensed Doctor of Medicine or Osteopathy, and/or a nurse practitioner with the requisite training not on the medical/APP staff.

Treatment, examinations, and tests ordered for Mary Greeley Medical Center inpatients should be performed at the Medical Center if the services are available in the Medical Center. Patients will be transported to area clinics for those treatments, examinations, and tests that are 1) related to the reason for the hospitalization, and 2) unavailable within the Medical Center.

Exceptions include: self-referral examinations, including but not limited to mammograms, laboratory wellness profiles, non-invasive tests/procedures ordered by a licensed practitioner not on the Medical Staff (specifically to include physician, dentist, podiatrist, certified health service provider in psychology, nurse practitioner or physician assistant for routine evaluatory or follow-up care). Chiropractors can order appropriate studies for musculoskeletal imaging, that do not require sedation, and appropriate labs needed for such imaging studies. These practitioners are exempt from going through the credentialing process. Examples include chest x- ray, routine laboratory work, or professional service assessment.

5.2 STANDING ORDERS

Standing orders for any department or other clinical unit may be developed, reviewed, and approved by the Department Chair or the physician director of the unit in consultation with the Department involved, the Medical Executive Committee, the Director of Nursing, and Pharmacy leadership.

An initiating order by the practitioner (a practitioner authorized to give such an order) must be ordered before a standing order is used, except in emergency cases, influenza vaccinations, and pneumococcal vaccinations. Additional standing orders may be formulated by a member of the Medical Staff, subject to the approval of the applicable Department Chair. Standing orders may be pre-printed, electronic standing orders, order sets and/or protocols. Standing orders shall be considered as a specific order by the attending practitioner for that patient and shall be followed in the absence of other specific orders by the attending practitioner, insofar as the proper treatment of the patient will allow. Once implemented, standing orders will need to be signed by the practitioner responsible for care. A periodic and regular review of all standing orders must be conducted by the Medical Staff (P&T Committee), Director of Nursing, and Pharmacy leadership to determine the continuing usefulness and safety of the order.

5.3 REMOTE TELEMETRY ORDERS

Remote telemetry (Ambulatory Care Services, Surgical Unit, Oncology Unit) can be ordered by a physician if a patient meets the following criteria. The time frame for telemetry monitoring is at the discretion of the physician based on dysrhythmia.

1. Patient is at risk for cardiac dysrhythmia or ischemia. Examples include cardiac history, congenital conditions, history of left ventricular hypertrophy, coronary artery / peripheral vascular disease.
2. Patient who has had a surgical procedure and develops a non-life-threatening dysrhythmia and is stable.
3. Patient who requires IV medication administration which requires cardiac monitoring. This includes, but is not limited to Digoxin, Dilantin, Lasix, potassium chloride, and Magnesium.
4. Oncology medications with cardiotoxic effects or medication at high risk.
5. Stable patient who has had a non-emergent coronary PCI with or without stents (Ambulatory Care Services only).

5.4 VERBAL ORDERS

5.4-1 BY WHOM AND CIRCUMSTANCE

It is the expectation that physicians manage their own orders; verbal orders may be given with the exception of admission orders, discharge orders, and post-op orders. Telephone or other verbal orders shall be limited in frequency and may be taken only by the following personnel:

- (a) Registered nurses and licensed practical nurses may take all categories of verbal orders as allowed by state and federal law. Behavioral Health and obstetric registered nurses and licensed practical nurses may take admission orders. Medication reconciliation remains the responsibility of the attending provider or their designee.
- (b) Imaging technologists and radiologic secretaries may take orders regarding the types of imaging procedures to be taken and the anatomical parts to be imaged.
- (c) Radiation therapists and dosimetrists may take orders for radiation therapy dose, technique, and scheduling.
- (d) All laboratory department employees, including laboratory patient access staff, may take orders for laboratory test procedures and for preparation of blood and blood products, but not for actual administration of blood.
- (e) Physical therapists, Occupational therapists and Speech pathologists may take verbal orders for beginning, modifying, or discontinuing physical, occupational, and speech therapy procedures, diet modification, and for consultation and evaluation of patients.
- (f) Respiratory therapists may take verbal orders for beginning, modifying, or discontinuing respiratory therapy procedures, including arterial blood gas.
- (g) Recreational therapists may take verbal orders for beginning, modifying, or discontinuing recreational therapy procedures for patients.
- (h) Pharmacists may take verbal orders for clarification or adjustment of a specific medication order.
- (i) Medical social workers may take orders for those activities and services offered by the Medical Social Services department.
- (j) Paramedics may take verbal orders for treatment modalities in the pre-hospital setting including orders for drug therapy (excluding anti-neoplastic agents).

Paramedics may take orders in the Emergency Department only in the event of an emergency according to Emergency Department policies. The registered nurse in the Emergency Department and the paramedics may relay verbal orders to the paramedics in the field. All verbal orders taken by paramedics but not executed in the field must be reported to the Emergency Department nurse immediately for their execution.

The above-named personnel may accept verbal orders personally given by the ordering practitioner or transmitted by an authorized agent of the practitioner, who is acting under the direct supervision of the practitioner and for whom the practitioner assumes legal responsibility.

5.4-2 DOCUMENTATION OF VERBAL AND TELEPHONE ORDERS

Verbal and telephone orders will be repeated back to the ordering practitioner in order to ensure effective and accurate communication amongst caregivers. All verbal and telephone orders shall be entered in the proper place in the medical record, shall include the date, time, name, and signature of the person receiving the order, and the name of the practitioner giving the order, and shall be countersigned, dated, and timed by the ordering practitioner. Verbal orders for administration of controlled substances must be verified by signature of the ordering practitioner within 24 hours.

For verbal restraint orders refer to the restraint policy.

5.5 ORDERS BY PHYSICAL THERAPY/OCCUPATIONAL THERAPY

An outpatient physical therapy/occupational therapy evaluation and treatment may be provided by a Mary Greeley Medical Center physical therapist/occupational therapist with or without a referral from a physician, podiatric physician, or dentist. Inpatient physical therapy and occupational therapy evaluation and treatment provided in the hospital shall be done only upon authorization of a member of the hospital's Medical Staff.

5.6 ORDERS BY ADVANCED PRACTICE PROVIDERS

An advanced practice provider (APP) must practice within the scope of their privileges.

5.7 AUTOMATIC CANCELLATION OF ORDERS

All previous orders are automatically cancelled, unless a specific order is entered otherwise, when the patient goes to surgery or is transferred to another service or another level of service.

5.8 MAXIMUM DURATION

5.8-1 DRUGS/TREATMENTS COVERED AND MAXIMUM DURATION

When feasible, and in order to assure that the proper and complete therapeutic regimen intended by the prescribing practitioner is carried out, the exact total dosage or total period of time for the drugs or treatments listed shall be specified. When that has not been done, a maximum duration notification will be placed in the medical record automatically for the termination date and time. In implementing the order, nursing/pharmacy/respiratory therapy will calculate the maximum duration permissible so as to cover the total number of hours indicated. In no event shall the drug or treatment be given for the maximum duration permissible if the last effective order specifies a shorter interval or particular dosage.

Controlled Substances Schedule II	5 days
Antibiotics	7 days
Zithromax (azithromycin)	5 days
Toradol (ketorolac)	5 days
Entereg (alvimopan)	15 doses
All other drugs	30 days

5.8-2 EXCEPTIONS

Exceptions to the maximum duration rule are made under the following conditions:

- (a) the last effective order indicated an exact number of doses to be administered; or
- (b) the last effective order specifies an exact period of time for the medications.

5.8-3 MAXIMUM DURATION NOTIFICATION

The applicable unit (nursing/pharmacy/respiratory therapy) shall notify the prescribing practitioner that a medication or treatment order has reached its maximum duration. The attending practitioner should acknowledge the notification by providing an order to renew, change, or discontinue the medication or treatment as appropriate. If the notification has not been acknowledged, the staff will continue giving the medication or treatment until the practitioner is contacted for further orders.

5.9 BLOOD TRANSFUSIONS AND INTRAVENOUS INFUSIONS

Blood transfusions must only be started by a practitioner or by a registered nurse who has the requisite training and has been credentialed to do so in the Medical Center. Blood will be transfused over 2-4 hours unless otherwise specified in the physician order.

Intravenous infusions may be started by a physician, registered nurse, or other health care practitioner who is credentialed to do so by the Medical Center, and the order must specifically state the rate of infusion.

In incidents where there are blood transfusion reactions (as defined in the Clinical Guideline for: Blood/Blood Component Therapy) the blood transfusion will be stopped, the physician will be notified, and lab will be contacted to begin testing. If the involved testing does not indicate that a transfusion reaction has occurred, the blood transfusion can be restarted as ordered by the physician.

5.10 SPECIAL ORDERS

5.10-1 PATIENT'S OWN DRUGS AND SELF-ADMINISTRATION

Drugs brought into the Medical Center by a patient may not be administered unless the drugs have been identified by the Pharmacy and there is an order from the attending practitioner to administer the drugs. Self-administration of legal medications by a patient is permitted on a specific order by the authorized prescribing practitioner and in accordance with established Medical Center policy.

5.10-2 DO NOT RESUSCITATE (DNR) ORDERS

- (a) Once the DNR decision has been made, this directive must be an order by the physician.
- (b) All facts and considerations pertinent to this decision should be documented by the physician either on the DNR order sheet or in the progress notes.
- (c) Verbal orders for DNR status generally are not appropriate or acceptable. However, verbal DNR orders may be used under circumstances where the patient is currently under the care of the physician from whom the order is sought, and the physician has personal knowledge of the patient's terminal condition and the wishes of the patient and/or family. Under these circumstances, a verbal telephone order from the physician may be received by a registered nurse or hospital paramedic in the pre-hospital setting who

repeats back the verbal/telephone order and witnessed by one other registered nurse or hospital paramedic who must also hear the order, repeat back, and co-sign the order entered on the chart. Telephone orders must be countersigned, dated, and timed by the ordering physician and appropriate documentation made in the progress notes within 24 hours of issuance. If the order is not countersigned within the 24- hour period, it is invalid.

- (d) DNR is suspended during general anesthesia unless otherwise specified. Families need to define what specific measures they want taken for DNR patients while they are under anesthesia.
- (e) DNR orders should be renewed upon each admission, as patient condition warrants, and when requested by the patient/family. DNR may be rescinded at any time.

5.10-3 ADVANCE DIRECTIVES

Mary Greeley Medical Center recognizes a person's right under Iowa law to execute a Living Will or a Durable Power of Attorney for Health Care decisions in accordance with the requirements of the law. Living Wills and Durable Powers of Attorney for Health Care are both advance directives. These documents outline patients' desires for medical care when they can no longer express their desires themselves.

Patients may have a Living Will or Medical Power of Attorney or both. The Medical Center will seek to honor a patient's wishes as expressed in a Living Will or Durable Power of Attorney for Health Care duly executed under Iowa law. The existence or lack of an advance directive does not determine an individual's access to care, treatment, or services.

Where disagreement regarding care exists between a patient and a physician, or the patient and the patient's family, or between family members, or in other cases, the hospital will work to resolve such disputes in ways that best serve the care needs of the patient. In the event the decision of the patient regarding a certain course of medical care and treatment cannot be honored for reasons of legal liability, medical ethics, personal conscience, or other appropriate reason, the Medical Center shall work with the patient's physician to inform the patient of this fact and will assist, where appropriate, in making arrangements for transfer of the patient's care to another physician and/or hospital.

The Medical Center will follow the procedure in Administrative

Operational Policy PR016 to initiate/implement an advance directive.

5.10-4 IOWA PHYSICIAN ORDER FOR SCOPE OF TREATMENT (IPOST)

The IPOST is a document that consolidates and summarizes patient preferences for key life-sustaining treatments including: CPR, general scope of treatment, antibiotics, nutrition, and hydration. Persons may refuse treatment, request full treatment, or specify limitations.

It is primarily intended to be used by the chronically, seriously ill person in frequent contact with healthcare providers, a person with a life-limiting illness, or the frail and elderly already residing in a nursing facility. The IPOST is completed by the patient or authorized agent in conversation with a person with sufficient knowledge or training to be able to explain the procedural and medical implications of the various treatment choices, and then signed by the patient/agent and a physician, advanced registered nurse practitioner, or physician's assistant.

The IPOST "travels" with the patient and is honored in any setting. Photocopies, faxes, and electronic scans are valid.

The IPOST is a medical order set, not an advance directive, and thus does not revoke or replace an advance directive. IPOST is designed to complement advance directives and defers to the current advance directive laws.

An IPOST form executed in this state or another state or jurisdiction in compliance with the law of that state or jurisdiction shall be deemed valid and enforceable in this state to the extent the form is consistent with the laws of this state, and may be accepted by a health care provider, hospital, or health care facility.

In the absence of actual notice of the revocation of an IPOST form, a health care provider, hospital, health care facility, or any other person who complies with an IPOST form shall not be subject to civil or criminal liability or professional disciplinary action for actions which are in accordance with reasonable medical standards.

A health care provider, hospital, or health care facility that is unwilling to comply with an executed IPOST form based on policy, religious beliefs, or moral convictions shall take all reasonable steps to transfer the patient to another health care provider, hospital, or health care facility.

5.11 INSERTION OF THERAPEUTIC DEVICES

In order to ensure quality of care and patient safety, proper placement of therapeutic devices needs to be confirmed prior to use. The licensed independent practitioner inserting the device is responsible for determining appropriate positioning of the device per standard of care. The device will not be utilized by another provider or Mary Greeley Medical Center staff until the responsible practitioner confirms in the medical record by verbal order or entered documentation that the device can be used. In emergency situations, use of the device would be at the discretion of the inserting practitioner.

Examples of devices that need such documentation include, but are not limited to:

- Central venous pressure lines
- Intracerebral/intrathecal devices
- Pleural/Peritoneal catheters
- Percutaneous endoscopic gastrostomy tubes
- Peripherally inserted central catheters
- Umbilical artery catheters
- Umbilical venous catheters
- Dobhoff feeding tubes

5.11-1 INSERTION OF ENDOTRACHEAL TUBE FOR RESPIRATORY FAILURE

The insertion and change out of an endotracheal tube (ET) for respiratory failure will be performed by those most qualified on the Medical Staff. This includes Anesthesia providers, Emergency Medicine providers, Pulmonologists, Pediatricians, and paramedics trained in emergency airway management.

5.12 FORMULARY AND INVESTIGATIONAL DRUGS

5.12-1 FORMULARY

The Medical Center formulary lists drugs available for ordering from stock. Each member of the Medical Staff assents to the use of the formulary as approved by the Pharmacy & Therapeutics Committee. All drugs and medications administered to patients, with the exception of drugs for bona fide clinical investigations, shall be those listed in the latest edition: United States Pharmacopoeia; National Formulary, New and Non-Official Drugs; American Hospital Formulary Service; or AMA Drug Evaluations.

5.12-2 INVESTIGATIONAL DRUGS/DEVICES/RESEARCH STUDIES

Use of investigational drugs/devices/research studies must be in full accordance with all regulations of the Food and Drug Administration and must be approved by the Institutional Review Board (Research Review Committee) and the Medical Executive Committee. Investigational drugs/devices/research studies shall be used only under the direct supervision of the investigator. The investigator shall be responsible for receiving all necessary consents and completing all necessary forms and shall prepare and clarify directions for the administration or use of investigational drugs/devices as to (1) untoward symptoms, (2) special precautions in administration, (3) proper labeling of the container, (4) proper storage of drugs/devices, (5) methods of recording doses when indicated, and (6) method of collection and recording specimens of urine and/or other specimens.

If the investigator is not a member of the Mary Greeley Medical Center Medical Staff, interim approval of a new protocol, drug, or device must be received by the Institutional Review Board (IRB) Chair pursuant to Pharmacy Policy 611 (PH611 in the Administrative Manual).

If a physician wants to offer an unapproved protocol to a patient on an emergent basis (either drug or device) in a life-threatening situation in which no standard acceptable treatment is available and in which there is not sufficient time to obtain IRB-approval, it is the responsibility of the physician investigator to document the situation in writing, obtain informed consent, and report the use to the IRB Chair within five working days, including:

- Number and title of protocol, drug, or device
- Description or application of protocol, drug, or device
- Parameters for usage of protocol, drug, or device
- Verification of informed consent process

The emergency use must be reviewed by the full IRB at its next convened meeting. If the IRB Chair is not available, the MGMC President/designee may act on the request.

Patients admitted to MGMC receiving treatment related to a protocol approved by the NCI Central Institutional Review Board or another FDA approved IRB may continue to participate in the protocol uninterrupted if ordered by the attending physician and documentation is provided. Documentation is to include the other IRB's approval of the complete protocol and a signed consent form. Emergency use procedures as discussed above then apply.

SECTION VI

MEDICAL RECORDS

6.1 GENERAL CONTENT AND CHART COMPLETION

The attending practitioner and other Medical Staff members involved in the care of the patient shall be responsible for the preparation of a complete and legible medical record for each patient. The records content shall be pertinent, accurate, legible, timely, and current. The practitioner is responsible for reviewing and making corrections to documentation they author prior to signing the note. This includes, but is not limited to, dictation transcribed by a third party, dictation using front end voice recognition, and notes typed by the author. Authentication includes electronic signature.

The inpatient medical record shall be completed within fourteen (14) days of the discharge date. The outpatient medical record shall be completed within seven (7) days of the service date. Specific individual note or record timeliness requirements are as noted within this chapter.

The medical record contains the following demographic information:

- (a) The patient's name, address, date of birth, and the name of any legally authorized representative
- (b) The patient's gender, race, and ethnicity
- (c) The legal status of any patient receiving court-ordered behavioral health care services
- (d) The patient's communication needs, including preferred language (if non-English speaking) for discussing health care

Clinical Information as required based on type of visit or care provided:

- (a) The reason(s) for admission for care, treatment, and services
- (b) The patient's initial diagnosis, diagnostic impression(s), or condition(s)
- (c) Any findings of assessments and reassessments
- (d) Any allergies to food, medications, latex, adhesives
- (e) Any conclusions or impressions drawn from the patient's medical history and physical examination

- (f) Any diagnoses or conditions established during the patient's course of care, treatment, and services
- (g) Any consultation reports
- (h) Any observations relevant to care, treatment, and services
- (i) The patient's response to care, treatment, and services
- (j) Any emergency care, treatment, and services provided to the patient before their arrival
- (k) Any progress notes
- (l) All orders
- (m) Any medications ordered or prescribed
- (n) Any medications administered, including the strength, dose, and route
- (o) Any access site for medication, administration devices used, and rate of administration
- (p) Any adverse drug or anesthesia reactions, complications, and hospital acquired infections
- (q) Treatment goals, plan of care, and revisions to the plan of care
- (r) Results of diagnostic and therapeutic tests and procedures
- (s) Any medications dispensed or prescribed on discharge
- (t) Discharge diagnosis
- (u) Discharge summary with outcome of hospitalization, disposition of case, and provision for follow-up care

As needed to provide care, treatment, and services, the medical record contains the following additional information:

- (a) Any advance directives
- (b) Any informed consent, when required by hospital policy
- (c) Any records of communication with the patient, such as telephone calls or email

- (d) Any patient-generated information

The medical record of a patient who receives urgent or immediate care, treatment, and services contains all of the following:

- (a) The time and means of arrival
- (b) Indication that the patient left against medical advice, when applicable
- (c) Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, or services
- (d) A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment, or services

6.2 MEDICATION RECONCILIATION

In medication reconciliation, the physician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies. This comparison addresses duplications, omissions, and interactions, and the need to continue current medications. Medication reconciliation occurs during the patient's admission and again during the patient's discharge.

6.3 HISTORY AND PHYSICAL EXAMINATION OR OUTPATIENT ASSESSMENT

6.3-1 GENERAL AND PREOPERATIVE HISTORY AND PHYSICAL

The General or Preoperative History and Physical (H&P) report must include a medically appropriate history and physical examination. The admitting diagnosis, details of the present illness, relevant past medical, social, and family histories, the patient's emotional, behavioral, and social assessments as appropriate. The physical examination should include a medically appropriate review of systems.

The H&P for each patient shall be completed and documented in the medical record no more than 30 days before or 24 hours after the patient physically arrives for admission or registration, but prior to surgery or a procedure requiring anesthesia services (Anesthesia services include General, Regional, and MAC including Deep Sedation).

In cases of emergency, the responsible practitioner shall attempt to document the patient's condition prior to induction of anesthesia and start of the procedure, and the H&P shall be recorded immediately (within 24 hours) after the emergency surgery has been completed.

When the history and physical is completed within 30 days prior to admission or registration, an updated medical record entry documenting an examination for any changes in the patient's condition shall be completed and documented in the patient's medical record within 24 hours after admission or registration, and prior to surgery or a procedure requiring anesthesia services. The update shall include and document the following:

- That the patient has been examined.
- That the H&P has been reviewed.
- Any changes in the patient's condition, or
- That "no change" has occurred in the patient's condition since the H&P was completed.

This examination and update of the patient's current medical condition shall be completed and placed in the medical record within 24 hours after admission or registration, and prior to surgery or other procedure requiring anesthesia services.

History and physical examination reports provided by practitioners who do not have privileges at MGMC will be accepted, however, this H&P must be a legible copy and must be reviewed by a provider who has privileges at Mary Greeley Medical Center and updated as described above. The update must be completed and placed in the medical record within 24 hours after admission or registration, and prior to surgery or a procedure requiring anesthesia services.

The properly executed H&P is valid for the entire length of stay as changes in the patient's condition are documented in daily progress notes. A new H&P or update to the H&P is not required when the patient remains continuously hospitalized. When a patient is discharged and then readmitted to this Medical Center within 30 days for the same or a related problem, an interval history and physical examination within 24 hours reflecting subsequent history and changes in physical findings may be used, provided the original information is readily available.

The H&P, or updates to the H&P, must be completed and documented by a Doctor of Medicine or Osteopathy, an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy.

6.3-2 OUTPATIENT ASSESSMENT

- (a) An outpatient assessment (Short Form H&P) may be used in lieu of an H&P for outpatient procedures performed in the Cardiac Cath Lab, GI Department, or interventional procedures performed in Radiology. These patients must not

- require anesthesia services (General, Regional MAC, including Deep Sedation).
- (b) The outpatient assessment shall include and document at least the following:
 - a. History of illness.
 - b. Patient's current condition including respiratory status, cardiovascular status, medications, vitals, and known allergies; and
 - c. Verification that the patient is cleared for the planned procedure.
 - (c) The outpatient assessment must be:
 - a. Completed and documented by a Doctor of Medicine or Osteopathy, an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy;
 - b. Completed and documented in the medical record after registration, but prior to the outpatient surgery or procedure.

6.3-3 ADDITIONAL DOCUMENTATION RECOMMENDATIONS

The Medical Staff recommends that:

- EKG reports (if ordered) should be in the record.
- The EKG must be a 12-lead type and have been performed within the previous six months.
- EKGs are at the discretion of the primary care physician performing the H&P and should be considered if the patient is:
 - Age fifty (50) or greater.
 - Any patient taking cardiac or anti-hypertensive medication.
 - Any patient with a recent change in cardiac history or symptoms, i.e., chest pains.
- The referring physician, surgeon, charge anesthesiologist, or OR will be notified of an abnormal EKG.
- Labs that should be considered for patients that are 60 years of age or older or are diabetic are BUN, CR, and GFR.
- The physician responsible for this patient(s) care in the event of admission must be identified.

6.3-4 WHEN A HISTORY AND PHYSICAL ASSESSMENT ARE NOT REQUIRED

A history and physical or outpatient assessment is not required when a patient utilizes the following services:

- Therapy services (PT, OT, Speech)
- Diabetes Education/Nutritional Services
- Laboratory Services

- Radiology services without sedation
- Pain Clinic
- Wound Clinic
- Blood/Blood product administration
- Medication administration
- Outpatient procedures requiring local or minimum sedation

6.4 NON-MD OR NON-DO MEDICAL STAFF

Non-MD or Non-DO members of the staff are responsible for the following, as applicable:

- (a) A detailed history and physical of the dental/podiatric/psychiatric problem or problem within the non-MD's or non-DO's scope of practice, documenting the need for hospitalization and any surgery;
- (b) A detailed description of the examination of the oral cavity/foot and a preoperative diagnosis;
- (c) A complete operative report, describing the findings, technique, specimens removed and postoperative diagnosis;
- (d) Progress notes as are pertinent to the patient's treatment of dental/podiatric/psychiatric or other problem-related condition;
- (e) Pertinent instructions relative to the dental/podiatric/psychiatric or other condition for the patient and/or significant other at the time of discharge; and
- (f) Discharge summary.

6.5 ADVANCED PRACTICE PROVIDERS

Advanced Practice Providers are responsible for the following as applicable:

- (a) A detailed history and description of the problem within the APP's scope of practice, documenting the need for hospitalization and any surgery;
- (b) Progress notes as are pertinent to the patient's treatment of problem-related condition;
- (c) Pertinent instructions relative to the condition for the patient and/or significant other at the time of discharge; and
- (d) Discharge summary.

6.6 ANESTHESIA SERVICES

- (a) Anesthesia services are defined as General, Regional, and MAC, including deep sedation, and must be under the direction of an anesthesiologist who is a member of the Active Medical Staff.
- (b) Anesthesia services can only be administered by an anesthesiologist, CRNA, or a physician qualified to administer anesthesia within their privileges.
- (c) Pre-Anesthesia Assessment
 - A pre-anesthesia evaluation for all inpatient and outpatient procedures (using generals, regional, or MAC which includes deep sedation) must be performed and documented within 48 hours of surgery or procedure. The delivery of the first dose of medication for inducing anesthesia marks the end of the 48-hour timeframe.
 - The pre-anesthesia evaluation must include:
 - Review of medical history, including anesthesia, drug, and allergy history (within 48 hours)
 - Interview and exam of the patient (within 48 hours)
 - Documented airway assessment
 - Notation of anesthesia risk (ASA level)
 - Potential anesthesia problems identification
 - Review of objective diagnostic data
 - Develop plan of care including type of medication for induction, maintenance, and post-operative care
 - Discussion of risks and benefits of the anesthesia with the patient or the legal representative
- (d) An intra-operative anesthesia record is required for patients who have General, Regional, or MAC which includes deep sedation and must contain:
 - Name and medical record number
 - Name of practitioner who administered anesthesia
 - Techniques used and patient position, including insertion of any intravascular or airway devices
 - Name, dosage, route, and time of drugs
 - Name and amount of IV fluids
 - Blood/blood products
 - Oxygenation and ventilation parameters

- Time based documentation of continuous vital signs
 - Complications, adverse reactions, problems during anesthesia with symptoms, vital signs, treatment rendered, and response to treatment
- (e) A post-anesthesia evaluation for recovery is required for each patient who will receive General, Regional, or MAC which includes deep sedation and must be conducted by an anesthesiologist, CRNA, or a physician qualified to administer anesthesia (MD, DO, dentist, oral surgeon, or podiatrist) and must be documented in the medical record no later than 48 hours after the surgery or procedure. The 48 hours starts at the time the patient is moved into PACU or a designated recovery area.

Individual risk factors may dictate that the evaluation be completed and documented sooner than 48 hours. The patient must be sufficiently recovered so as to participate in the evaluation, e.g., answer questions, perform simple tasks, etc. If the patient is still intubated and/or in the ICCU, it should be documented that the patient is unable to participate in the evaluation.

Assessment documentation must include:

- Respiratory function with respiratory rate, airway patency, and oxygen saturation
- CV function including pulse rate and blood pressure
- Mental status
- Temperature
- Pain
- Nausea and vomiting
- Post-operative hydration

6.7 PROGRESS NOTES

Pertinent progress notes must be documented daily by the attending physician or designated licensed independent practitioner and recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner. Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes recorded by a dependent advanced practice provider must be countersigned within 7 days and supplemented as appropriate by the responsible supervising licensed independent practitioner.

6.8 OPERATIVE, HIGH-RISK PROCEDURE AND TISSUE REPORTS

6.8-1 OPERATIVE AND HIGH-RISK PROCEDURE REPORTS

Invasive procedures that involve the use of minimal, moderate, or topical anesthesia require a procedure note be documented in the medical record, so that it is available to the next provider of care. In this case, the procedure note must be available in the patient record within 24 hours following the procedure, however, if there is an unintended outcome of a procedure, physician to physician communication will take place before the patient leaves the procedure room.

All surgeries or invasive procedures that require anesthesia services (excluding minimal or moderate sedation or topical analgesics, which are not considered to be “anesthesia”) require an operative report or an immediate post-procedure note if the operative report is not immediately available.

The operative report will contain at least the following:

- Name and hospital identification number of the patient;
- Date and times of the surgery;
- Preoperative diagnosis;
- Postoperative diagnosis;
- Name of the specific surgical procedure(s) performed;
- Type of anesthesia administered;
- A description of techniques, findings, and tissues removed or altered;
- Prosthetic devices, grafts, tissues, transplants, or devices implanted (if any);
- Estimated blood loss (specify N/A if no blood loss);
- Complications;
- Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical tasks include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues)

The operative report or immediate post-operative/post-procedure note (for those procedures that do have General,

Regional, or MAC which includes deep sedation) must be documented in the medical record upon completion of the procedure and before the patient is transferred to the next level of care. If the full report cannot be immediately entered into the medical record, the procedural physician must document an immediate postoperative/post-procedure note into the record before the patient is transferred to the next level of care (e.g., before the patient leaves the post anesthesia care area).

If the immediate post-operative/post-procedure is used, then the full operative note must be documented in the medical record or dictated within 24 hours of the procedure. If dictated, then the operative note must be transcribed and available in the medical record within 12 hours after dictation. This will provide for continuity of information and care.

The immediate postoperative/post-procedure note must include:

- Preoperative diagnosis;
- Postoperative diagnosis;
- Procedure(s) performed;
- Type of anesthesia administered;
- Specimen(s) removed;
- Grafts or implants (may indicate where in the chart for detail, if any);
- Estimated blood loss (specify N/A if no blood loss);
- Complications (if any encountered);
- Surgeon and assistants.

If the information identified in the immediate post-operative/post procedure note is available elsewhere in the medical record, it is acceptable if referred to and authenticated as accurate by the attending surgeon.

6.8-2 TISSUE EXAMINATION AND REPORTS

All tissues, foreign bodies, artifacts, and prostheses removed during a procedure, except those specifically excluded by policy of the Pathology Department, shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room or suite at the time of removal, and sent to the pathologist. The pathologist shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical

information and, to the degree known, the preoperative and postoperative diagnoses. An authenticated report of the pathologist's examination shall be made a part of the medical record.

6.9 OBSTETRICAL RECORD

The current obstetrical record should include a prenatal record. In situations of emergency or patient presentation without known prenatal care, the physician should try to obtain as much prenatal history as possible under the circumstances. All obstetrical patients undergoing surgery must have a history and physical examination recorded or updated as required under Section 6.3 of this chapter.

6.10 BEHAVIORAL HEALTH RECORD REQUIREMENTS

Documentation of the need for and use of the following procedures in the medical record shall be the responsibility of the attending physician:

- (a) Restraints or seclusion: In addition, a face-to-face assessment must occur after initiation, but within one-hour post-initiation of the restraint or seclusion for violent or destructive behavior and orders must be entered in accordance with policy.
- (b) Electroconvulsive therapy.

6.11 VIOLENT AND NON-VIOLENT RESTRAINTS

For further detail, refer to the Clinical Guideline for Restraint and Seclusion.

6.12 AUTHENTICATION

All practitioner entries in the patient's record must be accurately dated, timed, and individually authenticated. Authentication means to establish authorship by written signature, identifiable initials, or computer key.

6.13 USE OF SYMBOLS, ABBREVIATIONS AND DEFINITIONS

Symbols, abbreviations, and definitions may be used only when they have been approved by the Medical Staff. An official record of approved symbols, abbreviations, definitions, and prohibited abbreviations is available on the MGMC Intranet to each department and in the medical records department.

6.14 ENTRIES AT CONCLUSION OF HOSPITALIZATION

6.14-1 DISCHARGE SUMMARY

- (a) In General: A discharge summary must be recorded for all inpatients. The summary must recapitulate concisely the reason for hospitalization, the significant findings, including complications, the procedures performed, and treatment rendered, and the condition of the patient on discharge, stated in a manner allowing specific comparison with the condition on admission. The final summary of care for patients who leave prior to being physically seen by the oncoming attending physician must be completed by the last listed attending physician who saw the patient.
- (b) Exceptions: A final progress note may be substituted for the discharge summary in the case of the following categories of patients: (1) normal newborn infants; (2) patients having uncomplicated vaginal deliveries.

6.14-2 INSTRUCTIONS TO PATIENTS

The discharge summary or final progress note must indicate any specific instructions given to the patient and/or significant other relating to physical activity, medication, diet, and follow-up care. If no instructions were required, a record entry must be made to that effect.

6.15 CLOSING OF THE HOSPITAL ENCOUNTER

In the event that an encounter remains incomplete by reason of death, resignation, or other inability or unavailability of the responsible licensed independent practitioner to complete the record, the Department Chair shall consider the circumstances and may enter such reasons in the record and order it closed.

6.16 OWNERSHIP AND REMOVAL OF RECORDS

All original patient medical records, including imaging studies, pathological specimens and slides are the property of the Medical Center. Original medical records may be removed only in accordance with Federal or State law. Copies of records, films, slides, etc. may be released without specific authorization in situations involving transfer to another facility to assure continuity of care. Unauthorized removal of a medical record or any portion thereof from the Medical Center is grounds for such disciplinary action, including immediate and permanent revocation of staff appointment and Clinical Privileges, as determined by the appropriate authorities of the Medical Staff and Board of Trustees.

6.17 ACCESS TO RECORDS

6.17-1 BYPATIENT

A patient may, upon appropriate request, have access to all information contained in their legal medical record, unless access is restricted as required by federal or state law. All records will be released per HIPAA requirements as outlined in Administrative Policy CON002 "Individual Access to Protected Health Information."

6.17-2 FOR STATISTICAL PURPOSES AND REQUIRED ACTIVITIES

Patient medical records shall also be made available to authorized Medical Center personnel, Medical Staff members, or others with an official, Medical Center-approved interest for the following purposes:

- (a) Automated data processing of designated information
- (b) Activities concerned with assessing the quality, appropriateness, and efficiency of patient care
- (c) Clinical unit/support service review of work performance
- (d) Official surveys for Medical Center compliance with accreditation, regulatory, and licensing standards
- (e) Approved educational programs and research studies.

Use of a patient record for any of these purposes shall be such as to protect the patient from identification and confidential personal information extraneous to the purposes for which the data is sought shall not be used.

6.17-3 ON READMISSION

In the case of readmission of a patient, previous records shall be available for use of the current attending practitioner.

6.17-4 PATIENT AUTHORIZATION REQUIRED UNDER CIRCUMSTANCES

Written authorization of the patient or the patient's legally qualified representative is required for release of medical information to persons not otherwise authorized under Section 6.18 or by Federal or State law to receive this information.

6.17-5 SPECIAL DISCLOSURE CONSENT

Special informed disclosure consents and prohibitions against re-disclosure are required for release of patient information pertaining to mental health, substance abuse treatment, genetic testing, and Acquired Immune Deficiency Syndrome (AIDS) testing, including Human Immuno-Deficiency Virus (HIV) testing.

SECTION VII

CONSENTS

7.1 GENERAL CONSENT

7.1-1 EVIDENCE OF CONSENT

Each patient's medical record must contain evidence of the general consent of the patient or the patient's legal representative for treatment during hospitalization.

7.1-2 COMPLIANCE WITH PRIVACY PRACTICES

As a condition of appointment, each applicant shall, effective as of the date of appointment, become a participant in an Organized Health Care Arrangement with the Medical Center. As part of the Organized Health Care Arrangement, each Medical Staff member and any other individual exercising Clinical Privileges in the Medical Center shall comply with any federal or state laws or Medical Center policies and procedures related to the use or disclosure of individually identifiable health information.

7.2 INFORMED CONSENT

7.2-1 WHEN REQUIRED

A properly executed informed consent contains documentation of a patient's mutual understanding of and agreement for care, treatment, or services through written signature, electronic signature, or when a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision maker. The performing licensed independent practitioner is responsible for obtaining informed consent for the procedures and treatments listed below. Medical Center personnel may obtain signatures on consent forms, but the responsibility for informing the patient of the proposed procedure and its potential benefits, risks, and significant alternatives, and obtaining the informed consent of the patient, remains the sole responsibility of the performing practitioner. The consent form simply documents that the patient agrees that the informed consent process between the performing practitioner and the patient took place. The performing practitioner shall document in the medical record the discussion regarding informed consent with the patient and/or family.

The following procedures require a separate informed consent:

- (a) Anesthesia;
- (b) Surgical and other invasive and special procedures;
- (c) Use of experimental drugs/devices/research studies;
- (d) Organ donation;
- (e) Autopsy;
- (f) Photography, where the patient is identifiable;
- (g) Transfusions (blood and blood products);
- (h) Other procedures as referenced by the Consent policy.

7.2-2 DOCUMENTATION REQUIRED

The informed consent must be documented in the patient's medical record or on a form appended to the record and must include at least the following information:

- (a) Patient identity;
- (b) Date when patient informed and date/time when patient signed the form, if different;
- (c) Detailed nature (e.g., robotic, laparoscopic, etc.) of the proposed care, treatment, services, medications, interventions, or procedures;
- (d) Name(s) of the individual(s) who will perform the procedure or administer the treatment;
- (e) Authorization for any required anesthesia;
- (f) Potential benefits, risks, and reasonable alternatives to the proposed care, treatment, and services. The relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment and services;
- (g) A statement that the patient has been given the opportunity to ask questions of the performing practitioner, and all questions have been answered to the patient's satisfaction;

- (h) Authorization for disposition of any tissue or body parts as indicated;
- (i) Name of the performing practitioner who informs the patient;
- (j) When indicated, any limitations on the confidentiality of information learned from or about the patient.

7.2-3 SIGNATURES

An informed consent must be signed by the patient (or on the patient's behalf by the patient's authorized representative), and the signature witnessed by a legally competent person.

7.2-4 EMERGENCIES

If emergency circumstances arise where it is deemed medically advisable to proceed with a procedure or treatment specified in Section 7.2-1 without first obtaining the informed consent required therein, such circumstances must be documented in the patient's medical record. In order for informed consent to be implied in emergency cases, the patient must be incapable of giving informed consent and the patient's health will suffer serious harm if the procedure is not undertaken immediately.

SECTION VIII

MEDICAL CENTER DEATHS AND AUTOPSIES

8.1 MEDICAL CENTER DEATHS

8.1-1 PRONOUNCEMENT

In the event of a Medical Center death, the deceased shall be pronounced dead by the attending physician or on-call physician within a reasonable period of time. The pronouncement may be given by a telephone order.

8.1-2 REPORTABLE DEATHS

Reporting of deaths to the Medical Examiner's Office shall be carried out when required by and in conformance with State law. Reportable deaths, as stated in Iowa Code 331.802, are deaths affecting the public interest and includes, but is not limited to, any of the following:

- Violent death, including homicidal, suicidal, or accidental death;
- Death caused by thermal, chemical, electrical, or radiation injury;
- Death caused by criminal abortion including self-induced or by sexual abuse;
- Death related to disease thought to be virulent or contagious which may constitute a public hazard;
- Death that has occurred unexpectedly or from an unexplained cause;
- Death of a person confined in a prison, jail, or correctional institution;
- Death of a person who was prediagnosed as a terminal or bedfast case who did not have a physician in attendance within the preceding thirty (30) days, or death of a person who was admitted to and had received services from a hospice program as defined in Section 135J.1, if a physician or registered nurse employed by the program was not in attendance within thirty (30) days preceding death;
- Death of a person if the body is not claimed by a person authorized to control the deceased person's remains under section 144C.5, or a friend.
- Death of a person if the identity of the deceased is unknown;
- Death of a child under the age of two (2) years if death results from an unknown cause or if the circumstances

surrounding the death indicate that sudden infant death syndrome may be the cause of death.

- Death of a person committed or admitted to a state mental health institute, a state resource center, the state training school, or the Iowa juvenile home.

8.1-3 DEATH CERTIFICATE

The death certificate must be signed by the attending physician unless the death is a Medical Examiner's case, in which event the death certificate may be issued only by the Medical Examiner. When a reported case is declared "Jurisdiction Declined" by the Medical Examiner, the attending physician issues the death certificate.

8.1-4 RELEASE OF BODY

The body may not be released until an order has been given by a physician member of the Medical Staff. The body must have a physically attached hospital wrist band, toe tag, etc. for identification. In a Medical Examiner's case, the body may not be released to anyone other than Medical Examiner personnel or to police officers, except upon the receipt of an "Order to Release Body" form issued by the Medical Examiner. All other policies with respect to the release of dead bodies shall conform with State law.

8.2 AUTOPSIES

Autopsies for natural hospital deaths may be requested by the attending physician, and together with the pathologist, it will be decided if any autopsy is necessary. Proper consent for an autopsy shall be in accordance with applicable State law. The provisional anatomic diagnosis must be recorded in the medical record within 72 hours. The complete protocol shall be made a part of the medical record within 60 days unless special studies are being performed. It is the attending physician's responsibility to communicate autopsy results to the family.

1. Medical examiner cases are excluded. These cases will be triaged by the medical examiner investigator on-call.
2. Family requested autopsies are not available at this institution.
3. Fetal, infant, and adolescent autopsies are not available at this institution.

SECTION IX

PHYSICIAN HEALTH, WELL BEING AND PROFESSIONALISM

The Medical Staff expects practitioners to be in good physical health to care for patients. If a practitioner is ill, they shall use reasonable judgment before exposing patients, staff, and others to communicable illness.

The Medical Staff has adopted the following processes in instances of drug and alcohol abuse and/or unacceptable behavior. The purposes of these processes are to provide confidential assistance with diagnosis, assistance with facilitating treatment and rehabilitation to aid a practitioner in retaining or regaining optimal professional functioning, consistent with protection of patients, staff, and Medical Center operations.

The following key factors are included in the Practitioner Health and Well Being policies and procedures:

- Confidential self-referral by a practitioner and confidential referral by members of the Medical Staff or other Medical Center staff;
- The affected practitioner will be referred to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern.
- All complaints, allegations, or concerns regarding the affected practitioner will be thoroughly investigated, including review of the complainant and evaluated for validity.
- The affected practitioner will be monitored by the appropriate Medical Staff/Medical Center leadership until the rehabilitation, or any disciplinary process is complete, to assure the safety of the staff and the patient population under their care.
- Any individual within the organization has the responsibility to report concerns regarding unsafe treatment by practitioners.

Education of organizational leaders and the Medical Staff will be provided at Medical Center management meetings and Medical Staff meetings regarding recognition issues specific to these instances, including signs and symptoms. The confidentiality of the affected individuals will be strictly maintained, with the following exceptions:

- a. State and federal regulatory requirements (if applicable)
- b. Ethical obligations
- c. When maintaining confidentiality threatens the safety of a patient or staff member. In all instances, every effort to protect the confidentiality of the individual referred for assistance will be made.

9.1 ALCOHOL AND DRUG ABUSE

9.1-1 EXPECTED CONDUCT

The State regulations governing the practice of medicine in Iowa provide that:

Habitual intoxication, drug addiction, or the excessive use of alcohol, drugs, narcotics, chemicals, or other types of materials which may impair a practitioner's ability to practice their profession with reasonable skill and safety, are practices that are harmful or detrimental to the public.

Accordingly, the Medical Staff has determined that the best interests of patient care require that appropriate steps be taken to assure that no practitioner is permitted to provide patient care at the Medical Center while they are under the influence of alcohol, drugs, or other chemical substances. Therefore, in accordance with medical center policies pertaining to a drug free workplace, practitioners shall refrain from consumption of alcoholic beverages and/or substances that could cause potential impairment, while in any situation that may require their participation in direct patient care, including on-call situations. If not on call but called in for the care of a specific patient condition, the practitioner should disclose to the attending physician if the practitioner consumed alcohol or other substances. The attending physician and practitioner can then determine the course of treatment in the best interest of the patient.

It shall be the responsibility of all practitioners who observe or have knowledge of another practitioner in a chemically impaired condition within the medical setting which affects the practitioner's ability to practice their profession with skill and safety, or who poses a hazard to the safety or welfare of others, or is otherwise in violation of this section, to promptly report that fact to the Chief of the Medical Staff and the Medical Center President/Designee. In addition, licensed practitioners in Iowa have a continuing legal duty to report such acts or omissions of a fellow licensee to their professional licensing boards and are subject to discipline by their licensing board for their willful failure to make the report.

9.1-2 DEFINITION OF CHEMICALLY IMPAIRED PRACTITIONERS

A practitioner who emits the odor of alcohol, drugs, or other chemical substances, or whose behavior, appearance, or speech suggests impairment from the use of alcohol, illicit drugs, prescription drugs, or other chemical substances, must also be considered "under the influence" until determined otherwise.

If a practitioner questions the existence of odor or of fitness to proceed, a second practitioner or a supervisory professional staff member will be called to validate the interpretation.

1. If a practitioner appears to be under the influence of any chemical substance, it shall be the obligation of the practitioner's fellow practitioners (e.g., ED physician, Hospitalist, Chief of Staff, or partner) and the supervisory professional staff of the Medical Center to intervene immediately, whether prior to or during the care of a patient. This intervention is to address patient care needs and arrange alternate coverage as indicated/defined in step 3.

The Chief of Staff or designee shall require a chemical substance test at the time of the intervention. If the suspected practitioner refuses a chemical substance test, patient care shall not be rendered by the suspected practitioner and alternate coverage must be arranged as defined in step 3. The suspected practitioner must be informed of this action and that they will be contacted by the Chief of Staff and/or the Credentials Committee the first business day that a quorum can be assembled.

2. If a chemical substance test is performed, the test should be provided as defined by the Medical Center's policies and testing procedures. This testing will be performed in an expeditious and confidential manner following the chain of evidence protocols. Objective clinical criteria for determining that a practitioner is "under the influence" include:
 - a. a breath/blood ethanol level of 10 mg (.01%) or greater;
 - b. evidence of illicit drugs in urine toxicological screen;
 - c. evidence of prescription drugs in urine, known to cause impairment if taken in high enough doses, and subjective evidence of cognitive or behavioral impairment as determined in the evaluation performed face to face with the suspected practitioner, by the Chief of Staff or designee.
3. If it is determined that the practitioner is "under the influence," patient care shall not be rendered by the practitioner in question, and alternate coverage must be arranged. A partner of the practitioner, the practitioner on appropriate call for coverage, or the Department Chair will be called to provide backup coverage as is clinically indicated and as may be chosen by the family or patient when the suspected practitioner is removed from the case.

Prior to the practitioner resuming any patient care activities, they must be evaluated for competence in providing safe patient care which may include testing at an interval appropriate for the substance initially detected. If the practitioner refuses to retest, they will not resume patient care activities until the Credentials Committee meets on the first business day following the event.

4. Following the intervention and interruption of care, the intervening practitioner, Chief of Staff, or designee, or the administrator on call will ask and expect the affected practitioner to leave the Medical Center premises. Transportation will be provided as determined appropriate by the persons making the intervention.
5. The patient care shall not begin or continue until a determination of the practitioner's fitness to proceed has been made by the Chief of Staff or their designee in accordance with this policy.

9.2 CHEMICAL IMPAIRMENT FOLLOW-UP

The Credentials Committee, acting in its professional practice evaluation capacity, will meet the first business day after the event that a quorum can be assembled to review the matter with the intervening staff members and the practitioner and determine the appropriate follow-up. Professional practice evaluation activities and records are privileged and confidential under law; persons at all other levels of involvement are expected to exercise the utmost discretion to protect the privacy rights of all parties involved. It shall be the policy of the Medical Staff to attempt to address and resolve issues of chemical impairment through informal processes short of corrective action.

The Credentials Committee may encourage a chemically impaired practitioner to take a voluntary leave of absence for the purpose of treatment, in accordance with the provisions of Section 3.9 of the Governance and Structure chapter. Once the practitioner has completed their rehabilitation, they will be required to meet with the Credentials Committee prior to resuming practice, for the purpose of ascertaining the practitioner's current health status and whether any restrictions or conditions on the individual's resumption of practice are indicated.

9.3 PROFESSIONALISM POLICY

9.3-1 EXPECTED BEHAVIOR

It is the policy of Mary Greeley Medical Center that all individuals within the Medical Center's facilities will be treated courteously, respectfully, and with dignity. To that end, the Board of Trustees expects all employees, practitioners, and advanced practice providers, including those with temporary Clinical Privileges, to conduct themselves in a professional and cooperative manner in the Medical Center. All such individuals shall refrain from behavior that undermines a culture of safety and respect toward Medical Center patients, employees, practitioners, and visitors.

If employed staff of the Medical Center fail to conduct themselves in accordance with this expectation, the matter shall be addressed in accordance with Medical Center Human Resource policies.

9.3-2 APPLICABLE DEFINITIONS

"Appropriate behavior" means any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership, or activities of the organized Medical Staff, or to engage in professional practice, including practice that may be in competition with the hospital. Appropriate behavior is not subject to discipline under these Bylaws.

"Disruptive behavior" means any abusive conduct including verbal or non-verbal conduct that harms or intimidates others and/or sexual or other forms of harassment.

"Harassment" means conduct toward others based on their race, religion, gender, gender identity, sexual orientation, nationality, or ethnicity, which has the purpose or direct effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating, or otherwise hostile work environment.

"Inappropriate behavior" means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as "disruptive behavior."

“Sexual harassment” means unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of special favors or special considerations; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating or otherwise hostile work environment.

9.3-3 TYPES OF CONDUCT

Appropriate Behavior: Examples of appropriate behavior include, but are not limited to, the following:

- Criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care and safety;
- Encouraging clear communication;
- Expressions of concern about a patient’s care and safety;
- Expressions of dissatisfaction with policies through appropriate grievance channels or other civil, non-personal, means of communication;
- Use of cooperative approach to problem resolution;
- Constructive criticism conveyed in a respectful and professional manner, without blame or shame for adverse outcomes;
- Professional comments to any professional, managerial, supervisory, or administrative staff, or members of the Board of Trustees about patient care or safety provided by others;
- Active participation in Medical Staff and hospital meetings;
- Membership on other Medical Staffs;
- Seeking legal advice on the initiation of legal action for cause.

Inappropriate Behavior: Inappropriate behavior by Medical Staff members is discouraged. Persistent inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.” Examples of inappropriate behavior include, but are not limited to, the following:

- Belittling or berating statements;
- Name calling;
- Use of profanity or disrespectful language;
- Inappropriate comments documented in the medical record;
- Blatant failure to respond to patient care needs or staff requests;

- Personal sarcasm or cynicism;
- Deliberate lack of cooperation without good cause;
- Deliberate refusal to return phone calls, pages, or other messages concerning patient care or safety;
- Intentionally condescending language;
- Intentionally degrading or demeaning comments regarding patients and their families, nurses, physicians, hospital personnel and/or the hospital.

Disruptive Behavior: Disruptive behavior by Medical Staff members is prohibited. Examples of disruptive behavior include, but are not limited to, the following:

- Physically threatening language directed at anyone in the hospital including physicians, nurses, other Medical Staff members, or any hospital employee, administrator, or member of the Board of Trustees;
- Physical contact with another individual that is threatening or intimidating;
- Throwing instruments, charts, or other things;
- Threats of violence or retribution;
- Sexual harassment;
- Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation.

9.3-4 REPORTING AND DOCUMENTATION

All events or suspicions of events of inappropriate and disruptive behavior and/or drug or alcohol abuse concerns shall be reported in writing promptly to the Chief of the Medical Staff and the President of the Medical Center as described below:

1. Any employee, practitioner, patient, or visitor who observes or experiences behavior by a practitioner that disrupts the operation of the Medical Center or jeopardizes patient care shall immediately report the event verbally to the Department Director or their designee, with a follow-up written report prepared within the shift of the event, if possible. If the Department Director or designee is unavailable, reports of events should be made to the House Manager or administrator on call.
2. Documentation of the concern is critical. The documentation shall include:

- the date, time, and location of the inappropriate or disruptive behavior;
 - a factual description of the inappropriate or disruptive behavior;
 - the circumstances which precipitated the event;
 - the name and medical record number of any patient or patient's family member who was involved in or witnessed the event;
 - the names of other witnesses to the event;
 - the consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care or safety, or hospital personnel or operations;
 - any action taken to intervene in, or remedy, the event, including the names of those intervening; and
 - the name of the complainant; complainant will be interviewed if the event is not sufficiently detailed.
3. The documentation shall be submitted to the President or their designee, who shall present a copy to the Department Chair or their designee. Reports of behavior will be investigated by the President or the President's designee and the Department Chair, in consultation with the Chief of Staff.

9.3-5 MEETING WITH PRACTITIONER

1. A single reported event of inappropriate or disruptive behavior warrants a discussion with the practitioner. The Department Chair, or their designee, should discuss the event with the practitioner within one week of the event being reported and emphasize that such behavior is inappropriate. The event report is confidential. Written details of the violation will be shared with the practitioner during follow-up; however, the name of the reporter and credentials will be removed. The initial approach should be collegial and intended to be helpful in nature. The practitioner shall be given a copy of this policy and advised to take immediate steps to end the behavior. If determined to be a serious event, the practitioner may be asked to meet with the Medical Executive Committee about the event.
2. All confirmed events of inappropriate or disruptive behavior will be reviewed by the Credentials Committee to determine if validated. Practitioners will be informed of a reported event. If validated, the report and follow-up documentation will be placed in their credentials file.

3. If a second validated event of inappropriate or disruptive behavior occurs, the practitioner will receive a letter from the Chief of Staff reminding them of the expectation of behavior. If determined to be a serious event, the practitioner may be asked to meet with the Medical Executive Committee about the event.
4. All validated first and second events will be discussed at Medical Executive Committee after the practitioner has had the opportunity to review complaint and respond (within one week).
5. If a third validated event occurs, and/or it appears that a pattern of inappropriate or disruptive behavior is developing, the practitioner will be asked to meet with the Medical Executive Committee to explain their behavior. The Medical Executive Committee will then determine the next steps. The Credentials Committee will determine the timeframe allowed between events on a case-by-case basis.
6. All meetings with the practitioner regarding validated events shall be documented and placed into the practitioner's file.
7. Meetings with the practitioner do not constitute a "hearing" subject to the procedural requirements of the Credentialing Policies; however, the practitioner may submit a rebuttal to the complaint, which shall be maintained in the practitioner's credentials file.
8. Reports which are not validated by the Credentials Committee may be dismissed, and the person initiating the report so apprised. Reports that are confirmed will be addressed as follows:
 - a. After any meeting with the practitioner, with the exception of the first, a certified or hand-delivered letter shall be sent to the practitioner confirming that the practitioner is required to behave professionally and cooperatively, or that further action will be taken.
 - b. If the practitioner's inappropriate or disruptive behavior continues, or if the President, Chief of

Staff, or the Board Trustees determines it to be necessary, they or individuals acting on their behalf shall meet with and advise the practitioner that they are receiving a final warning. The meeting shall be followed with a certified or hand-delivered letter reiterating the final warning, and that letter shall become a part of the practitioner's file. The letter shall articulate in detail what behavior is unacceptable and shall state that the consequences of continued inappropriate or disruptive behavior may include suspension or termination of privileges in accordance with the Credentialing Policies.

9. While this policy outlines a progressive discipline approach with a practitioner to remedy inappropriate or disruptive behavior, the conduct at issue may be so egregious, including but not limited to, criminal acts, sexual harassment, or physical assault, as to make these multiple opportunities inappropriate. Based on the conduct at issue, corrective action under the Credentialing Policies may be pursued immediately instead of following this progressive discipline approach.

9.3-6 SUBSEQUENT EVENT AFTER INTERVENTION

If a practitioner has had an intervention and/or disciplinary action due to disruptive behavior and has a subsequent validated event following the intervention/disciplinary action, the practitioner will be required to meet with the Medical Executive Committee to explain their behavior. Each incident will be handled individually and, on a case-by-case basis, with consequences that could include termination of Medical Staff appointment and/or privileges.

9.3-7 PROMOTING AWARENESS OF PROFESSIONALISM POLICY

The Medical Staff shall, in cooperation with the Medical Center, promote continuing awareness of this Professionalism Policy among the Medical Staff and the Medical Center community, by:

- sponsoring or supporting educational programs on disruptive behavior to be offered to Medical Staff members and hospital employees;
- disseminating this Professionalism Policy to all current Medical Staff members upon its adoption and to all new applicants for membership to the Medical Staff;

- encouraging the Credentials Committee to assist members of the Medical Staff exhibiting inappropriate or disruptive behavior to obtain education, behavior modification, or other treatment to prevent further infractions;
- informing the members and the hospital staff of the procedures the Medical Staff and hospital have put into place for effective communication to hospital administration of any Medical Staff member's concerns, complaints and suggestions regarding hospital personnel, equipment, and systems.

9.4 DISCIPLINARY ACTION

Where an employee, practitioner, or APP is determined to have violated this policy, either through a significant single event or a pattern of repeated offenses, the Medical Center, in consultation with the Chief of Staff, will take prompt remedial measures to end the offending conduct, and will initiate appropriate disciplinary action as defined in Section 3.2, Corrective Action, of the Credentialing Policies. Where a person other than an employee, practitioner, or APP is determined to have violated this policy, the Medical Center will take prompt action reasonably calculated to end the inappropriate or disruptive behavior.

9.5 PROTECTION AGAINST RETALIATION

The Medical Center will not retaliate or permit retaliation against any individual who makes a report of inappropriate or disruptive behavior or cooperates in an investigation. Retaliation is considered a very serious violation of this policy and should be reported immediately to the persons identified in this policy. Any individual found to have confronted, intimidated, or otherwise retaliated against any employee or Medical Center practitioner who makes a report or cooperates in the investigation of a complaint of harassment will be subject to appropriate disciplinary action up to and including termination of employment or privileges.

9.6 FITNESS EVALUATIONS

Physicians/Advanced Practice Providers will be required by the Department Chair, Medical Director of Quality, Credentials Committee, and/or Medical Executive Committee to undergo a fitness evaluation, based upon evidence, when there are substantiated concerns regarding their ability to perform the essential functions of their medical practice in the hospital without posing a risk to themselves or others. Such evidence could include, among other facts, patient complaints, observations of co-workers or fellow professionals, and/or a decline in clinical practice outcomes. Situations will be handled on a case-by-case basis.

9.7 IOWA PHYSICIANS' HEALTH PROGRAM (IPHP)

The Iowa Board of Medicine has established the IPHP for the purpose of monitoring licensees (M.D.s and D.O.s) who are impaired by any mental or physical disorder or disability or as a result of alcohol or drug abuse, dependency, or addiction. These descriptions may be helpful in determining who should be reported to the Board:

- Any physician who requires a leave due to health concerns that potentially impairs the physician's ability to practice medicine in a safe manner;
- Any physician who fails to fulfill major obligations at home or elsewhere.

Do not wait to report until problems show up in the work setting because patient harm may be done and, as a result, the physician may no longer be eligible for the IPHP.

A physician who suspects that a physician colleague is impaired may report the individual to the IPHP and direct the colleague to self-report within 24 hours. If the self-report occurs within that time period, and the reported physician meets the program eligibility, the Board may not initiate the disciplinary process.

The IPHP doesn't always find reported physicians to be impaired or in need of monitoring. A physician's participation in the IPHP is confidential to the public. The public does not have access to information that identifies participants in the program, except in those few cases where a participant has formal disciplinary charges filed by the Board of Medicine, including charges for noncompliance with an IPHP contract.

The IPHP is administered by the Iowa Physician Health Committee, a committee of at least five members, all appointed by the Board. Staff members of the Board manage the program within the parameters established by 653 Iowa Administrative Code Chapter 14.

More information about the program is available at:
www.dial.iowa.gov/licenses/medical/physician/iphp

9.8 PROFESSIONALISM IN THE USE OF SOCIAL MEDIA

Participating in social networking and other similar Internet opportunities can support practitioners' personal expression, enable individual practitioners to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunity to widely disseminate public health messages, and other health communication.

Social networks, blogs, and other forms of communication online also create new challenges to the patient practitioner relationship.

- (a) Practitioners should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.
- (b) If they interact with patients on the Internet, practitioners must maintain appropriate boundaries of the patient- practitioner relationship in accordance with professional ethical guidelines, just as they would in any other context.

SECTION X

DEPARTMENTS

10.1 FUNCTIONS OF DEPARTMENTS

To carry out its responsibility, each Department shall:

- (a) Ensure patient care reviews are performed to analyze and evaluate the quality and appropriateness of care and treatment provided to patients within the Department. Periodically assess this information and develop objective and current criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the Department, regardless of whether the member whose work is subject to review is a member of that Department. These reviews may be delegated to the Patient Care Review Committee.
- (b) Provide reports at least quarterly following department meetings to the Medical Executive Committee concerning:
 - (i) The Department's review, monitoring, and evaluation activities, actions taken thereon, and the results of such action; and
 - (ii) Recommendations for maintaining and improving the quality of care provided in the Department and the Medical Center.
- (c) Recommend to the Credentials Committee guidelines for granting of Clinical Privileges and the performance of specific services within the Department.
- (d) Review and evaluate departmental adherence to:
 - (i) Medical Staff policies and procedures;
 - (ii) Requirements for alternate coverage and for consultations; and
 - (iii) Sound principles of clinical practice
- (e) Meet at least quarterly to receive, review, and consider patient care review findings and the results of the Department's other review, evaluation, and monitoring activities, as well as reports on other Department and staff functions.

- (f) Conduct, participate in, or make recommendations regarding continuing education programs pertinent to departmental clinical practice.
- (g) Participate in the coordination of patient care provided by the Department's members of nursing and ancillary patient care services and with administrative services.
- (h) Establish and appoint such committees and other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocol.
- (i) Take appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.
- (j) Formulate recommendations for departmental rules and regulations that are reasonably necessary for the proper discharge of its responsibilities, subject to the approval by the Medical Executive Committee, the Medical Staff, and the Board of Trustees.

10.2 MODIFICATIONS IN CLINICAL ORGANIZATION UNIT

When deemed appropriate, the Medical Executive Committee and the Board of Trustees, by their joint action, may create, eliminate, subdivide, further subdivide, or combine Departments.

CHAPTER THREE
CREDENTIALING POLICIES

SECTION I

CREDENTIALING POLICIES FOR APPOINTMENT AND REAPPOINTMENT

1.1 GENERAL PROCEDURES

1.1-1 APPLICATION REQUIREMENT

Only those licensed independent practitioners who meet the basic criteria for Medical Staff membership and privileges set forth in the Governance and Structure chapter, shall be eligible to apply for Medical Staff appointment. Practitioners requesting applications for appointment will be sent a letter by the President or his or her designee outlining the basic criteria for eligibility along with the application packet. The procedural due process rights set forth in Section IV of these Credentialing Policies shall not be available to practitioners who are determined to be ineligible to apply for appointment because they do not meet the basic criteria.

1.1-2 NATURE OF MEDICAL STAFF CONSIDERATION

The Medical Staff through its designated Departments, committees, and officers shall consider each application for appointment, reappointment, and Clinical Privileges and each request for modification of Staff membership status or Clinical Privileges, utilizing the resources of the President and their staff to investigate and validate the contents of each application, before adopting and transmitting its recommendations to the Board of Trustees.

1.2 APPLICATION FOR INITIAL APPOINTMENT

1.2-1 CONTENT

All applications for initial appointment to the Medical Staff shall be submitted on a form prescribed by the Medical Executive Committee and the Medical Center, with all provisions completed (or an explanation of why answers are unavailable) and signed by the applicant. The applicant shall be given a copy of the Medical Staff Bylaws and shall be given access to the Medical Staff documents and other relevant policies relating to clinical practice.

The application shall require detailed information including, but not limited to:

- (a) the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, and documentation of current CPR training (as required);
- (b) a minimum of 2 peer references familiar with the applicant's professional competence and ethical character;
- (c) requests for membership categories, departments, and Clinical Privileges;
- (d) past or pending professional disciplinary action, voluntary or involuntary relinquishment of licensure or such DEA/CSA registration limitations, or related matters including voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at another hospital;
- (e) actions alleging fraud, abuse, or the violation of statutory or regulatory requirements governing the provision of professional services or reimbursement there of;
- (f) the applicant's ability to carry out the responsibilities and prerogatives of the Medical Staff membership category and perform the Clinical Privileges applied for with reasonable skill and without exposing the applicant or others to significant health or safety risks;
- (g) a statement from the applicant regarding their health status;
- (h) evidence of professional liability insurance coverage with a company licensed or approved to do business in Iowa, together with information regarding professional liability claims, complaints, or causes of action against the applicant and the status or outcome of such matters;
- (i) information as to details of any prior, or pending government agency or third-party payer proceeding or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection, or utilization practices;

- (j) certification of the applicant's agreement to terms and conditions set forth in Section 1.2-2 regarding the effect of the application;
- (k) an acknowledgment that the applicant has received (or has been given access to) the Medical Staff Bylaws, that they have received a summary explanation of the appointment requirements set forth therein and of the appointment process, and that they agree to be bound by the terms.
- (l) a background investigation check conducted by the Medical Center for initial applicants; and
- (m) a current hospital ID card or a valid picture ID issued by a state or federal agency (e.g., driver's license or passport).

The application shall also include:

- (a) an acknowledgement of the applicant's responsibility to inform the Medical Staff of any changes in the information provided through the application process during the application period, or at any subsequent time;
- (b) a pledge to maintain an ethical practice and to provide for continuous quality of care for their patients;
 - a signed confidentiality agreement;
 - a signed Practitioner Professionalism Policy agreement.

1.2-2 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff, reappointment, advancement, or transfer, each applicant thereby:

- signifies their willingness to appear for interviews in regard to their application;
- authorizes the Medical Center and its representatives or designees to consult with members of Medical Staffs of other hospitals or faculty of training institutions with which the applicant has been associated and with others who may have information bearing on their competence, character, and ethical qualifications, and authorizes such persons to provide all such information;

- consents to the Medical Center's inspection of all records and documents that may be material to an evaluation of:
 - their professional qualifications;
 - demonstrated ability to work cooperatively with others;
 - moral and ethical qualifications for membership;
 - professional competence and ability to carry out the requirements and prerogatives of the Medical Staff membership category and perform the privileges requested with reasonable skill and without exposing the applicant or others to significant health or safety risks.

The applicant directs individuals who have custody of such records and documents to permit inspection and/or copying and certifies that they will report to the Credentials Committee and the President in writing any changes in the information submitted on the application form, which may subsequently occur. The applicant releases from any liability, to the fullest extent permitted by law, all individuals and organizations providing information to the Medical Center concerning the applicant and all Medical Center representatives for their acts performed in connection with evaluating the applicant and their credentials.

1.3 PROCESSING THE APPLICATION

1.3-1 APPLICANT'S BURDEN

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and ability to perform the requirements and prerogatives of the membership category and privileges applied for with reasonable skill and safety and for resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be deemed a voluntary withdrawal of the application.

Failure to adequately complete and update the application form, the withholding of requested information, or the providing of false or misleading information, shall, in and of itself, constitute a basis for denial or revocation of Medical Staff appointment.

1.3-2 BACKGROUND INVESTIGATIONS

The Medical Staff conducts background investigations on all Medical Staff and Advanced Practice Providers prior to commencement of their initial appointment, within the guidelines of our policies and/or federal, state, and local law.

The Medical Staff reserves the right to conduct background investigations on Medical Staff and Advanced Practice Providers during the term of their appointment regarding any allegation of wrongdoing or improper or unethical behavior.

Medical Staff Services will process all background investigation orders, receive results, and communicate results to applicants where appropriate.

Screening Services: In order to facilitate the background investigation, the following levels of screening services upon initial appointment have been devised:

- Positive Identification—SSN Trace & SSN Death Index Search;
- Maiden & Alias Name Search;
- Criminal Record Search—County or Statewide Level;
- Sex Offender Registry Search;
- Federal Criminal Court Search—National;
- Federal Civil Court Search—National;
- Federal Bankruptcy Court Search—National SanctionCheck™ Sanction Screening;
- Investigative Application Review by Licensed Investigator;
- Adverse Action Management.

Procedure:

- (a) All applicants are provided with notice of MGMC's policies and procedures with regard to conducting background investigations.
- (b) All applicants must complete a "Waiver of Liability and Consent for Release of Information" form. If the applicant refuses to complete the form, the applicant will not be considered for appointment. By Federal law, authorization is required prior to conducting a background investigation.

Reporting Results:

- (a) All results will be reported by the investigating agency.
- (b) The Medical Staff Credentialing Specialist will notify the President/designee of all reports designated as "Pending review."

Access to Records:

Due to the sensitive nature of the information obtained through a background investigation, only those persons as determined by MGMC President or designee shall have access to the information and only on an “as-needed” basis. Records of background checks will be maintained in the non-discoverable file within the credentials file.

Applicant Notification In the Event of Adverse Information:

- (a) The President/designee will notify by certified letter all applicants who failed to meet the screening criteria. A copy of the background check report will be sent to the applicant.
- (b) The applicant will be sent a five-day letter informing applicant that they have five (5) business days from receipt of the letter to dispute the findings on the background report by contacting the investigating agency.
- (c) If applicant timely notifies the investigating agency of their right to dispute, clarify, or reinvestigate their consumer summary report, the investigating agency will notify the Medical Staff Credentialing Specialist and the applicant’s file will be placed on hold until the investigating agency has completed its investigation.
- (d) If the applicant has not responded to the above notification within the timeframe of the application process and/or the investigating agency has not contacted the Medical Staff Credentialing Specialist regarding the information provided, it will be considered a voluntary withdrawal of the application.
- (e) The investigating agency will send a written report to the Medical Staff office and the applicant of the results of the reinvestigation within no more than thirty (30) days from the request date of the reinvestigation.

1.3-3 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the Medical Center President or his or her designee, who shall, in timely fashion, seek to collect or verify the references, licensure, and other qualification evidence

submitted from the primary source, when feasible. In accordance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986 (HCQIA), as amended, the Medical Center will query the National Practitioner Data Bank. The President or their designee shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. An applicant whose application is not completed within six months after it was received by the President or his or her designee shall be deemed to have voluntarily withdrawn their application from consideration for staff membership. Such an applicant's application may, thereafter, be reconsidered only if all information therein which may change over time, including, but not limited to, hospital reports and personal references, have been resubmitted. The physician profile provided by the American Medical Association may be utilized as source verification.

Just as credentialing assesses an applicant's professional abilities outlined in licensing scopes of practice, it also detects professional incompetence, malevolence, behavioral problems, or other red flags that may deter a health facility and system from credentialing an applicant. Although red flags do not automatically preclude a practitioner from the Medical Staff, comprehensive review of a practitioner with any red flags will be performed.

Examples of red flags include, but are not limited to:

- Resignation from a Medical Staff at any time in an applicant's career;
- Reports of problems in an applicant's professional practice;
- All past or pending state licensing board, Medical Staff organization, or professional society investigative proceedings;
- Unexplained or unaccounted time gaps;
- No response to a reference inquiry from an applicant's past affiliation;
- Disciplinary actions by Medical Staff organizations, hospitals, state medical boards, or professional societies;
- Any claims or investigations of fraud, abuse and/or misconduct from professional review organizations, third-party payers, or government entities;
- Jury verdicts and settlements for professional liability claims (which should still be individually reviewed);
- Inability to maintain a medical practice within the facility's service jurisdiction for any amount of time.

Primary source verification of the following 13 criteria will generate the information necessary to assess an applicant's professional competence and personal decorum as well as help identify red flags or the need for further investigation:

- Proof of identity
- Relevant education and training
- Military service
- Professional licensure
- DEA registration and CSA registrations, if applicable
- Board certification, if applicable
- Affiliation and work history
- Criminal background disclosure
- Sanctions disclosure
- Health status
- National Practitioner Data Bank
- Malpractice insurance
- Professional references

When collection and verification is accomplished, applications for initial appointment shall be reviewed by the credentialing staff and divided into two classes. Class 1 includes applications that have no questions or concerns and contain complete documentation; Class 2 includes all other applications, including those in which there is a question, concern, or needed discussion of training, education, current competency, malpractice claims, or character of the applicant, including those that have been satisfactorily resolved. The credentialing staff will transmit the application and all supporting materials to the Chair of each Department in which the applicant seeks privileges.

1.3-4 DEPARTMENT ACTION

Upon receipt, the Chair/designee of each such Department shall review the application and supporting documentation and transmit to the Credentials Committee their written report prepared in accordance with Section 1.3-7. A Department Chair may ask the applicant to appear for an interview or request further documentation.

1.3-5 CREDENTIALS COMMITTEE ACTION

Class 1 applications, supporting documentation, Department Chair recommendations, and other relevant information will be reviewed by the Chair of the Credentials Committee and the Chief of Staff, who will transmit their report to the Credentials Committee. All

applications will be available to the Credentials Committee members for their review. The Credentials Committee will review all Class 2 applications, supporting documentation, and report(s) submitted by the Department Chair, and such other relevant information as may be available. The Credentials Committee may ask the applicant to appear for an interview or request further documentation. The Credentials Committee shall transmit to the Medical Executive Committee its report and recommendations prepared in accordance with Section 1.3-7.

1.3-6 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the Credentials Committee report and recommendations, the Medical Executive Committee shall consider the Credentials Committee and Department Chair's reports and such other relevant information as may be available. The Committee shall then forward to the President, for transmittal to the Board of Trustees, its written report and recommendations prepared in accordance with Section 1.3-7. The Committee may also defer action on the application pursuant to Section 1.3-9(a).

1.3-7 APPOINTMENT REPORTS

The Department Chair, Credentials Committee, and Medical Executive Committee reports and/or recommendations shall be submitted in the form prescribed by the Medical Executive Committee. Each report and recommendation shall specify whether Medical Staff appointment is recommended, and, if so, the membership category, Department affiliation, and Clinical Privileges to be granted and any special conditions to be attached to the appointment. The reasons for each recommendation shall be stated, and supported by reference to the completed application and all other documentation which was considered, all of which shall be transmitted with the report.

1.3-8 BASIS FOR APPOINTMENT

Each recommendation concerning an applicant for Medical Staff membership and Clinical Privileges shall be based upon whether the applicant meets the applicable qualifications specified in Section 3.2 of the Governance and Structure chapter, can carry out the applicable responsibilities specified in Section 3.6 of the Governance and Structure chapter, and meets all of the standards and requirements set forth in all sections of the Governance and Structure and Rules and Regulations chapters. Every effort is

made to ensure that the decision to grant or deny privileges, or renew an existing privilege is an objective, evidence-based process. Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of their profession and other hospitals' Medical Staff bylaws, rules and regulations, and policies; rendition of services to their patients; ability to carry out the requirements and prerogatives of staff membership, and perform the Clinical Privileges applied for with reasonable skill and safety; their provision of accurate and adequate information to allow them to evaluate their competency and qualifications; information obtained from the National Practitioner Data Bank, the American Medical Association, and specialty boards and academics, as appropriate; and the representations set forth in the paragraph that follows. By his or her application for membership and privileges, the licensed independent practitioner makes the following representations and includes appropriate documentation:

- (a) that neither the practitioner nor any of their employees, contractors, or agents, nor any member of the practitioner's household or immediate family, who now has or has had a direct or indirect ownership of 5% or more in the practitioner's professional practice, has ever been: assessed civil monetary penalties under the Social Security Act; debarred, suspended, or excluded from participating in either Medicare or Medicaid; sanctioned under Medicare or Medicaid for reasons bearing on professional competence or professional performance; has ever had an ownership interest in any other organization which has ever had a civil monetary penalty under Medicare or Medicaid; or has ever been convicted or pled guilty or nolo contendere to any criminal violation which could cause a disqualification under applicable state law.

- (b) that neither the practitioner nor their employees, contractors, or agents, nor any member of the practitioner's immediate family, has or will have a "financial relationship" (as that term is defined in Section 1877 of the Social Security Act—see Section 3.2-1(e) in the Governance and Structure chapter) with the Medical Center which fails to qualify for an exception to the prohibition contained therein against certain referrals of designated health services. For purposes of this provision, "immediate family" is defined to mean spouse, natural or adoptive parent, child or sibling, step-parent, step-child, step-brother or step-sister, father-in-law, mother-in-law, daughter-in-law, son-in-law, brother-in-

law, sister-in-law, grandparent, grandchild and spouse of a grandparent or grandchild. The practitioner shall immediately report to the Medical Center President, or their designee, any known or suspected financial relationship to permit analysis to determine compliance with this provision.

- (c) that, to the best of their knowledge, the practitioner is not at risk of offset or other disallowance of future payments due under Medicare, Medicaid or other federal or state health programs, or other third-party payment programs for professional services to be rendered, because of current or past billing, coding or documentation errors, or disputes with a professional review organization. The practitioner agrees to make all reasonable attempts to ensure that patient signs and symptoms, and services rendered to patients, are appropriately documented, and agrees to cooperate with any compliance program or compliance audit that the Medical Center may undertake to ensure that billing and coding for services rendered is conducted in full compliance with all laws and regulations.

The practitioner agrees to immediately notify the Medical Center of any threatened, proposed, or actual exclusion of the practitioner from participation in any governmental health care program.

1.3-9 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

- (a) Interviews, Further Documentation, Deferral: Action by the Medical Executive Committee to interview the applicant, seek further documentation, or defer the application for further consideration must be followed up within sixty (60) days with a subsequent recommendation for appointment with specified Clinical Privileges, or for denial of the request for Medical Staff membership.
- (b) Favorable Recommendation: When the Medical Executive Committee's recommendation is favorable to the applicant, the President shall promptly forward it, together with all supporting documentation, to the Board of Trustees. For the purposes of this Section 1.3-9(b), "all supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the Department Chair, the Credentials Committee, and the Medical Executive Committee.

- (c) Adverse Recommendation Which Constitutes an Adverse Professional Review Action: When the Medical Executive Committee's recommendation is adverse to the applicant, and when the adverse recommendation constitutes a recommended "adverse professional review action" as defined in Section 4.1-2, the Chief of Staff shall give or cause to be given to the applicant written notice of the recommended adverse professional review action and of the applicant's right to request a hearing in the manner specified in Section 4.3, and the applicant shall be entitled to the procedural rights as provided in Section IV of these Credentialing Policies. The Board of Trustees shall be informed of, but not take action on, the pending adverse professional review action until the applicant has exhausted or waived their procedural rights under Section IV.
- (d) Adverse Recommendation Which Does Not Constitute an Adverse Professional Review Action: When the Medical Executive Committee's recommendation is adverse to the applicant but does not give rise to a hearing under Section 4.2, the President shall promptly forward the adverse recommendation, along with all supporting documentation, to the Board of Trustees.

1.3-10 ACTION BY THE BOARD OF TRUSTEES

- (a) On Favorable Medical Executive Committee Recommendation or On Adverse Recommendation Which Does Constitute an Adverse Professional Review Action: The Board of Trustees shall, in whole or in part, adopt or reject a Medical Executive Committee recommendation which is favorable to the applicant or which is adverse but does not constitute an "adverse professional review action" under Section 4.1-2, or refer the recommendation back to the Medical Executive Committee for further interviews, documentation, or consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the recommendation of the Board of Trustees constitutes an adverse professional review action as set forth in Section 4.2, the President shall give the applicant written notice of the recommended adverse professional review action and of the applicant's right to request a hearing in the manner specified in Section 4.3; and the applicant shall be entitled to the procedural rights as provided in Section IV of this

Chapter before any final adverse action is taken by the Board, otherwise, the Board shall take final action and provide notice of such final action to the applicant. If the Board of Trustees makes a privileging decision contrary to the recommendation of the Medical Executive Committee, its rationale for doing so shall be clearly documented.

- (b) **Without Benefit of Medical Executive Committee Recommendation:** If the Board of Trustees does not receive a Medical Executive Committee recommendation within the time period specified in Section 1.3-13, it may, after notifying the Medical Executive Committee, take action on its own initiative. If such recommendation is favorable to the applicant or is not favorable but is not an adverse professional review action under Section 4.1-2, it shall become effective as the final decision of the Board of Trustees. If the recommendation is for an adverse professional review action set forth in Section 4.2, the President shall give the applicant written notice of the recommended adverse professional review action and of the applicant's right to request a hearing in the manner specified in Section 4.3; and the applicant shall be entitled to the procedural rights as provided in Section IV of this Chapter before any final adverse action is taken.
- (c) **After Procedural Rights:** In the case of an adverse Medical Executive Committee recommendation pursuant to Section 1.3-9(c) or an adverse Board of Trustees recommendation that constitutes an adverse professional review action pursuant to Section 1.3-10(a) or (b), the Board of Trustees shall take final action in the matter only after the applicant has exhausted or has waived their procedural rights as provided in Section IV. Action thus taken shall be the conclusive decision of the Board of Trustees, except that the Board of Trustees may defer final determination by referring the matter back to the Medical Executive Committee for further reconsideration. Any such referral back shall state the reasons therefor, shall set a time limit within which a subsequent recommendation to the Board of Trustees shall be made and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board of Trustees shall make a final decision.

1.3-11 NOTICE OF FINAL DECISION

- (a) Notice of the Board of Trustees' final decision shall be given to all applicants and will be shared at the quarterly Medical Staff meetings to all members present.

1.3-12 REAPPLICATION AFTER ADVERSE PROFESSIONAL REVIEW ACTION DECISION DENYING APPLICATION, ADVERSE CORRECTIVE ACTION DECISION, OR RESIGNATION IN LIEU OF MEDICAL DISCIPLINARY ACTION

Practitioners shall not be eligible to reapply for Medical Staff membership and/or Clinical Privileges affected by any of the following actions for a period of one (1) year from the date the adverse professional review action decision became final, the date the application or request was withdrawn, or the date the former Medical Staff member's resignation became effective, whichever is applicable.

- (a) An applicant who:
- has received a final adverse professional review action decision regarding appointment; or
 - withdrew their application or request for membership or privileges following recommendation of an adverse professional review action by the Medical Executive Committee or Board of Trustees;
- (b) A former Medical Staff member who:
- received a final adverse professional review action resulting in termination of Medical Staff membership and Clinical Privileges, or
 - resigned from the Medical Staff following the issuance of a Medical Staff or Board of Trustees recommendation adverse to the member's Medical Staff membership or Clinical Privileges which constituted an adverse professional review action; or
- (c) A Medical Staff member who has received a final adverse professional review action decision resulting in:
- termination or restriction of their Clinical Privileges; or
 - denial of their request for additional Clinical Privileges.

A decision shall be considered to be an adverse professional review action, for disciplinary reasons, only if it meets the definition of "adverse professional review action" in Section 4.1-2. Actions which are not considered adverse professional review actions include but are not limited to actions based on a failure to maintain a practice in the

area, which can be rectified by a move, or to maintain professional liability insurance, which can be rectified by securing such insurance. Further, for the purpose of this Section, an adverse professional review action shall be considered final at the time of completion of: (1) all hearing, appellate review, and other quasi-judicial proceedings conducted by the Medical Center bearing on the decision and (2) in the event that, at the time of a reapplication, a judicial proceeding has commenced related to the adverse professional review action, all such judicial proceedings bearing upon the decision which are filed and served after the completion of the Medical Center proceedings described in (1) above.

After the one (1) year period, the former applicant, former Medical Staff member, or Medical Staff member may request an application for Medical Staff membership and/or Clinical Privileges, which shall be processed as an initial application. The former applicant, former Medical Staff member, or Medical Staff member shall also furnish evidence that the basis for the earlier adverse professional review action no longer exists and/or of reasonable rehabilitation in those areas which formed the basis for the previous adverse professional review action, whichever is applicable. In addition, such applications shall not be processed unless the applicant or member submits satisfactory evidence to the Medical Executive Committee that they have complied with all of the specific requirements any such adverse professional review action decision may have included, such as completion of training or proctoring conditions. The Medical Executive Committee's decision as to whether satisfactory evidence has been submitted shall be final, subject only to further review and final approval by the Board of Trustees within 45 days after the Medical Executive Committee decision was rendered.

1.3-13 TIME PERIODS FOR PROCESSING

Applications shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this Section (1.3-13). The President or their designee shall transmit an application to the Department Chair and notify the Chair of the Credentials Committee of the transmittal within 35 days after all information collection and verification tasks are completed and all relevant materials have been received. In the event the relevant materials are not received within 60 days after the application is received, the applicant shall be notified, and the

application shall remain pending until either the materials are received by the Medical Staff Office or until the expiration of six months from the date the application was received. Applications which are not completed within six months after receipt shall automatically be removed from consideration, as specified in Section 1.3-1. The applicable Department Chair shall act on an application within 45 days after receiving it from the President's Office. The Credentials Committee shall then make its recommendation within 45 days after the Department Chair has acted. The Medical Executive Committee shall review the application and make its recommendation to the Board of Trustees within 45 days after receiving the Credentials Committee report. The Board of Trustees shall then take final action on the application within 45 days. The Board of Trustees may elect to delegate the authority to render initial appointment, reappointment, and renewal or modification of privileges decisions to a committee of the governing body. The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have their application processed within those periods.

A reappointment review of each Medical Staff member shall occur at least every three years.

1.4 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

1.4-1 FOR INITIAL APPOINTMENTS

Except as otherwise recommended by the Executive Committee and approved by the Board of Trustees, all practitioners with privileges initially appointed to the Medical Staff shall complete a period of performance evaluation. This evaluation may include direct observation of the practitioner's performance, outcome review, statistical trending, and other screening criteria as may be designated by the departmental chair.

Each initial appointee shall be assigned to a Department where their performance shall be evaluated by the Credentials Committee during the term of performance evaluation required by that Department, as established pursuant to Section 3.8 of the Governance and Structure chapter, to determine the initial appointee's eligibility to exercise the Clinical Privileges initially granted in that Department. Their exercise of Clinical Privileges in any other Department shall also be subject to performance evaluation for the term of evaluation required by that Department.

FPPE review forms will be completed by a peer of the initial appointee. The process for medical specialties includes reviewing a

minimum of five (5) randomly selected cases that reflect the practitioner's practice. The review will encompass utilization review & quality management, drug usage evaluation, clinical pertinence documentation, and patient satisfaction and risk management. Case review can be through direct observation, concurrent or retrospective review. The Department Chair will determine who should provide the professional practice evaluation.

The following criteria will be included in the focused professional practice evaluation:

- Appropriateness of initial level of care;
- Appropriateness of monitoring and treatment of patient's condition;
- Appropriateness of diagnostic tests and procedures;
- Appropriate management of complications;
- Appropriate length of stay, including discharge to an appropriate level of care;
- Drug usage evaluation;
- History & Physical, progress notes, operative notes, and discharge summary within the defined timeframes;
- Any patient dissatisfaction with the practitioner;
- Evidence of unethical behavior, including behavior that undermines a culture of safety on the part of the practitioner.

For providers who perform procedures, the FPPE includes direct observation by a peer with requisite privileges for at least five (5) cases of a sufficient variety. If there is not a practitioner on staff with requisite privileges to conduct the observation, an outside expert who has been granted temporary privileges may be used. The proctor should be someone with adequate experience to monitor and evaluate the technical and cognitive skills of the provider being proctored. A spouse should not serve as a proctor due to either the real or perceived inability to be objective in the clinical evaluation and monitoring.

The criteria to be reviewed includes the following:

- Pre-procedure note in chart;
- Indications for procedure met;
- Informed consent obtained;
- Surgical technique;
- Complications documented and appropriately managed;
- Interactions with colleagues and staff.

The proctor's primary responsibility is to evaluate the proctored practitioner's performance. However, if the proctor believes that intervention is warranted in order to avert harm to the patient, they may take such action as they believe is reasonably

necessary to protect the patient.

The proctor shall complete a proctoring form and submit it to the Medical Staff Office. Forms are available in the Operating Room and Medical Staff Office. The proctor's reports shall be maintained in the practitioner's credentials file and should be taken into consideration at the time the new staff member is considered for reappointment.

The Credentials Committee evaluates the FPPE of each initial appointee upon its completion. The Department Chairs evaluate the Ongoing Professional Practice Evaluations of each practitioner in their department every six months. If issues arise, the Department Chair may involve the Credentials Committee or the Patient Care Review Committee. The Credentials Committee evaluates whether the appointee meets all of the qualifications and has discharged all of the responsibilities of the category to which they were appointed. The Credentials Committee also evaluates whether the appointee has satisfactorily demonstrated their ability to exercise the Clinical Privileges granted.

1.4-2 FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

When recommended by the Executive Committee, and approved by the Board of Trustees, Medical Staff members who change Medical Staff category or Department assignment or who are initially granted additional special requested privileges shall complete a period of FPPE as deemed appropriate by the Credentials Committee.

1.4-3 TERM OF FPPE

The term of FPPE for initial appointment or for a modification of membership status or privileges shall extend for a minimum period of three months or for a reasonable number of cases to be determined by the Department. Each Department may establish, in this chapter, a term of performance evaluation which establishes a longer period of time and/or a specific number of additional cases applicable to particular Clinical Privileges whenever such requirements are appropriate in view of the Clinical Privileges which are involved. If a Medical Staff member requesting modification fails within that period to complete the number of cases and/or furnish the certifications required in Section 3.8-1 (Governance and Structure chapter), the change in Medical Staff category or Department assignment or the additional privileges, as applicable, shall be terminated, and the affected practitioner shall not have the right to request a hearing pursuant to Section IV of the Credentialing

Policies chapter. The Executive Committee Chair shall give the initial appointee or Medical Staff member so affected written notice that their Medical Staff membership and/or Clinical Privileges have been terminated because they failed to satisfactorily complete the performance monitoring requirements.

FPPE may be conducted at any time during a practitioner's appointment should a concern arise regarding their outcomes, practice performance, and/or Clinical Privileges, or when a known practitioner requests a new privilege that they were not previously granted. Triggers for a FPPE can be a single incident or a clinical practice trend. Examples include, but are not limited to:

- Number of events occurring;
- Number of individual peer reviews with adverse determinations;
- Elevated infection rates;
- Sentinel events;
- Increasing length of stay compared to others;
- Increasing number of returns to surgery;
- Patterns of unnecessary tests/treatments;
- Failure to follow approved clinical practice guidelines.

If FPPE needs to be conducted for a specialty in which the practitioner has no peers on the Medical Staff, an external source may be utilized. The proctor should be someone with adequate experience to monitor and evaluate the technical and cognitive skills of the provider being proctored. A spouse should not serve as a proctor due to either the real or perceived inability to be objective in the clinical evaluation and monitoring.

1.5 REAPPOINTMENTS

1.5-1 APPLICATION FOR REAPPOINTMENT; SCHEDULE FOR REVIEW

At least ninety (90) days prior to the expiration of each member's current staff appointment, the President or their designee shall mail a reappointment application to the staff member.

At reappointment, the Medical Staff office will primary source verify current licensure, required certifications, and Federal Narcotics Registration Certificate (DEA). The Medical Staff office will review involvement in any professional liability action and individual performance data for variation from benchmark. The provider's NPDB profile will be reviewed at this time. A member's request for a change in membership category or in privileges may be processed in a year in which they are not scheduled for review.

Such member's appointment nevertheless shall be reviewed as stated in Section 1.3-13.

If at the end of their appointment period, the practitioner has not had any patient activity at the Medical Center, this may be deemed a voluntary resignation from the Medical Staff. This provision is limited to members of the Active, Community Based (Admit Only), and the APP Staff.

Practitioners who voluntarily resign from the Medical Staff for any reason and reapply within two years for Medical Staff membership will be charged a fee as defined by the Medical Executive Committee.

No less than sixty (60) days prior to the expiration date of their Staff appointment, each Medical Staff member shall submit to the President and his or her designee a completed reappointment application form. The reappointment application shall be in writing, on a form prescribed by the Medical Staff, and it shall require detailed information concerning the changes in the applicant's qualifications since their last review. Specifically, the reappointment application form shall request all of the information and certifications requested in the initial appointment application form, as described in Section 1.2, except for that information which cannot change over time, such as information regarding the member's premedical and medical education, date of birth, and so forth. Each Medical Staff member is responsible for tracking their own continuing medical education (CME) credits to ensure state licensure requirements are met. For CME credits earned through education at MGMC, a report may be obtained from the Medical Staff Office. The form shall also require information as to whether the applicant requests any change in staff status and/or in Clinical Privileges, including any reduction of, deletion of, or additional privileges. Requests for additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application for same.

1.5-2 ONGOING PROFESSIONAL PRACTICE EVALUATION

Ongoing professional practice evaluation (OPPE) is used to assess the competence of Medical Staff members and those practitioners privileged through the Medical Staff process. Data is collected every six months and analyzed for review. Criteria for review may include, but are not limited to:

- Review of operative and other clinical procedures performed and their outcomes;
- Pattern of blood usage;

- CMS Quality Indicators (if applicable);
- Length of stay patterns;
- Professional practice evaluation cases;
- Patient satisfaction;
- Clinical pertinence review;
- Medical records compliance;
- Other relevant criteria as determined by the organized Medical Staff.

The Medical Staff is responsible for ensuring the OPPE is consistently implemented and that clearly defined indications are uniformly applied.

Procedure:

Continuing review of patient care and the professional performance of practitioners is the responsibility of the Department Chairs as delineated in the Governance and Structure chapter. The organized Medical Staff has a leadership role in performance improvement activities to improve quality of care, treatment, and services as well as patient safety. This is accomplished through the mechanisms of the Medical Center Patient Care Review Committee and other organization-wide performance improvement activities.

Individual Medical Staff departments determine the type of data to be collected, relevant to their specialty. The Medical Center's Medical Staff uses the six general competencies as defined by the Accreditation Council for Graduate Medical Education (ACGME) as a general framework for evaluation of practitioners. The six competencies include:

- Patient Care and Procedural Skills: Provide care that is compassionate, appropriate, and effective treatment for health problems and to promote health.
- Medical Knowledge: Demonstrate knowledge about established and evolving biomedical, clinical, and related sciences and their application in patient care.
- Practice Based Learning and Improvement: Able to investigate and evaluate their patient care practices, appraise, and assimilate scientific evidence and improve their practice of medicine.
- Interpersonal and Communication Skills: Demonstrate skills that result in effective information exchange and teaming with patients, their families, and professional associates (e.g., fostering a therapeutic relationship that is ethically sound, uses effective listening skills with non-verbal and verbal communication; working as both a team member and at times as a leader).
- Professionalism: Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and

sensitivity to diverse patient populations.

- Systems Based Practice: Demonstrate awareness of and responsibility to larger context and systems of healthcare. Be able to call on system resources to provide optimal care (e.g., coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professionals, or sites).

All reviews shall be considered a part of the confidential professional practice evaluation activity of the Medical Staff and are intended to enhance the quality and safety of patient care, and as such is entitled to peer review protection and privilege.

The written results of OPPE will become part of the practitioner's credentials file and will be included in the decision to maintain existing privileges, revise existing privileges or to revoke an existing privilege prior to or at the time of renewal. Results of ongoing professional practice evaluations are communicated to the practitioner every six months.

1.5-3 VERIFICATION OF INFORMATION

The President or his or her designee shall, in timely fashion, seek to collect or verify, from the primary source when feasible, the additional information made available on each reappointment application form and to collect any other materials or information deemed pertinent. At time of reappointment, if Mary Greeley Medical Center is not the practitioner's primary practice facility, a practitioner evaluation form will be sent only to the primary practice facility(s) of the practitioner.

When collection and verification is accomplished, applications for reappointment shall be reviewed by the credentialing staff and divided into two classes. Class 1 includes applications that have no questions or concerns and contain complete documentation; Class 2 includes all other applications, including those in which there is a question, concern or needed discussion of training, education, competency, or character of the applicant, and those that have been satisfactorily resolved. The credentialing staff will transmit the application and all supporting materials to the Chair of each Department in which the applicant seeks privileges.

1.5-4 DEPARTMENT ACTION

The Department Chair shall review the application and the Staff member's file and shall transmit to the Credentials Committee their written report and recommendations, which are prepared in accordance with Section 1.5-7. A Department Chair may request

further documentation.

1.5-5 CREDENTIALS COMMITTEE ACTION

Following receipt of the Department Chair's report, Class 1 applications, supporting documentation, and other relevant information will be reviewed by the Chair of the Credentials Committee and the Chief of Staff, who will transmit their report to the Credentials Committee. All applications will be available to the Credentials Committee members for their review. The Credentials Committee will review all Class 2 applications, supporting documentation, and report(s) submitted by the Department Chair, and such other relevant information as may be available. The Credentials Committee may ask the applicant for further documentation. The Credentials Committee shall transmit to the Medical Executive Committee its report and recommendations prepared in accordance with Section 1.5-7.

1.5-6 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the Credentials Committee report and recommendations, the Medical Executive Committee shall review the Department Chair and Credentials Committee's reports as well as all other relevant information available to it and shall forward to the Board of Trustees, through the President, its written reports and recommendations, which are prepared in accordance with Section 1.5-7.

When the Medical Executive Committee recommends an adverse professional review action, as defined in Section 4.2, either in respect to reappointment or Clinical Privileges, the Chief of Staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 4.3 and the applicant shall be entitled to the procedural rights as provided in Section IV of this chapter.

The Board of Trustees shall be informed of, but not take action on, the pending recommendation until the applicant has exhausted or waived their procedural rights.

Thereafter the procedures specified in Sections 1.3-10 (Action by the Board of Trustees), 1.3-11 (Notice of Final Decision) and 1.3-12 (Reapplication After Adverse Decision Denying Application, Adverse Corrective Action Decision, or Resignation in Lieu of Medical Disciplinary Action) shall be followed. The Committee may also defer action; however, any such deferral must be followed up within seventy (70) days with a subsequent recommendation.

1.5-7 REAPPOINTMENT REPORTS

The Department Chair, Credentials Committee, and Medical Executive Committee reports and recommendations shall be written and shall be submitted in the form prescribed by the Medical Executive Committee. Each report and recommendation shall specify whether the applicant's appointment should be renewed; renewed with modified membership category, Department affiliation, and/or Clinical Privileges; or terminated. Where non-reappointment, denial of requested privileges, a reduction in status, or a change in Clinical Privileges is recommended, the reason for such recommendation shall be stated and documented.

1.5-8 BASIS FOR REAPPOINTMENT

Each recommendation concerning the reappointment of a Medical Staff member and the Clinical Privileges to be granted upon reappointment shall be based upon whether such member has met the applicable qualifications specified in Section 3.2 of the Governance and Structure chapter, carried out the applicable responsibilities specified in Section 3.6 of the Governance and Structure chapter, and met all of the standards and requirements set forth in all sections of the Governance and Structure and Rules and Regulations chapters. Specifically, recommendations shall also be based upon the practitioner's compliance with the following:

- legal requirements applicable to the practice of his profession;
- these Bylaws and Medical Center policies;
- rendition of services to their patients;
- any physical or mental impairment which might interfere with the applicant's ability to practice medicine with reasonable skill and safety;
- their provision of accurate and adequate information to allow the Medical Staff to evaluate their competency and qualifications;
- information obtained from the National Practitioner Data Bank and other data sources as appropriate; and
- the representations set forth in the paragraph that follows.

Every effort is made to ensure that the decision to grant or deny privileges, or renew an existing privilege is an objective, evidence-based process.

By his or her application for membership and privileges, the practitioner makes representations as outlined in Section 1.3-8.

The practitioner agrees to immediately notify the Medical Center of any threatened, proposed, or actual exclusion of the practitioner from participation in any governmental health care program.

1.5-9 FAILURE TO FILE REAPPOINTMENT APPLICATION

If the member fails to submit an application for reappointment completed as required, they shall be deemed to have voluntarily resigned their membership in the Medical Staff.

1.5-10 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Section IV of this chapter unless the termination meets the definition of "adverse professional review action" under Section 4.1-2. A subsequent request for Medical Staff membership received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

SECTION II

CLINICAL PRIVILEGES

2.1 EXERCISE OF PRIVILEGES

Every practitioner providing clinical or professional services at this Medical Center shall be entitled to exercise only those privileges specifically granted to them by the Board of Trustees, except as provided in Sections 2.4 and 2.6 of this Section II. Privileges must be within the scope of any license, certificate, or other legal credential authorizing them to practice in this State and consistent with any restrictions thereon. Privileges will be activated only after the practitioner has completed the MGMC electronic medical record training.

2.2 DELINEATION OF PRIVILEGES IN GENERAL

2.2-1 REQUESTS

Each practitioner must make a request for the specific Clinical Privileges desired by the applicant. Requests from an applicant for privileges or from members for modification of privileges must be supported by documentation of the requisite training, experience, qualifications, and competency to exercise such privileges.

2.2-2 BASIS FOR PRIVILEGES DELINEATION

Requests for Clinical Privileges shall be evaluated on the basis of the applicant's education, training, experience, demonstrated ability to practice with reasonable skill and safety, and judgment. The elements to be considered in making determinations regarding privileges, whether in connection with periodic reappointment or otherwise, shall include education, training, observed clinical performance and judgment, continuing medical education information related to the Clinical Privileges to be exercised by the applicant, and the documented results of the ongoing professional practice evaluation required by these Bylaws to be conducted at the Medical Center. Privileges determinations shall also take into account pertinent information concerning clinical or professional performance obtained from other sources, including other institutions and health care settings where the applicant exercises Clinical Privileges.

An applicant must submit a statement that no health problems exist that could affect his or her ability to perform the privileges requested. Documentation regarding an applicant's health

status should be indicated as confirmed. In instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by an internal and/or external source may be required.

At time of reappointment, if Mary Greeley Medical Center is not the practitioner's primary practice facility, a practitioner evaluation form, along with a copy of their requested privileges, will be sent only to the primary practice facility(s) of the practitioner.

2.2-3 PROCEDURE

All requests from practitioners for Clinical Privileges shall be processed pursuant to the procedures outlined in Section I of this chapter. The decision to grant, limit, or deny a requested privilege will be communicated to the requesting practitioner.

The granted privileges for each practitioner are made available to all appropriate Medical Center staff via the MGMC Intranet. When a procedure is scheduled in an area of the hospital, the scheduling staff checks our online privilege viewer to ensure that the provider has the needed privileges to perform the requested procedure. If our staff has any questions, they contact the Medical Staff Office directly to confirm.

2.3 SPECIAL CONDITIONS APPLICABLE TO NON-MD OR NON-DO MEMBERS

2.3-1 ADMISSIONS

Dentists, oral surgeons, podiatrists, and certified health service providers in psychology who are members of the Medical Staff may admit patients if a fully licensed physician member of the Medical Staff conducts the admitting history and physical examination (except the portion related to dentistry, oral surgery, podiatry or psychology), and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization that are outside of the lawful scope of the practitioner's practice.

2.3-2 MEDICAL APPRAISAL

All patients admitted for care in the Medical Center by a dentist, oral surgeons, podiatrists, and certified health service providers in psychology shall be co-admitted by a fully licensed MD/DO physician member of the Medical Staff and shall receive the same basic medical appraisal as patients admitted to other services, and the fully licensed physician member shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient.

2.4 TEMPORARY PRIVILEGES

2.4-1 CIRCUMSTANCES

Temporary privileges may be granted only for one of the two circumstances below and will be activated only after the practitioner has completed the MGMC electronic medical record training. Upon the written concurrence of the President, the Chair of the Department where the privileges will be exercised, and the Chief of Staff, the President or their designee, may grant temporary privileges to a practitioner who meets the following requirements for each circumstance.

- (a) Pendency of Initial Application: Temporary privileges may be granted to an applicant with a complete Class I application that is waiting review and approval of the Medical Executive Committee and the Board of Trustees. Class II applications will be reviewed on a case-by-case basis. Temporary privileges for new applicants will not exceed 120 days. Use of locum tenens or similar temporary medical service may be used for a period not to exceed six months.
- (b) Providing Important Patient Care Need: Upon receipt of the credentialing application for privileges to provide an important service need, a practitioner of documented competence who is providing an important service for an Active Medical Staff member may, without applying for membership on the Staff, be granted temporary privileges for an initial period of up to 120 consecutive days but not to exceed their services in providing the service need, and shall be limited to treatment of the patients or service of the practitioner for whom they are serving. Applications of practitioners applying for privileges to provide an important service need and approved will be granted temporary privileges and will be reviewed at the next Board of Trustees scheduled meeting. If the temporary privileges have not previously been approved, the application shall be subject to review and consideration by the Board of

Trustees as defined in Section 1.3-10.

The following will be verified prior to submitting an application for temporary privileges for approval:

- Application/request for privileges
- Form of photo identification
- Privilege request form (if applicable)
- Current Iowa license in good standing
- Current, adequate malpractice insurance
- Current DEA/CSA registrations
- One letter of reference (if time allows)
- National Practitioner Data Bank (NPDB) report
- American Medical Association (AMA) profile
- Background check (if time allows)
- Current CPR (if applicable)
- Primary verification of education
- Demonstration of competence

2.4-2 CONDITIONS

Temporary privileges may be granted only when the practitioner has submitted a written application for appointment and the information available reasonably supports a favorable determination regarding the requesting practitioner's licensure, qualifications, ability, and judgment to exercise the privileges requested, and only after the practitioner has satisfied the requirement, if any, of Section 10.9 of the Governance and Structure chapter regarding professional liability insurance. The Chair of the Department to which the practitioner is assigned shall be responsible for supervising the performance of the practitioner granted temporary privileges, or for designating a department member who shall assume this responsibility. Special requirements of consultation and reporting may be imposed by that Chair.

2.4-3 TERMINATION

On the discovery of any information or the occurrence of any event of a nature which raises a question about a practitioner's professional qualifications, ability to exercise any or all of the temporary privileges granted, or compliance with any of these Bylaws or special requirements, the President/designee, or the Chief of Staff may, after consultation with the Department Chair/designee responsible for supervision, terminate any or all of such practitioner's temporary privileges. In addition, if a patient's life or well-being is determined to be endangered by continued

treatment by the practitioner, the termination may be affected by any person entitled to impose suspensions under Section III of this chapter. In the event of any such termination, the practitioner's patients then in the Medical Center shall be assigned to another practitioner by the Department Chair responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

2.5 TELEMEDICINE

The policy of this hospital is that telemedicine services may be provided at this facility in a manner that seeks to ensure a high level of care consistent with the standards of care for other hospital services.

Practitioners providing telemedicine services must be granted privileges at this hospital. To the extent telemedicine services are permitted by law to be delivered to patients located outside of the hospital, and by practitioners in locations outside of a hospital, the hospital shall permit such practice by its Medical Staff members as long as each practitioner complies with all applicable Medical Staff and hospital policies related to delivering such telemedicine services outside of the hospital (e.g. clinical privileges and other clinical requirements, privacy and security requirements, and medical record completion).

For a practitioner to be eligible to request telemedicine privileges to deliver care to hospital patients under an agreement with a distant site hospital or distant site telemedicine entity, the following requirements must be met in order to utilize the credentialing decisions of the distant site:

- The Medical Executive Committee (MEC) has recommended that the scope of telemedicine services provided by the distant site practitioner on behalf of this originating site hospital meet the needs of this hospital.
- The practitioner must concurrently maintain privileges, at a minimum, for the same scope of services at the distant site hospital as he or she is requesting at the originating site hospital.
- The practitioner must hold a license issued or recognized by the state in which the hospital whose patients are receiving such services is located.
- The Medical Executive Committee (MEC) has recommended that the scope of telemedicine services provided at this originating site hospital include privileges to meet the needs of this hospital. If the practitioner is not affiliated with an accredited organization that is recognized by the originating hospital, the practitioner will be credentialed and privileged in accordance with the Medical Staff Bylaws.

Requests for telemedicine privileges by a practitioner affiliated with a distant site organization to practice medical or psychiatric services within

the practitioner's scope of service at the originating site hospital will be processed through the established procedure for reviewing and granting privileges at the originating site hospital. Information included in the completed practitioner application for telemedicine privileges at the originating site hospital may be collected in the usual manner or may be collected from the distant site hospital if the distant site hospital is an accredited organization and as specified in the contracted agreement for the telemedicine services.

In order for the originating site to use credentialing and privileging information from the distant site in credentialing and privileging decisions, the following three conditions must be fulfilled:

- The distant site hospital is accredited with CMS deeming authority;
- The practitioner is privileged at the distant site for those services to be provided at the originating site hospital;
- The originating site hospital has evidence from the distant site of an internal review of the practitioner's performance of these privileges and the originating site sends to the distant site hospital information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information will include all adverse outcomes related to sentinel events considered reviewable by the accrediting organization that results from the telemedicine services provided and complaints about the distant site from patients, other licensed independent practitioners, and staff members at the originating site hospital.

2.6 EMERGENCY PRIVILEGES

For the purpose of this Section, an "emergency" is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by their license and regardless of Department, Medical Staff status, or Clinical Privileges, shall be permitted to do, and shall be assisted by Medical Center personnel in doing everything possible to save a patient from such danger. If a practitioner wishes to continue to treat the patient when an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are either not requested or denied, the patient shall be assigned to an appropriate member of the Staff by the Chief of Staff or their designee.

2.7 CREDENTIALING VOLUNTEERS IN THE EVENT OF DISASTER

The Medical Center may grant disaster (defined as any officially declared disaster, whether it is local, state, or national) privileges to volunteers

eligible to be licensed independent practitioners. Disaster privileges are granted only when the following two conditions are present: the Emergency Operations Plan has been activated, and the Medical Center is unable to meet immediate patient needs. Disaster privileges will be granted by the Chief of Staff, Medical Director of Emergency Services, and the President, or their designees, who will also coordinate the Medical Staff by assigning practitioners to appropriate departments as requested by those departments. Volunteer licensed independent practitioners should report to the Medical Center West Patient Tower entrance where they will be directed.

While disaster privileges are granted on a case-by-case basis, volunteers considered eligible to act as licensed independent practitioners in the Medical Center must at a minimum present a valid government-issued photo identification issued by a state or federal agency (for example, a driver's license or passport) and at least one of the following:

1. A current picture hospital ID card that clearly identifies professional designation.
2. A current license to practice.
3. Primary source verification of the license.
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organizations or groups.
5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
6. Confirmation of identification by current hospital staff or Medical Staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.

Primary source verification of licensure and verification of malpractice insurance will begin as soon as the immediate situation is under control and will be completed within 72 hours from the time the volunteer practitioner presents to the Medical Center. In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (for example, no means of communication or a lack of resources), it will be done as soon as possible. Documentation will include why primary source verification could not be performed in the required time frame, evidence of a demonstrated ability to continue to provide adequate care, treatment, services, and an attempt to rectify the situation as soon as possible. A record of this information will be retained in the Medical Staff Office.

A practitioner's disaster privileges may be immediately terminated in the event that any information received through the verification process indicates any adverse information or suggests the person is not capable of rendering services in a disaster. The practitioner will be provided a name badge, will be paired with a currently credentialed Medical Staff member, and will act under the supervision of a Medical Staff member. The practitioner's privileges will be for the period needed during the duration of the disaster only. Based on its oversight of each volunteer practitioner, the hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue. When the disaster situation no longer exists, these disaster privileges terminate.

2.8 CONTINUING EDUCATION

All licensed practitioners privileged through the Medical Staff process are encouraged to participate in continuing education. Hospital-sponsored educational activities are prioritized by the Continuing Medical Education Committee, consisting of physicians and representatives from Pharmacy, Quality Management, Nursing, Medical Services, and Administration. The activities relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital. Each individual's participation in continuing education is documented. Participating in continuing education is considered in decisions about reappointment to membership on the Medical Staff or renewal or revision of individual Clinical Privileges. The Medical Center requirements for continuing medical education are satisfied if the practitioner meets the Iowa Board of Medicine's continuing education requirements for licensure. At least 50% of the practitioners' minimum number of required hours of continuing education must be directly related to the privileges requested. Providers must maintain applicable CME hours required for their specialty/service line.

SECTION III

COLLEGIAL INTERVENTION AND CORRECTIVE ACTION

3.1 COLLEGIAL INTERVENTION

- (a) This Manual encourages collegial and educational efforts by Medical Staff leaders and Medical Center administration to address questions relating to a licensed independent practitioner's clinical practice and/or professional conduct. The goal of these informal collegial efforts is to arrive at voluntary, responsive actions by the practitioner to resolve questions that have been raised.
- (b) Collegial efforts may include, but are not limited to, counseling, monitoring and additional training or education.
- (c) All collegial intervention efforts by Medical Staff leaders and Medical Center administration are part of the Medical Center's performance improvement and professional practice evaluation activities, and any records of such efforts shall be considered privileged and confidential.
- (d) Collegial intervention efforts are encouraged before formal corrective action is pursued, if appropriate to do so, but such efforts are not mandatory and shall be within the discretion of the appropriate Medical Staff leaders.
- (e) Medical Staff leaders may also engage in collegial intervention using other applicable policies (e.g., Practitioner Health and Well Being, Section IX of the Rules and Regulations chapter).

3.2 CORRECTIVE ACTION

3.2-1 CRITERIA FOR INITIATION

If a licensed independent practitioner with Clinical Privileges engages in, makes, or exhibits acts, statements, demeanor, or professional conduct, either within or outside of the Medical Center, including social media, that is reasonably likely to be detrimental to patient safety, to the delivery of quality patient care, disruptive to the Medical Center operations, or constitutes improper use of Medical Center resources, fraud or abuse, or could result in the imposition of sanctions by any governmental authority, then corrective action under this Section shall occur. Corrective action may be initiated by the Chair of any Department in which the practitioner is a member or exercises Clinical Privileges, by the Board of Trustees, or by the President if collegial intervention efforts have not resolved the issue.

3.2-2 CONFIDENTIALITY

Corrective action and hearing and appellate review proceedings, as set forth in these Credentialing Policies, shall be considered professional practice evaluation committee proceedings entitled to the confidentiality protections of Federal and State laws. The written request for investigation or corrective action, as well as complaint files, investigation files, reports, and other investigative information prepared for the purpose of the professional practice evaluation matter at issue shall be considered professional practice evaluation records that are privileged and confidential in the hands of the professional practice evaluation committee and the Medical Center and shall be released only as required or permitted by law.

3.2-3 INITIATION

Proposed corrective action, including a request for an investigation, must be initiated by the Chief of Staff or designee on their own initiative or by a written request which is submitted to the Chief of Staff (or by the Chief of Staff Elect if the Chief of Staff is the subject of the request), the Medical Executive Committee, or the President, and identifies the specific activities or conduct which are alleged to constitute the grounds for proposing an investigation or specific corrective action. The Chief of Staff (or the chief of Staff Elect if the Chief of Staff is the subject of the request) shall promptly notify the President and Board of Trustees of all proposals for corrective action so initiated and shall continue to keep them fully informed of all action taken in conjunction therewith.

3.2-4 INVESTIGATION

The Medical Executive Committee shall receive the request for corrective action and shall take action on the request or direct that an investigation be undertaken. The Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriately charged officer or to a standing or ad hoc Medical Staff committee. No such investigation process shall be deemed to be a "hearing" as that term is used in Section IV of this chapter.

During the investigative process, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the investigating officer or body. At such interview, the practitioner shall be informed of the general nature of the charges against them, and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall be made and included in the report to the Medical Executive Committee.

If the investigation is delegated to an officer or Committee other than the Medical Executive Committee, such officer or Committee shall forward a written report of the investigation to the Medical Executive Committee as soon as it is practicable under the circumstances, but in any event within 30 days after the assignment to investigate has been made. The Medical Executive Committee may at any time within its discretion and shall, at the request of the Board of Trustees, terminate the investigative process and proceed with action as provided in Section 3.5.

3.2-5 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as is practicable after the conclusion of the investigative process, if any, but in any event within 60 days after the initiation of proposed corrective action, unless deferred pursuant to Section 3.2-6, the Medical Executive Committee shall act thereon. Such action may include, without limitation, the following recommendations:

- (a) No corrective action be taken and, if the Medical Executive Committee determines that no credible evidence existed for the complaint, the removal of any complaint-related information from the member's file.
- (b) Rejection or modification of the proposed corrective action.
- (c) Formal letters of admonition, censure, reprimand, or warning be issued, although nothing herein shall be deemed to preclude Department Chairs from issuing informal written or oral warnings outside the corrective action mechanism. If such formal letters are issued, the affected member may make a written response that shall be placed in the member's file.
- (d) Probation or special limitations be imposed on continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.
- (e) Reduction or revocation of Clinical Privileges.
- (f) Suspension of Clinical Privileges until completion of specific conditions or requirements.
- (g) Reduction of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care.

- (h) Suspension of Medical Staff membership until completion of specific conditions or requirements.
- (i) Revocation of Medical Staff membership.
- (j) Other actions appropriate to the facts which prompted the investigation.

Nothing set forth herein shall inhibit the Medical Executive Committee from implementing suspension at any time, in the exercise of its discretion pursuant to Section 3.3.

3.2-6 DEFERRAL

If additional time is needed to complete the investigative process, the Medical Executive Committee may defer action on the request for a reasonable period of time, and it shall so notify the affected practitioner. A subsequent recommendation for any one or more of the actions provided in Section 3.2-5, Paragraphs (a) through (j) above must be made within the time specified by the Medical Executive Committee, and if no such time is specified, then within 30 days of the deferral.

3.2-7 PROCEDURAL RIGHTS

Any recommendation by the Medical Executive Committee pursuant to Section 3.2-5 which constitutes grounds for a hearing as set forth in Section 4.2 shall entitle the practitioner to the procedural rights as provided in Section IV of this chapter. In such cases, the Chief of Staff (or the Chief of Staff Elect if the Chief of Staff is the subject of the matter) shall give the practitioner written notice of the recommended adverse professional review action and of their right to request a hearing in the manner specified in Section 4.3-2.

3.2-8 OTHER ACTION

- (a) If the Medical Executive Committee's recommended action is to recommend no corrective action, such recommendation, together with such supporting documentation as may be required by the Board of Trustees, shall be transmitted thereto. Thereafter, the procedure to be followed shall be the same as that provided for applicants in Sections 1.3-10 (Action by the Board of Trustees) and 1.3-11(a) (Notice of Final Decision), as applicable.
- (b) If the Medical Executive Committee's recommended action is an admonition, reprimand, or warning to a practitioner, it

shall, at the practitioner's request, grant them an interview as provided in Section 3.5. Following the interview, if one is requested, if the Medical Executive Committee's final recommendation to the Board of Trustees is an admonition, reprimand, or warning, this shall conclude the matter when approved by the Board of Trustees without substantial modification, and notice of the final decision shall be given to the Board of Trustees, President, Medical Executive Committee, the Chair of each Committee concerned, and the practitioner.

- (c) If any proposed corrective action by the Board of Trustees will substantially modify the Medical Executive Committee's recommendation, the Board of Trustees may submit the matter to the Joint Conference Committee for review and recommendation before making its decision final. Any recommendation of the Board of Trustees which constitutes grounds for a hearing as set forth in Section 4.2, shall entitle the practitioner to the procedural rights as provided in Section IV of this chapter. In such cases, the Board of Trustees shall give the practitioner written notice of the recommended adverse professional review action and of their right to request a hearing in the manner specified in Section 4.3-2.
- (d) Should the Board of Trustees determine that the Medical Executive Committee has failed to act in timely fashion on the proposed corrective action, the Board of Trustees, after notifying the Medical Executive Committee, may take action on its own initiative. If such action is favorable to the practitioner, or constitutes an admonition, reprimand or warning to the practitioner, it shall become effective as the final decision of the Board of Trustees. If such action is one of those set forth in Section 4.2, the Board of Trustees shall give the practitioner written notice of the recommended adverse professional review action and of their right to request a hearing in the manner specified in Section 4.3-2 and their rights shall be as provided in Section IV of this chapter.

3.3 SUSPENSION

3.3-1 CRITERIA FOR INITIATION

Whenever a practitioner's conduct requires immediate action to be taken to reduce a substantial likelihood of imminent impairment of the health or safety of any patient, prospective patient, employee or other person present in the Medical Center, any person or body authorized to initiate proposed corrective action pursuant to Section

3.2-1 hereof shall have the authority to suspend the Medical Staff membership status or all or any portion of the Clinical Privileges of such practitioner.

Such suspension shall become effective immediately upon imposition, and the person or body responsible therefor shall promptly give oral or written notice of the suspension to the practitioner, Board of Trustees, Medical Executive Committee, and President. The notice of the suspension given to the Medical Executive Committee shall constitute a request for corrective action and the procedures set forth in Section 3.2 shall be followed. In the event of any such suspension, the practitioner's patients whose treatment by such practitioner is terminated by the suspension shall be assigned to another practitioner by the Department Chair or by the Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

3.3-2 MEDICAL EXECUTIVE COMMITTEE ACTION

A practitioner whose privileges have been suspended may request an interview with the Medical Executive Committee, as provided in Section 3.4. The interview shall be convened as soon as reasonably possible under all of the circumstances, within 30 days of the date of suspension. The Medical Executive Committee may at any time before or after the interview, modify, continue, or terminate the terms of the suspension order, and written notice of its decision shall be given to the practitioner, Board of Trustees, and President.

3.3-3 PROCEDURAL RIGHTS

Unless the Medical Executive Committee terminates the suspension, it shall remain in effect during the pendency and completion of the corrective action process and of the hearing and appellate review process, unless the suspension is terminated by the Hearing Committee. The practitioner shall not be entitled to the procedural rights afforded by Section IV until such time as the Medical Executive Committee or Board of Trustees has taken action pursuant to Section 3.2-5 through 3.2-8, and then only if the action taken constitutes grounds for a hearing as set forth in Section 4.2.

3.4 AUTOMATIC SUSPENSION

3.4-1 LICENSE

- (a) Revocation or Expiration: Whenever a practitioner's license authorizing them to practice in this state is revoked or has

expired pursuant to the rules of the Iowa Board of Medicine, their Medical Staff membership, prerogatives, and Clinical Privileges shall be immediately and automatically terminated. Such practitioners shall not be entitled to the procedural rights afforded by Section IV of this chapter.

- (b) Restriction: Whenever a practitioner's license authorizing them to practice in this state is limited or restricted by the applicable licensing authority, those Clinical Privileges which they have been granted rights to perform that are within the scope of said limitation or restriction shall be immediately and automatically terminated.
- (c) Suspension: Whenever a practitioner's license authorizing them to practice in this state is suspended, their Staff membership and Clinical Privileges shall be automatically suspended effective upon and for at least the term of the suspension.
- (d) Probation: Whenever a practitioner is placed on probation by the applicable licensing authority, their applicable membership status, prerogatives, privileges and responsibilities, if any, shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation.

3.4-2 DRUG ENFORCEMENT ADMINISTRATION

- (a) Revocation or Expiration: Whenever a practitioner's DEA certificate is revoked or has expired, they shall immediately and automatically be divested of their right to prescribe medications covered by the certificate.
- (b) Suspension: Whenever a practitioner's DEA certificate is suspended, they shall be divested, at a minimum, of their right to prescribe medications covered by the certificate effective upon and for at least the term of the suspension.
- (c) Probation: Whenever a practitioner's DEA certificate is subject to an order of probation, their right to prescribe medications covered by the certificate shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation.

3.4-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A practitioner who fails without good cause to appear and satisfy the requirements of Section 3.3-1 of the Credentialing Policies chapter shall automatically be suspended from exercising all or such portion of their Clinical Privileges as may be suspended in accordance with the provisions of said Section 3.3-1.

3.4-4 MEDICAL EXECUTIVE COMMITTEE DELIBERATION ON MATTERS INVOLVING LICENSE, DRUG ENFORCEMENT ADMINISTRATION, AND FAILURE TO SATISFY SPECIAL APPEARANCE

As soon as practicable after action is taken as described in Section 3.4-1, paragraphs (b), (c), or (d), or in Section 3.4-2 or 3.4-3, the Medical Executive Committee shall convene to review and consider the facts upon which such action was predicated. The Medical Executive Committee may then recommend such further corrective action as may be appropriate based upon information disclosed or otherwise made available to it and/or it may direct that an investigation be undertaken pursuant to Section 3.2-4. The procedure to be followed shall be as provided in Sections 3.2-7 and 3.2-8, as applicable, if the Medical Executive Committee takes action, or as described in Section 3.2-4 through 3.2-8 if the Medical Executive Committee directs a further investigation.

3.4-5 MEDICAL RECORDS

For failure to complete inpatient or outpatient medical records, within the time limits established in the Rules and Regulations chapter and Medical Center policies, a practitioner's Clinical Privileges (except with respect to patients already in the Medical Center) and their rights to admit or attend new patients and to provide any other professional services in the Medical Center, shall be suspended upon receipt of the suspension notice, which follows prior deficiency/delinquency notifications. The physician's privileges will be suspended 14 days after discharge date or outpatient service date and the privileges will remain suspended until all delinquent records have been completed. Following the effective date of such a suspension, failure without good and sufficient cause to complete the medical records within 14 days shall require the practitioner to meet with the Credentials Committee within one week. Failure without good cause to appear for the meeting shall result in the termination of the practitioner's Medical Staff membership. Notification of the privilege suspension, resumption, or termination of the practitioner's Medical Staff membership will be made by the

Chief of Staff/designee. Additionally, providers who have shown a trend or pattern of not meeting chart completion requirements will present to the Patient Care Review committee with an action plan to address this non-compliance. A trend or pattern includes receiving a final notice of delinquency for three months in a row or receiving a final notice of delinquency six times in a 12-month time period.

3.4-6 PROFESSIONAL LIABILITY INSURANCE

For failure to maintain the amount of professional liability insurance required pursuant to Section 10.9 of the Governance and Structure chapter, a practitioner's membership and Clinical Privileges shall be automatically suspended and shall remain so suspended until the practitioner provides acceptable evidence to the Medical Staff Office and the President that they have secured professional liability insurance coverage in the amount required. Failure to provide such evidence within six months after the date the automatic suspension became effective shall result in termination of the practitioner's Medical Staff membership.

3.4-7 TERMINATION OR REVOCATION OF MEDICARE OR MEDICAID STATUS

There will be immediate and automatic suspension of privileges due to the termination or revocation of the provider's Medicare or Medicaid status.

3.4-8 FAILURE TO PAY DUES OR ASSESSMENTS

For failure to pay dues or assessments, if any, as required under Section 10.3 in Governance and Structure chapter, a practitioner's Medical Staff membership and Clinical Privileges, after written warning of delinquency, shall be automatically suspended and shall remain so suspended until the practitioner pays the delinquent dues or assessments. A failure to pay such dues or assessments within six (6) months after the date the automatic suspension became effective shall result in termination of the practitioner's Medical Staff membership.

3.4-9 CONVICTION OF A FELONY OR OTHER TYPES OF CRIMES

An automatic relinquishment of medical staff membership and/or all Clinical Privileges of a Medical Staff member shall be imposed upon notification received by the President or his or her designee regarding the member's conviction of: (1) a felony; (2) any crime related to healthcare fraud and abuse; (3) any crime related to the member's treatment, billing, discharge, collections or utilization

practices; or (4) any crime that could form the basis for exclusion from participation in governmental healthcare programs.

3.4-10 PROCEDURAL RIGHTS -- MEDICAL RECORDS, PROFESSIONAL LIABILITY INSURANCE AND FAILURE TO PAY DUES

Practitioners whose Clinical Privileges are automatically suspended and/or whose Medical Staff membership has been terminated pursuant to the provisions of 3.4-5 (MEDICAL RECORDS), 3.4-6 (PROFESSIONAL LIABILITY INSURANCE), 3.4-7 (FAILURE TO PAY DUES OR ASSESSMENTS), or 3.4-8 (CONVICTION OF A FELONY OR OTHER TYPES OF CRIMES), shall not be entitled to the procedural rights set forth in Section IV of this chapter, but shall be entitled to an interview limited solely to a factual determination of whether the requisite continuous insurance coverage was maintained, the medical records were timely completed, or good cause was shown for their failure to be timely completed, and/or Medical Staff dues or assessments were timely paid.

3.4-11 NOTICE OF AUTOMATIC SUSPENSION; TRANSFER OF PATIENTS

Whenever a practitioner's privileges are automatically suspended in whole or in part, notice of such suspension shall be given to the practitioner, the Medical Executive Committee, the President, and the Board of Trustees. Giving of such notice shall not, however, be required in order for the automatic suspension to become effective. In the event of any such suspension, the practitioner's patients whose treatment by such practitioner is terminated by the automatic suspension shall be assigned to another practitioner by the Department Chair or Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

3.4-12 ENFORCEMENT

It shall be the mutual duty of the Chief of the Medical Staff, the President, and the Board of Trustees to cooperate fully in enforcing all automatic suspensions.

3.5 INTERVIEWS

Interviews shall neither constitute nor be deemed a "hearing," as that term is used in Section IV of this chapter, shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. The Medical Executive Committee shall be required, at the practitioner's request, to grant an interview only when so specified in this Section III. In all other cases and when the Medical Executive

Committee or the Board of Trustees has before it an adverse recommendation, as defined in Section 4.2, it may, but shall not be required to, furnish the practitioner an interview. In the event an interview is granted, the practitioner shall be informed of the general nature of the circumstances leading to such recommendation and may present information relevant thereto. A record of the matters discussed and findings resulting from such interview shall be made.

SECTION IV

HEARINGS AND APPELLATE REVIEWS

4.1 PREAMBLE AND DEFINITIONS

4.1-1 EXHAUSTION OF REMEDIES

If an adverse professional review action (as defined in Section 4.1-2) is made with respect to a practitioner's Staff membership, Staff status, or Clinical Privileges at any time, regardless of whether an applicant or a Medical Staff member, they must exhaust the intra-organizational remedies afforded by Credentialing Policies before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claim against the Medical Center or participants in the decision process.

4.1-2 DEFINITIONS

Except as otherwise provided in this chapter, the following definitions shall apply under this Section:

- (a) "Adverse professional review action" refers to those adverse actions or recommendations which provide grounds for a hearing, as further described in Section 4.2.
- (b) "Body whose decision prompted the hearing" refers to the Medical Executive Committee in all cases where the Medical Executive Committee or authorized officers, members or committees of the Medical Staff took the action or rendered the decision which resulted in a hearing being requested; and refers to Board of Trustees in all cases where the Board of Trustees or authorized officers, directors or committees of the Board of Trustees took the action or rendered the decision which resulted in a hearing being requested.
- (c) "Notice" refers to a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested, addressed to the required addressee at the address that appears in the records of the Medical Center delivered via e-mail, fax or other means of electronic communication.
- (d) "Petitioner" refers to the practitioner who has requested a hearing pursuant to Section 4.3 of this chapter.

- (e) "Date of Receipt" of any notice or other communication shall be deemed to be the date of such notice or communication was delivered personally to the required addressee or, if delivered by mail, such notice or communication shall be deemed received 48 hours after being deposited, postage prepaid, in the United States mail in compliance with paragraph (b) of this Section 4.1-2, or if sent electronically, the date of receipt shall be the following business day.

4.2 GROUNDS FOR HEARING

Any one or more of the following actions or recommended actions shall be determined "adverse professional review actions" which constitute grounds for a hearing only if such action would require a mandatory report to the National Practitioner Data Bank (NPDB) upon final action by the Medical Center:

- (a) Denial of Medical Staff membership.
- (b) Denial of requested advancement in Staff membership status.
- (c) Denial of Staff reappointment
- (d) Demotion to lower Staff category or membership status.
- (e) Suspension of Staff membership until completion of specific conditions or requirements. The suspension is reportable to NPDB if the suspension is for more than thirty (30) days.
- (f) Suspension of Staff membership during the pendency of corrective action and hearing and appeals procedures. The suspension is reportable to NPDB if the suspension is for more than thirty (30) days.
- (g) Expulsion from Staff membership.
- (h) Denial of requested privileges.
- (i) Reduction in privileges.
- (j) Suspension of privileges until completion of specific conditions or requirements. The suspension is reportable to NPDB if the suspension is for more than thirty (30) days.

- (k) Suspension of privileges during the pendency of corrective action and hearing and appeals procedures. The suspension is reportable to NPDB if the suspension is for more than thirty (30) days.
- (l) Termination of privileges.
- (m) Requirement of consultation as a result of a professional review action, which results in a proctor being required in order for a Practitioner to proceed in freely exercising clinical privileges for a period lasting longer than thirty (30) days.
- (n) Any other action that would be reportable to the National Practitioner Data Bank upon final action.

Recommendation of any of these actions shall constitute an "adverse professional review action" for the purpose of these Credentialing Policies. No practitioner shall be entitled to hearing rights set forth in this Section 4 as a result of any action recommended or taken that would not require a mandatory report to the National Practitioner Data Bank, upon final action. However, in the event of a recommended action described in 4.2 (a-m) against a Medical Staff Member or an Advanced Practice Provider, which would not require a mandatory report to the National Practitioner Data Bank as a result of such practitioner's license, such practitioner shall be afforded the due process set forth in Section 1.9 of the Advanced Practice Provider Manual ("Right of Review").

A Fair Hearing will not be offered for:

- (a) Issuance of a letter of guidance, warning, or reprimand;
- (b) Imposition of a requirement for proctoring with no restriction on privileges;
- (c) Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;
- (d) Requirement to appear for a special meeting under the provisions in the Bylaws;
- (e) Conducting an investigation into any matter or the appointment of an ad hoc investigation committee.

4.3 REQUESTS FOR A HEARING

4.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which the body which, under these Credentialing Policies has the authority to, and pursuant to that authority, has recommended or taken any of the actions constituting grounds for hearing as set forth in Section 4.2, then said body shall give the affected practitioner notice of its proposed adverse professional review action, the reason(s) for the proposed adverse professional review action, of their right to request a hearing pursuant to Section 4.3-2, below and a summary of the hearing procedures and rights of the practitioner, which summary can be accomplished by furnishing the practitioner a copy of the Fair Hearing and Appeal Procedures contained in these Bylaws with the notice.

4.3-2 REQUEST FOR HEARING

The petitioner shall have thirty (30) days following the date of receipt of notice of such action to request a hearing by an ad hoc Hearing Committee. Said request shall be affected by notice to the President. Upon receipt of a timely request for hearing, the President of the Hospital shall deliver such request to the Chief of Staff or the Chair of the Board of Trustees, depending upon whose recommendation or action prompted the request for hearing. In the event the petitioner does not request a hearing within the time and in the manner hereinabove set forth, they shall be deemed to have accepted the recommendation, decision, or action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Board of Trustees within forty-five (45) days but shall not be binding on the Board of Trustees.

4.3-3 TIME AND PLACE FOR HEARING

Upon receiving a request for hearing, the body whose action prompted the request for a hearing shall schedule and arrange for a hearing. Such body shall give notice to the petitioner of the time, place, and date of the hearing. Unless otherwise agreed by the parties, the date of the commencement of the hearing shall be not less than thirty (30) days, nor more than sixty (60) days from the date of receipt of the request for a hearing (unless otherwise requested by the petitioner). However, that when the request for a hearing is received from a petitioner who is under suspension which is then in effect, the hearing shall be held as soon as the

arrangements may reasonably be made, but not to exceed thirty (30) days from the date of receipt of the request for hearing.

4.3-4 MOTIVE OF CHARGES OR GROUNDS FOR ACTION

As a part of, or together with the notice of hearing required by Section 4.3-3 above, the Chief of Staff, on behalf of the Medical Executive Committee, or the Board Chair, on behalf of the Board of Trustees (depending on which body took the action giving rise to the request for a hearing) shall state in writing the acts or omissions with which the petitioner is charged, including a list of the charts being questioned or the grounds upon which the application was denied, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose decision prompted the hearing. However, the list of witnesses may be amended at any time.

4.3-5 AD HOC HEARING COMMITTEE

When a hearing is requested, the Chief of Staff (or the Board Chair depending on the body whose decision prompted the hearing) shall appoint a Hearing Committee consisting of at least three (3) Medical Staff members, and alternates as appropriate. However, if the body whose decision prompted the hearing is not able to secure three members of the Medical Staff to serve as a hearing committee, the body may select hearing committee members from outside of the Medical Staff. The members selected to serve on the Hearing Committee shall be impartial peers not having actively participated in the formal consideration of the matter at any previous level and who are not in economic competition with the petitioner. When the practitioner requesting the hearing is a member of the dental, psychologist or podiatric staff, one member of the Hearing Committee shall be a licensed dentist, psychologist, or podiatrist, as appropriate. The Chief of Staff (or the Board Chair depending upon the body whose decision prompted the hearing) shall designate a Chair who shall preside in the manner described in Sections 4.4-1 and 4.4-3 below and handle all pre-hearing matters and preside until a hearing officer, as described in Section 4.4-4 below, is appointed.

4.3-6 FAILURE TO APPEAR

Failure without good cause of the petitioner to appear and proceed at such a hearing shall be deemed a resignation from the Medical Staff, which is reportable to the National Practitioner Data Bank.

4.3-7 POSTPONEMENTS AND EXTENSIONS

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by an affected person and shall be permitted by the Hearing Committee or its Chair acting upon its behalf on a showing of good cause.

4.4 HEARING PROCEDURE

4.4-1 PREHEARING PROCEDURE

At least 10 days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as then reasonably known or anticipated, who may give testimony in support of that party at the hearing. Either party may amend their witness list at any time. If witnesses are added after this list has been given to the other party, it shall be the duty of that party to notify the other of the change.

The failure, without good cause, to timely provide the names of a witness or witnesses shall prevent such witness or witnesses from appearing or testifying at the hearing. The hearing officer should confer with both parties to encourage and advance mutual exchange of documents relevant to the issues to be presented at the hearing.

- (a) It shall be the duty of the petitioner and the Medical Executive Committee, or its designee (or the Board depending upon the body whose decision prompted the hearing), to exercise reasonable diligence in notifying the hearing officer of the Hearing Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, so that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be made at the hearing.
- (b) The Medical Executive Committee (or the Board depending upon the body whose decision prompted the hearing) shall forward to the petitioner a copy of and shall provide access to all evidence on which the charges or reasons are based or will be supported at the hearing.

4.4-2 REPRESENTATION

Any party, including the petitioner, the Medical Executive Committee and the Board of Trustees, may choose to be represented at the hearing or the appellate review, provided the party desiring to be so represented shall give written notice regarding such representation to the other party or parties and the Hearing Committee or Board of Trustees, as appropriate, at least 15 days prior to the commencement of the hearings.

While legal counsel may attend and assist the respective parties in proceedings provided herein, due to the professional nature of the review proceedings, it is intended that the proceedings will not be judicial in form but rather a forum for professional evaluation and discussion. Accordingly, the Chair, Presiding Officer, or Hearing Officer, as applicable, and/or appellate review body retains the right to limit the role of counsel's active participation in the hearing process. Any practitioner who incurs legal fees in their behalf shall be solely responsible for payment thereof.

4.4-3 THE PRESIDING OFFICER

The presiding officer at the hearing shall be a hearing officer as described in Section 4.4-4 or, if no such hearing officer has been appointed, the Chair of the Hearing Committee. The presiding officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. They shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing. They will have the authority and discretion, in accordance with this chapter, to make all rulings on questions which, with reasonable diligence, could not have been raised prior to the hearing and which pertain to matters of law, procedure, or the admissibility of evidence.

4.4-4 THE HEARING OFFICER

At the request of the petitioner, the Medical Executive Committee, the Hearing Committee, or the Board of Trustees, the President or their designee may, but is not required to, appoint a hearing officer to preside at the hearing. The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, and preferably with experience in Medical Staff matters. They must not act as a prosecuting officer, as an advocate for the Medical Center, Board of Trustees, Medical Executive Committee,

the body whose action prompted the hearing, or the petitioner. If requested by the Hearing Committee, they may participate in the deliberations of such body and be a legal advisor to it, but they shall not be entitled to vote. The cost of any hearing officer shall be borne equally by both parties.

4.4-5 RECORD OF THE HEARING

The Hearing Committee shall maintain a record of the hearing by one of the following methods: a certified court reporter present to make a record of the hearing or a recording of the proceedings. The cost of any certified court reporter shall be borne equally by both parties. The Hearing Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person designated by such body and entitled to notarize documents in this state or by affirmation under penalty of perjury to the presiding officer.

4.4-6 RIGHTS OF THE PARTIES

At a hearing both sides shall have the following rights: to ask Hearing Committee members questions which are directly related to determining whether they are impermissibly biased and to challenge such members, to call and examine witnesses, to introduce exhibits or other documents, to cross-examine or otherwise attempt to impeach any witness who shall have testified orally on any matter relevant to the issues, and otherwise to rebut any evidence. Any challenge directed at the acceptability of one or more members of the Committee shall be resolved by the Committee prior to the continuation of the proceedings. The petitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination. There shall be no rights to discovery of evidence in the hearing or appeals procedures herein except as allowed by the Hearing Committee Chair, Presiding Officer, or Hearing Officer, as appropriate.

4.4-7 MISCELLANEOUS RULES

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, shall be admitted by the presiding officer if it is the sort of evidence which responsible persons are accustomed to relying on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement in support of its position and the Hearing Committee may

request such a statement to be filed following the conclusion of the presentation of oral testimony. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

4.4-8 BASIS OF DECISION

If the Hearing Committee should find any of the charge(s) or ground(s) to be true, it shall impose such form of discipline or action as it shall find warranted, including such form of discipline or action that may be more stringent than that recommended by the body whose decision prompted the hearing. The decision of the Hearing Committee shall be based on the evidence produced at the hearing. Such evidence may consist of the following:

- (1) Oral testimony of witnesses.
- (2) Briefs or written statements presented in connection with the hearing.
- (3) Any material contained in the Medical Center or Medical Staff files regarding the petitioner, which shall have been made a part of the hearing record.
- (4) Any and all applications, references, medical records, exhibits and other documents and records which shall have been made a part of the hearing record.
- (5) Any other evidence admissible hereunder.

4.4-9 BURDENS OF PRESENTING EVIDENCE AND PROOF

The body whose adverse professional review action occasioned the hearing shall have the initial obligation to present evidence in support thereof. The petitioner shall thereafter be responsible for supporting a challenge to the adverse professional review action by clear and convincing evidence that the grounds therefor lack any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable or capricious.

4.4-10 ADJOURNMENT AND CONCLUSION

The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The Hearing Committee shall thereupon, outside of the presence of any other person, conduct its deliberations and render a decision and accompanying report.

4.4-11 DECISION OF THE HEARING COMMITTEE

Within 15 days after final adjournment of the hearing (provided that in the event the petitioner is currently under suspension, this time shall be 10 days), the Hearing Committee shall render a decision which shall be accompanied by a written report that contains findings of fact which shall be in sufficient detail to enable the parties, any appellate review board, and the Board of Trustees to determine the basis for the Hearing Committee's decision on each matter contained in the notice of charges. The decision and report shall be delivered to the Medical Executive Committee, the President, and the Board of Trustees. Upon completion of the hearing, the petitioner has the right:

- (a) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
- (b) to receive a written decision of the Medical Center, including a statement of the basis for the decision.

A copy of the report and decision shall be delivered to the petitioner by registered or certified mail, return receipt requested. The decision of the Hearing Committee shall be considered final, subject only to the right of appeal to the Board of Trustees as provided in Section 4.5.

4.5 APPEALS TO THE BOARD OF TRUSTEES

4.5-1 TIME FOR APPEAL

Within 30 days after the date of receipt of the Hearing Committee decision, either the petitioner or the body whose decision prompted the hearing may request an appellate review by the Board of Trustees. Said request shall be delivered to the President in writing either in person, or by certified or registered mail, return receipt requested and it shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Board of Trustees within forty-five (45) days but shall not be binding on the Board of Trustees.

4.5-2 GROUNDS FOR APPEAL

The written request for an appeal shall include the grounds for appeal, and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

- (a) Substantial non-compliance with the procedures required by these Credentialing Policies or applicable law so as to deny a fair hearing;
- (b) The decision was not supported by substantial evidence based on the hearing record or such additional information as may be permitted pursuant to Section 4.5-5; or
- (c) Action taken arbitrarily, unreasonably, or capriciously.

4.5-3 TIME, PLACE AND NOTICE

When appellate review is requested pursuant to the preceding subsection, the Board of Trustees shall, within thirty (30) days after the date of receipt of such an appeal notice, schedule and arrange for an appellate review. The Board of Trustees shall give the petitioner notice of the time, place, and date of the appellate review. The date of appellate review shall not be less than fifteen (15) nor more than sixty (60) days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from a petitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed 45 days from the date of receipt of the request for appellate review. The time for appellate review may be extended for good cause by the Board of Trustees, or appeal board (if any).

4.5-4 APPEAL BOARD

When an appellate review is requested, the Board of Trustees may sit as the appeal board or it may appoint an appeal board which shall be composed of Board of Trustees members and shall have at least three members. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. For the purposes of this section, participating in an initial decision to recommend adverse action shall not be deemed to constitute participation in a prior hearing on the same matter.

4.5-5 HEARING PROCEDURE

The proceedings by the appeal board shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Hearing Committee hearing; or may remand the matter of the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to present a written statement in support of its position on appeal and, in its sole discretion, the appeal board may allow each party or representative to personally appear and make oral argument. At the conclusion of oral argument, if allowed, the appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. If an appeal board is appointed, the appeal board shall present to the Board of Trustees its written recommendations as to whether the Board of Trustees should affirm, modify, or reverse the Hearing Committee decision, or remand the matter to the Hearing Committee for further review and decision. If no appeal board is appointed, the procedures outlined in this subsection shall apply to a hearing before the Board of Trustees.

4.5-6 DECISION

Within fifteen (15) days after the conclusion of the appellate review proceedings the Board of Trustees shall render a final decision in writing. The Board of Trustees may affirm, modify, or reverse the Hearing Committee decision, or, in its discretion, remand the matter for further review and recommendation by the Hearing Committee or any other body or person. Copies of the decision shall be delivered to the petitioner and to the Medical Executive Committee, by personal delivery or by certified or registered mail, return receipt requested.

4.5-7 FURTHER REVIEW

Except where the matter is remanded for further review and recommendation pursuant to Section 4.5-6, the final decision of the Board of Trustees following the appeal procedures set forth in this Section IV shall be effective immediately and shall not be subject to further review. However, if the matter is remanded to the Hearing committee or any other body or person, said committee, body, or person shall promptly conduct its review and make its recommendations to the Board of Trustees in accordance with the

instructions given by the Board of Trustees. This further review process and the time required to report back shall in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate.

4.5-8 RIGHT TO ONE HEARING

Notwithstanding any other provision of this Manual, no practitioner shall be entitled as a right to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of action by either the Medical Executive Committee or the Board of Trustees or by both.

4.5-9 MANDATORY REPORTING

4.5-9(a) NATIONAL PRACTITIONER DATA BANK

Any professional review action that adversely affects a physician or practitioner's privileges for a period of more than 30 days is reportable to the National Practitioner Data Bank, as follows:

- Physicians and Dentists: Mandatory Report
 - Based on assessment of professional competence (not the standard FPPE process), a proctor is assigned to a physician or dentist for a period of more than 30 days. The physician or dentist must be granted approval before certain medical care is administered.
 - A physician or dentist voluntarily resigns their privileges after a recommendation for additional proctoring based on an assessment of professional competence.
 - Based on significant clinical competency concerns identified through the FPPE process, the organization determines to terminate or restrict the physician or dentist's clinical privileges.
 - Any professional review action that adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days.
 - Acceptance of the surrender of clinical privileges or any restriction of such privileges by a physician or dentist.
 - While the physician or dentist is under investigation by the health care entity relating to possible incompetence or improper professional conduct, or
 - In return for not conducting such an investigation or proceeding
- Any of the above actions that are required to be reported to the National Practitioner Data Bank for physicians or dentists, may voluntarily be reported for other practitioners.

4.5-9(b) IOWA BOARD OF MEDICINE (IBM)

Iowa law requires a hospital administrator or the chief of Medical Staff to report hospital disciplinary action to the IBM if the following occurs:

- The hospital takes final disciplinary action based on a physician's professional competence.
- The disciplinary action results in a limitation, suspension, or revocation of the physician's privileges, and
- The hospital Board of Trustees approves the disciplinary action.

The hospital administrator or the chief of Medical Staff must also report a physician who voluntarily relinquishes or limits privileges to avoid formal hospital disciplinary action. A physician's unethical or unprofessional conduct is also reportable if such behavior interferes with, or has the potential to interfere with, patient care or the effective functioning of health care staff.

Iowa law does not establish a minimum period of suspension of a physician's privileges before the suspension is reportable to the IBM. When a hospital board takes final disciplinary action against a physician, or a physician voluntarily relinquishes or restricts privileges to avoid final hospital action, the information must be reported to the Board within 10 days. Individuals participating in the hospital's disciplinary proceedings that resulted in action and the individual who makes the report to the IBM are immune from civil liability with respect to the disciplinary proceedings and reporting.

4.5-10 IMMUNITY

The petitioner extends absolute immunity to the Medical Center, its employees, agents and representatives, members of the Medical Staff and its agents and representatives and to the members of the Board of Trustees for any actions taken under these Bylaws relating to proceedings for any adverse professional review actions or for any other disciplinary action which did not give rise to a fair hearing under Section IV.

4.6 EXCEPTIONS TO HEARING RIGHTS

4.6-1 CLOSED STAFF OR EXCLUSIVE USE DEPARTMENTS AND MEDICAL ADMINISTRATIVE OFFICERS

- (a) Closed Staff or Exclusive Use Departments: The fair hearing rights of Section IV of this chapter do not apply to a

practitioner whose application for Medical Staff membership and privileges was denied on the basis the privileges they seek are granted only pursuant to a closed staff or exclusive use policy. Such practitioners shall have the right, however, to request that the Board of Trustees review the denial, and the Board of Trustees shall have the discretion to determine whether to review the request and, if it decides to review the request, to determine whether the practitioner may personally appear before and/or submit a statement in support of their position to the Board of Trustees.

- (b) Medical Administrative Officer: The fair hearing rights of Section IV of this chapter do not apply to those persons serving the Medical Center in a Medical administrative capacity. Removal from office of such persons shall instead be governed by the terms of their individual contracts and agreements with the Medical Center. However, the fair hearing rights of Section IV shall apply to the extent that Medical Staff membership status or Clinical Privileges, which are independent of the practitioner's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.
- (c) Advanced Practice Providers: The fair hearing rights of Section IV of this chapter do not apply to members of the Advanced Practice Provider staff.

CHAPTER FOUR

RULES AND REGULATIONS, POLICIES AND BYLAWS: REVISION AND APPROVAL MECHANISM

SECTION I

MEDICAL STAFF POLICIES, RULES, AND REGULATIONS

- 1.1 Policies: There are two methods by which Policies may be adopted or amended:

1.1-1 BY THE MEDICAL EXECUTIVE COMMITTEE:

The Medical Staff delegates authority to the Medical Executive Committee to adopt or amend policies of the Medical Staff, provided however, that the Medical Staff also retains independent authority to adopt or amend policies in accordance with paragraph (2), immediately below. Policies may be adopted, amended, or repealed at any regular or special meetings of the Medical Executive Committee, provided that copies of the proposed amendments, additions or repeals are made available to members of the Medical Executive Committee fourteen (14) days before being voted on, and that written comments on the proposed changes are brought to the attention of the Medical Executive Committee before the vote. Policies will be adopted, amended, or repealed by a majority of a quorum at a meeting, or by a majority of the votes cast by ballot, and the adopted, amended, or repealed provision shall be forwarded to the Board of Trustees for approval; or

1.1-2 BY THE MEDICAL STAFF:

Alternatively, the voting members of the Medical Staff may adopt and amend policies as they deem appropriate by a majority of votes cast by the Active Medical Staff Members eligible to vote who are present at any Medical Staff meeting called for such purposes, or by a majority of the ballot votes cast by the Active Medical Staff Members eligible to vote in a mail ballot, and may propose such policies and amendments thereto directly to the Board of Trustees. However, prior to presenting the policy or amendment to the Board of Trustees, the voting members of the Medical Staff must first communicate the proposal to the Medical Executive Committee.

1.2 RULES AND REGULATIONS

There are two methods by which Rules and Regulations may be adopted or amended:

1.2-1 BY THE MEDICAL EXECUTIVE COMMITTEE:

The Medical Staff delegates authority to the Medical Executive Committee to adopt or amend rules and regulations of the Medical Staff, provided however, that the Medical Staff also retains independent authority to adopt or amend rules and regulations in accordance with paragraph (2), immediately below.

(a) Regular adoption or amendment:

When the Medical Executive Committee proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff with enough time to allow the Medical Staff to respond. Upon review and comment by the Medical Staff, rules and regulations may be adopted, amended or repealed at any regular or special meeting of the Medical Executive Committee, or by mail ballot, provided that copies of the proposed amendments, additions, or repeals are made available to members of the Medical Executive Committee fourteen (14) days before being voted on, and that written comments on the proposed changes are brought to the attention of the Medical Executive Committee before the vote. Rules and regulations will be adopted, amended, or repealed by a majority of a quorum of the Medical Executive Committee at a meeting, or by a majority of the votes cast by mail ballot; or

(b) Urgent adoption or amendment:

If there is a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, then the Medical Executive Committee may provisionally adopt and submit to the Board of Trustees, and the Board of Trustees may provisionally approve, an urgent amendment without prior notification to the Medical Staff. In such case, the Medical Staff will be immediately notified by the Medical Executive Committee and will have the opportunity for retrospective review and comment on the provisional amendment. If there is no conflict between the Medical Executive Committee and Medical Staff, the provisional amendment stands. If there is a conflict, the Medical Executive Committee and Medical Staff must follow the applicable conflict resolution process. If necessary, a

revised amendment is then submitted to the Board of Trustees; or

1.2-2 BY THE MEDICAL STAFF:

Alternatively, the voting members of the Medical Staff may adopt such rules and regulations and amendments thereto as they deem appropriate by a majority of votes cast by the Active Medical Staff Members eligible to vote who are present at any Medical Staff meeting called for such purposes, or by a majority of the votes cast by the Active Medical Staff Members eligible to vote in a electronic or mail ballot, and may propose such rules and regulations and amendments thereto directly to the Board of Trustees. However, the voting members of the Medical Staff must first communicate the proposal to the Medical Executive Committee.

1.3 APPROVAL

These policies, rules and regulations become effective upon approval by the Board of Trustees. All Medical Staff Members will be advised in writing of changes to the policies, rules and regulations implemented pursuant to the procedure describe above, and they will be provided with revised texts or copies of revised affected pages, as appropriate. If there is a conflict between the Medical Staff and the Medical Executive Committee in adopting any policy, rule and regulation or amendment thereto, the Medical Executive Committee and Medical Staff must follow the applicable conflict resolution process (Governance Chapter, Section 10.10).

SECTION II
ADOPTION AND AMENDMENT OF MEDICAL STAFF
BYLAWS

2.1 PROCEDURE

2.1-1 PROCESSES

- (a) On the request of the Chief of Staff, the Medical Executive Committee, the Bylaws Committee or on timely written petition signed by at least 10 percent of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws.

- (b) Suggestions to proposals for amendments to these Bylaws may be made by any member of the Active Medical Staff to the Medical Executive Committee for the Committee's review and recommendation to the full Medical Staff. If the Medical Executive Committee fails to make a recommendation to the full Medical Staff within 60 days of receipt of the proposed amendment, the proposed amendment may be presented to the full Medical Staff without a Medical Executive Committee recommendation. Adoption of an amendment to these Bylaws during the biennial review shall require the affirmative vote of a majority of the Active Medical Staff members in good standing present at a regular or special staff meeting at which a quorum is present, provided that a copy of the proposed amendment was made available to each staff member entitled to vote therein at least two weeks in advance of the meeting. The Medical Staff's adopted amendment shall be forwarded to the Board of Trustees for its action. Amendments adopted by the Medical Staff shall become effective following approval by the Board of Trustees.

- (c) Notwithstanding the forgoing, the Medical Executive Committee has the power to adopt such amendments to the Bylaws as are, in the Committee's judgment, technical modifications or clarifications; reorganization or renumbering; or amendments necessary because of spelling, punctuation, or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff, or the Board of Trustees within ninety (90) days of adoption by the Medical Executive Committee. The action to amend, in such circumstances, may be taken by motion acted upon in the same manner

as any other motion before the Medical Executive Committee.

- (d) Amendments to the Medical Staff Bylaws are accomplished through a cooperative process involving both the Medical Staff and the Board of Trustees and are effective upon approval by the Board of Trustees. The Board of Trustees gives full consideration to the recommendations and view of the Medical Staff before taking final action.
- (e) All Medical Staff Members shall be advised in writing of Medical Staff Bylaws changes that are implemented pursuant to the procedure described above, and they will be provided with revised texts or copies of the revised affected pages, as appropriate.

2.2 ACTION ON BYLAWS CHANGES

If a quorum, as defined in the Governance and Structure chapter, is present for the purpose of enacting a Bylaws change proposed during the biennial review, the change shall require an affirmative vote of 2/3 of the active members of the Medical Staff voting in person or 50% plus one by electronic or written ballot.

2.3 APPROVAL

Bylaws changes adopted by the Medical Executive Committee or the Medical Staff shall become effective following approval by the Board of Trustees.

2.4 EXCLUSIVITY

The mechanism described herein shall be the sole method for the initiation, adoption, amendment or repeal of the Medical Staff Bylaws.

ADOPTED by the Medical Staff on June 3, 2025.

Chief of Staff

Secretary

ADOPTED by the Board of Trustees on June 24, 2025.

Chair

Secretary

New: 1994

Revised: 11/96, 2/99, 4/01, 7/03, 5/05, 6/09, 6/11, 6/13, 4/14, 6/15, 6/17, 6/19, 6/21, 6/23, 12/23,
6/25, 9/25