TITLE: **(POL) BYLAWS MANUAL**

AFFECTS: Medical Staff

OBJECTIVE:

Any change to this document needs first to be presented at Medical Staff & Board of Trustees meeting for approval before final approval in Policy Tech. See meeting minutes for documentation.

Preamble

WHEREAS, the Guttenberg Municipal Hospital is a nonprofit, city owned organization, licensed as a Critical Access Hospital (CAH), under the laws of the state of Iowa; and

WHEREAS, its purpose is to serve as a rural Hospital and Provider Based Rural Health Clinics providing patient care services and patient education;

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Board of Trustees, and

WHEREAS, it is the position of the Guttenberg Municipal Hospital that the Medical Staff representation and participation in any Hospital deliberation affecting the discharge of Medical Staff responsibilities will be ensured, and that the cooperative efforts of the Medical Staff, the Chief Executive Officer and the Board of Trustees are necessary to fulfill the Hospital's obligation to its patients;

THEREFORE, recognizing that the best interests of the patients are protected by this concerted effort, the Practitioners and Allied Health Professionals practicing in the Guttenberg Municipal Hospital hereby organize themselves into a Medical Staff in conformity with the Bylaws, rules and regulations hereinafter stated.

DEFINITIONS

1. The term “Medical Staff” refers to Practitioners and Allied Health Professionals granted privileges via the credentialing process to provide patient care at Guttenberg Municipal Hospital.

2. Whenever the term “Board of Trustees”, “Board”, “Governing Board”, or “Board of Directors” appears, it shall be interpreted to refer to the Board of Trustees of the Guttenberg Municipal Hospital.

3. The term “Physician” means an individual with a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) degree who is licensed in the State of Iowa to practice medicine.

4. The term “Dentist” means and individual with a Doctor of Dental Science (DDS) or Doctor of Medical Dentistry (DMD) degree who is licensed in the State of Iowa to practice dentistry or oral surgery.

5. The term “Podiatrist” refers to a Doctor of Podiatry (DPM) with a Doctoral degree who is licensed in the state of Iowa to independently practice podiatry.

6. The term “Psychologist” refers to a Practitioner with a Doctoral degree in Psychology (PhD) who is licensed in the state of Iowa to independently practice Psychology.

7. The term “Allied Health Professional” refers to licensed Advanced Registered Nurse Practitioners (including ARNP, DNP, CRNA) or Physician Assistants who work in the Hospital and/or clinics either independently or under the supervision of his/her Sponsoring Physician, who is a member of the medical staff.

8. Practitioner” refers to Physicians, Dentists, Podiatrists, Psychologists and Allied Health Professionals granted clinical privileges via the Medical Staff credentialing process to provide patient care within the Hospital. Active practitioners have overall responsibility and provide quality oversight for the patient care provided at Guttenberg Municipal Hospital. The management and coordination of each patient’s care, treatment, and services is the responsibility of a practitioner with appropriate privileges.

9. The Medical Staff year commences on the 1st day of January and ends the 31st of December of each year.

10. The term “Chief Executive Officer” and “CEO” means the individual appointed by the Board of Directors to act in its behalf in the overall management of the Hospital.

11. The term “Admitting Privileges” refers to the privilege to admit inpatients. (Refer to (POL) PATIENT ADMISSION, TREATMENT, DISCHARGE AND TRANSFER)

12. “History & Physical” refers to a medical history and physical (H&P) (Refer to (POL) MEDICAL RECORD RESPONSIBILITIES)

13. Non-employee physician sponsored professional staff (formerly included as Allied Health Professionals) are those health care professionals who work on occasion at GMH under supervision of a sponsoring practitioner. These professionals are now processed under Human Resources Department of Guttenberg Municipal Hospital and not through the Medical Staff credentialing system. Patient care services provided by non-employee Health Professionals are limited to the sponsoring practitioner's scope of practice. Levels of supervision include:

   a) Immediate - The Sponsoring Practitioner is physically present to observe the Allied Health Professional.
   b) Direct - The Sponsoring Practitioner is physically present in the Hospital and immediately available to the Allied Health Professional.
   c) General - The Sponsoring Practitioner is able to be physically present in the Hospital within 30 minutes.
   d) Protocol Supervision - The Allied Health Professional carries out medically delegated tasks that are specifically defined in standardized protocols or procedures, and have been approved by the Board of Directors after input from the Medical Staff Committee.
   e) With Consultation - The Allied Health Professional carries out medically delegated Outpatient tasks independently with consultation by the Sponsoring Practitioner as needed

ARTICLE I

NAME

The name of this organization shall be the Guttenberg Municipal Hospital Medical Staff, located in Guttenberg, Iowa.

ARTICLE II

PURPOSE

The purposes of this organization shall be:

1. To provide all patients admitted to or treated by the Hospital with medical care that is consistent with recognized standards.

2. To initiate, review and evaluate each practitioner's and Allied Health Professionals performance in the Hospital through the appropriate delineation of the clinical privileges that each Practitioner and Allied Health Professional may exercise and through ongoing review or evaluation of each practitioner's performance in the Hospital and/or clinic setting.

3. To provide an appropriate educational setting that will maintain medical standards and lead to continuous advancement in professional knowledge and skill for the medical staff and the hospital staff.

4. To initiate and maintain self-governance of the Medical Staff.

5. To provide a means of communication between the Medical Staff, Hospital Administration and the Board of Trustees.

ARTICLE III

MEDICAL STAFF MEMBERSHIP

Section 1 Nature of Membership

Membership on the Medical Staff of the Guttenberg Municipal Hospital is a privilege that will be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Any denial of privileges, revocation and/or suspension of privileges, or any disciplinary actions, will be in accordance with Articles X and XII of these Bylaws.

Section 2 Qualifications for Membership

1. Only Practitioners licensed to practice in the State of Iowa, who can document the following, shall be eligible for membership:
    a. His/Her background, experience, training and demonstrated competence,
    b. His/Her adherence to the ethics of His/Her profession,
    c. His/Her good reputation, and
    d. His/Her ability to work with others.

    Documentation must be provided with sufficient adequacy to assure the Medical Staff and the Board of Trustees that any patient treated by him/her in the Hospital will be given high quality medical care. No Practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that s/he is duly licensed to practice, or that s/he is a member of any professional organization or that s/he had in the past or presently has, such privileges at another Hospital.

2. Each member of the Medical Staff shall assume responsibility for abiding by Medical Staff and organizational policies of hospital and/or clinic. A major responsibility in this context is that of appropriate documentation of his/her patients' illnesses and care utilizing the electronic health record and tools provided. Beyond this requirement, a member of the Medical Staff should take an active role in the development of policies and standards of patient care through the mechanisms of Medical Staff organization. She/He accepts Medical Staff controls as a protection to her/himself as well as others.

3. Practitioners who are obligated by their professional responsibilities to take after hours call for patient care needs shall reside within a reasonable distance that can be traveled within 30 minutes of the Hospital to be eligible for Active Medical Staff membership. Each member of the Medical Staff, not living in the city or immediate vicinity, with admitting privileges for inpatients, shall, by mutual agreement, name a Practitioner with similar type clinical privileges, who is a resident in the area, who may be called to attend his/her patients in the Hospital. No such non-resident Practitioner will be admitted to the Medical Staff without such prior designation. The designated resident must supply written documentation, which will be re-verified at the time of a non-resident Practitioner's reappointment, of his/her agreement to provide this coverage prior to admission of the non-resident Practitioner to the Medical Staff. Staff membership and privileges will be contingent at all times on maintaining this coverage. Each Practitioner must state in writing his/her agreement to provide

adequate coverage in his/her absence throughout the period of appointment. Medical Staff membership and privileges will be contingent upon maintaining this coverage.

4. Acceptance of membership on the Medical Staff shall constitute the staff member's agreement to abide by the principle of Medical Ethics of his or her profession.

5. Medical staff applications and/or appointments will not be denied on the basis of age, race, creed, color, religion, sex, or national origin.

6. All Practitioners are required to maintain individual Malpractice Liability Insurance with a company licensed in Iowa at a minimum of $1,000,000 per occurrence in order to obtain and keep their privileges. A certificate of coverage must be verified prior to reappointment of staff privileges and before all initial staff appointments are made. Failure to maintain $1,000,000 (per claim) of liability insurance will result in immediate loss of Medical Staff eligibility until the appropriate level of insurance is restored (see Article X).

7. Revocation of suspension of the applicant's State of Iowa licensure to practice Medicine, Dentistry or his/her profession shall result in the immediate loss of Medical Staff eligibility until the license is restored in accordance with Article X.

8. Any significant misstatements in or omissions from the Medical Staff application shall constitute cause for summary denial or revocation of Medical Staff membership in Accordance with Article XX.

Section 3 Conditions and Duration of Appointment

1. Initial appointment and reappointment shall be made by the Board of Trustees upon recommendation of the Medical Staff as provided in these Bylaws. If the Medical Staff fails to act on a completed application within 100 days of receipt of such application, the Board of Trustees may act without Medical Staff recommendation upon receiving pertinent information from other reliable sources concerning the applicant's professional and ethical qualifications. Delays beyond 100 days duration may occur at the direction of the Medical Staff if investigation of the applicant's documentation and/or professional status is required.

2. Initial appointment shall be made for a period of 1 year at which time the applicant will be reviewed by active staff. Reappointments shall be for a period of not more than two (2) years.

3. Every two years, the Medical Staff will re-evaluate and appraise the performance and delineate clinical privileges of each practitioner. The process for the re-evaluation and appraisals of the Medical Staff will come due on the month of the practitioner's birth month.

4. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board of Trustees in accordance with these Medical Staff Bylaws.

5. Every application for Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligation to provide continuous care and supervision of his/her patients, to assure coverage of his/her patients by a practitioner in his/her absence, to participate, by separate agreement, in staffing the emergency service area and to have a residence close enough to provide emergency care response in person

within 30 minutes, to abide by the Medical Staff By-Laws, to accept committee assignments, to accept consultation assignments.

6. The application form shall also include a statement that the applicant has received and read the Medical Staff Bylaws and that they agree to be bound by the terms thereof if granted membership and clinical privileges.

Section 4 Medico-Administrative Staff and/or Contracted Practitioners and Allied Health Professionals

Full time salaried and contracted Practitioners should qualify for and maintain Medical Staff membership and privileges in the same manner prescribed for voluntary Practitioners and Allied Health Professionals. If applicable, membership on the Medical Staff may be made contingent on continuing in a medico-administrative position. Any Practitioner whose engagement by the Hospital requires membership on the Medical Staff as described above shall not have his/her privileges terminated without the same due process provisions as must be provided for any other member of the medical Staff, unless otherwise stated by contract.

Section 5 Leave of Absence

A Practitioner or Allied Health professional who elects to temporarily leave his/her practice for a period of time greater than 120 days, MUST request a voluntary leave of absence from the Medical Staff by submitting a written request to the Chief of Staff stating the reason and period of time for the leave, which may not exceed one (1) year, or the remainder of his/her current Medical Staff appointment. Refer to Article XX – Appointment & Reappointment, Leave of Absence in the Credentials Manual for an outline of the complete process for requesting a leave of absence and subsequent reinstatement.

Section 6 Network Hospital / Credentialing Process

1. As a Critical Access Hospital, the Guttenberg Municipal Hospital works in conjunction with its Network Hospital and Health System to assist in the credentialing process.
   a. Application Request for membership to the GMH Medical Staff shall be presented in writing to The Finley Hospital that serves as the Network Hospital to GMH.
   b. An application packet will be issued by The Finley Hospital. The applicant will document all requested information as to qualifications & references and will signify agreement to abide by the Bylaws of the GMH Medical Staff. The applicant will also complete a GMH privilege request form.
   c. The application will be processed by The Finley Hospital Medical Staff Services Office (MSSO) and the Health System Credentialing Coordinator including:
      a. Primary Source verification,
      b. Multiple Physician Data Bank inquiries,
      c. Reference checks
   d. The Health System's Coordinator forwards the completed application packet to The Finley Hospital's Medical Staff Credentials Committee for initial review.
   e. The Finley Hospital's Credentials Committee will sign off on the application indicating review and recommendations/concerns to be forwarded to Guttenberg Municipal Hospital Medical Staff Committee.

2. When the above process is completed at the first regular meeting thereafter the application shall be presented to the Medical Staff Committee of the Guttenberg Municipal Hospital at which

time it shall either be recommended for rejection or acceptance. This recommendation of the Medical Staff Committee shall be transmitted to the Board of Trustees of Guttenberg Municipal Hospital. The recommendation of the Medical Staff, if the application is to be accepted, shall include the privileges to be granted. Final approval/disapproval for recommendation to the Board of Trustees lies with the Medical Staff Committee of Guttenberg Municipal Hospital.

3. The Board of Trustees shall either accept the recommendation of the Medical Staff Committee or shall refer it back to the Medical Staff Committee for further consideration. In the latter case, the Board of Trustees shall instruct its secretary to state to the Medical Staff Committee the reasons for such action.

4. When final action is taken by the Board of Trustees, the Chief Executive Officer of the Hospital shall be authorized to transmit this decision to the candidate for membership.

ARTICLE IV

CATEGORIES OF THE MEDICAL STAFF

Section 1 The Medical Staff

The Medical Staff shall be divided into Honorary, Provisional, Active, Courtesy and Allied Health Professional categories (Refer to the Credentials Manual, Article XXII, for further details regarding Allied Health Professionals categories).

Section 2 Honorary Medical Staff

The honorary Medical Staff shall consist of Practitioners who are not active in the Hospital or who have been granted honored emeritus status as recommended by the Medical staff and approved by the Hospital Board of Trustees. These practitioners may be retired from active hospital practice or who are of an outstanding reputation, not necessarily residing in the community. Honorary Staff members shall not be eligible to admit patients, to vote, hold office or to serve on standing Medical Staff committees.

Section 3 Provisional Status

1. The Provisional medical staff shall consist of Practitioners who, at the time of initial appointment, are being considered for advancement to his/her appropriate Medical Staff status. It is necessary to serve up to one (1) year on the Provisional medical staff prior to advancement to allow sufficient time for evaluation of the applicant. The provisional period may be extended for maximum of three (3) months at the discretion of the Medical Staff Committee. This extension is for first time applicants only.

2. He/she shall be appointed to the a specific department where their clinical competence and their ethical and moral conduct shall be observed by designated members of the Active Staff of the respective department until the probationary requirement has be fulfilled.

3. During the Provisional period, Practitioners who request Active status are required to attend Medical Staff Meetings. He/she is eligible to serve on Department or Hospital Committees, but is ineligible to vote or hold office during the Provisional period. He/she is eligible to serve as a Clinical Physician Advisor and enjoy all privileges requested according to the scope and level of supervision requested and approved.

4. The Provisional Medical Staff members shall advance to their appropriate Staff Status upon recommendation from the Medical Staff Committee who, in turn, will forward their recommendation to the Board of Trustees. The decision of the Board of Trustees will be forwarded to the practitioner in writing from the Hospital Chief Executive Officer, or his designee.

Section 4 Active Medical Staff

The Active Medical Staff shall consist of Practitioners (Physicians and Allied Health Professionals) who regularly attend patients in the Hospital or provide clinical services to inpatients and/or outpatients. Active Physicians and Allied Health Professionals assuming call responsibilities must reside close enough to the Hospital to provide continuous care to his/her patients, and assume all functions and responsibilities of membership on the Active Medical Staff including, where appropriate, emergency service for assigned and unassigned patients. Members of the Active Medical Staff shall be appointed to a specific Department, shall be eligible to vote, and serve on Medical Staff Committees, and shall be required to attend 50% of all Medical Staff meetings. Active Medical Staff members are responsible to take a lead role in hospital performance improvement activities to improve the quality of care, treatment, service and patient safety.

Section 5 Courtesy Staff

The Courtesy medical staff shall consist of Practitioners qualified for staff membership but who only occasionally provide patient care to Hospital inpatients and/or Hospital/Clinic outpatients or who act as consultants and do not admit patients. Courtesy staff members may submit reports to incorporate into the hospital records. Courtesy staff shall be appointed to a specific service but shall not be able to vote or hold office in this Medical Staff organization. The Medical Staff Committee may appoint courtesy members to serve on Medical Staff committees.

SECTION 6 Allied Health Professional Staff

Active and Courtesy Allied Health Professional Staff may:

1. Carry out appropriate medical tasks common to his/her specialty practice area after demonstration of proficiency and competence via the Medical Staff credentialing process. The sponsoring practitioner must agree to the level of supervision required for the privileges requested and ultimately granted to the Allied Health Professional.

2. Write orders and document in the medical record, but not beyond the scope of his/her license, certificate or other credentials. Supervising physician co-signatures will be required for all notes provided in the electronic medical record by Allied Health Professional staff. This standard is applicable to both the inpatient and ambulatory care setting.

3. Serve on Medical Staff committees.

4. Exercise such other prerogatives as shall be accorded to Allied Health Professionals, by resolution or written policy, duly adopted by the Medical Staff and approved by the Board of Trustees.

SECTION 7 Temporary Staff Status to Support Disaster Operations

In the case of disaster operations and/or disaster recovery, GMH Emergency Preparedness planning supports the use of volunteer temporary Medical Staff Practitioners, who are eligible to function as licensed independent practitioners assigned under the supervision of active medical staff members. In addition, the plan supports the use of temporary volunteer Allied Health Professionals who will also be assigned to supervising active medical staff members. The following roles and responsibilities support the Granting of Temporary Privileges during a disaster event. (Refer also to Emergency Preparedness Manual Policy / Procedure, Granting Temporary clinical and Staff Privileges in a Disaster Event).

Physician On Call:

- May grant temporary privileges to volunteer Physicians and Allied Health Professionals by signing the *Emergency Credentialing Application* as the Hospital Representative.
- Oversees the professional practice of the volunteer Physicians and Allied Health Professionals.

Hospital Administrator/Human Resource Manager:

- May grant temporary privileges to volunteer Physicians and Allied Health Professionals by signing the *Emergency Credentialing Application* as the Hospital Representative.

Incident Commander/Physician On Call:

- Assign and coordinate eligible Physicians and Allied Health Professionals to appropriate assignments.

ARTICLE V

OFFICERS

Section 1 Officers of the Medical Staff

Physicians will serve as Officers of the Medical Staff. Officers of the Medical Staff shall provide effective governance of its affairs so as to ensure proper acceptance and discharge of the overall responsibility for the quality of medical care delegated to the Medical Staff by the Board of Trustees.

The officers of the Medical Staff include:

1. President
2. Vice President
3. Secretary

Section 2 Qualifications of Officers

Officers must be physician members of the Active Medical Staff at the time of nomination and election and must remain a member in good standing during his/her term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Officers should be chosen on the basis of ability and willingness to devote the necessary time to the office. The President of the Medical Staff must be a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO). Physicians holding "Provisional" status are not eligible to serve as a Medical Staff Officer.

Section 3 Election of Officers

Officers shall be elected by voice vote at the December meeting of the Medical Staff Committee.

Section 4 Term of Office

All officers shall serve a one (1) year term from their election date or until a successor is elected. Officers shall take office on January 1, the first day of the Medical Staff year.

Section 5 Vacancies in Office

The Medical Staff Committee shall fill vacancies in office during the Medical Staff year, except for the Presidency. If there is a vacancy in the office of President, the Vice President shall serve out the remaining term.

Section 6 Duties of Officers

1. President

   The President shall act in coordination and cooperation with the chief executive officer in all matters of mutual concern within the Hospital; he/she shall:

- Call, preside at, or be responsible for the agenda of all general meetings of the Medical Staff Committee;
- Be responsible for the enforcement of Medical Staff Bylaws for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner.
- Appoint committee members to all standing, special, and multi-disciplinary Medical Staff committees;
- Represent the views, policies, needs and grievances of the Medical Staff to the Board of Trustees and to the chief executive officer;
- Receive, and interpret the policies of the Board of Trustees to the Medical Staff and report to the Board of Trustees on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
- Be responsible for the educational activities of the Medical Staff;
- Be the spokesman for the Medical Staff in its external professional and public relations; and
- Attend monthly meetings of the Board of Trustees as a non-voting Medical Staff representative.

2. Vice President / President Elect

   In the absence of the president, the President-Elect shall assume all duties and have the authority of the president; he/she shall automatically succeed the president if the latter fails to serve for any reason.

3. Secretary

   The Secretary shall be a member of the Medical Staff Committee; and shall perform duties as assigned by the President of the Medical Staff. The Secretary will insure that minutes are kept of all Medical Staff Committee meetings.

Section 7 Removal of an Officer from His/Her Position

Removal of an Officer during his/her term of office may be initiated by a two-thirds (2/3) majority vote of all Active Medical Staff members, but no such removal shall be effective unless and until it has been ratified by the Board of Trustees.

Grounds for removal of a Medical Staff Officer include, but are not limited to:

* Failure to perform the duties of the position held in a timely and appropriate manner
* Failure to continuously satisfy the qualifications for the position.
* Having an automatic or summary suspension imposed by Article X of these Medical Staff Bylaws or a corrective action matter pursuant to Article XII of these Medical Staff Bylaws resulting in a final decision other than to take no action.
* Physical or mental infirmity that renders the Medical Staff Officer incapable of fulfilling the duties of his/her office.

ARTICLE VI

CLINICAL SERVICES

Organization of the Clinical Services

The medical staff provides services in the areas of: Anesthesiology, Emergency Medicine, Medicine (includes Psychiatry), Family Practice, Obstetrics and Gynecology, Surgery, Oral Surgery and Dentistry, Pediatrics and Newborn, Radiology and Pathology.

The Medical Staff Committee shall have overall responsibility for overseeing the Clinical Services.

ARTICLE VII

CLINICAL PHYSICIAN ADVISORS

Section 1 Organization of Clinical Physician Advisors

1. The members of the Medical Staff Committee shall serve as clinical physician advisors for the following departments. Assignments shall be reviewed and approved annually at the beginning of each New Year.
    a. Emergency Room / Ambulance
    b. Laboratory
    c. Medical (includes Cardiac & Pulmonary Rehab)
    d. Obstetrics-Nursery-Pediatrics
    e. Pharmacy
    f. Rehab Services – Physical, Occupational, and Speech Therapy
    g. Health Information & Utilization Review
    h. Radiology
    i. Respiratory Therapy
    j. Trauma
    k. Surgery / Anesthesia
    l. Medical Nutrition Therapy, Swing Bed Program / Dental for Swing Population
    m. Infection Control / Employee Health

Section 2 Duties of Clinical Physician Advisors

1. Clinical Physician Advisors will:
    a. Voluntarily serve
    b. Serve in a clinical advisory role to hospital staff
    c. Take a lead role in hospital performance improvement to improve quality of care, service, treatment and patient safety.

ARTICLE VIII

COMMITTEES

Section 1 Committees

Unless otherwise designated by these By-Laws, the Medical Staff President shall appoint the medical staff members to committees. All committees shall make written reports. Special and "ad hoc" committees shall be appointed from time to time to carry out the duties of the Medical Staff, as may be necessary, upon completion of the assignment the committee shall be dissolved and will at periodic intervals, present reports at the monthly Medical Staff Meeting.

Section 2 Medical Staff Committee

Duties of the Medical Staff Committee shall be:

1. To consider carefully and act on all matters which are of a clinical nature and it is to be expected that such business of the Medical Staff shall be transacted in large parts by the Medical Staff Committee in order that the time of the regular meetings of the Medical Staff may be devoted to matters pertaining to the professional care of patients;

2. To coordinate the activities and general policies of the various departments.

3. To represent and to act on behalf of the Medical Staff subject to such limitation as may be imposed by these By-Laws;

4. To receive and act on the Tissue and Transfusion reports;

5. To receive and act on the Infection Control Committee report;

6. To receive and act on the Pharmacy and therapeutics report;
    a. to establish a formulary system to ensure quality pharmaceuticals and reasonable cost
    b. to evaluate the clinical data concerning new drugs or preparations
        i. requested for the hospital use;
    c. to recommend drugs to be stocked on various hospital units; and
    d. to prevent unnecessary duplication in stocking basic drugs.

7. To review all death records that occur within the hospital

8. To provide input and feedback to support decision making related to equipment purchase and contracted clinical services.

9. To consider and act upon all medical administrative matters and policies, as may be presented; to provide leadership and liaison between the Medical Staff, Chief Executive Officer, and Board of Trustees.

10. To perform the specific and general duties as set forth in these By-Laws.

11. To review the credentials of all applicants and to make recommendations to the Board for Trustees membership and delineation of clinical privileges;

12. To review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations regarding reappointments and renewal or changes in clinical privileges; and

13. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of the members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.

Section 3 Medical Records Committee

The Medical Records Committee shall consist of Health Information Manager, at least one (1) Medical Staff Committee member, PCU Clinical Coordinator, Administrative Director and other departments, as required. The committee shall meet once a month and report monthly at the Medical Staff Committee meeting.

1. The Committee will evaluate quality and appropriateness of medical care and proper documentation of the medical chart.
    a. Communicate and suggest improvement for documentation.
    b. Review chart audit results and make recommendations.
2. Ensure the hospital-approved abbreviations are reviewed and updated annually.
3. Approve and manage the content of the medical record forms.

ARTICLE IX

MEETINGS

Section 1 Annual Meeting

The annual meeting of the Medical Staff Committee shall be the last meeting before the end of the calendar year. At this meeting, the retiring officers and the committees shall make such reports as may be desirable and officers for the ensuing year shall be elected.

Section 2 Regular Meetings

Regular meetings of the Medical Staff Committee shall be held monthly with a minimum of 10 meetings per year. The Hospital Chief Executive Officer will be expected to attend all meetings as an ex-officio member, without vote.

Section 3 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Medical Staff President and shall be called at the request of the Board of Trustees or any three members of the Medical Staff Committee. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Notice of such meeting shall be given at least one day before the time set for the meeting.

Section 4 Attendance

1. All active and/or provisional members of the Medical Staff Committee are requested to attend all meetings. Absence from fifty percent (50%) of the Medical Staff meetings for the year, without acceptable excuses, shall be considered at the time of reappointment and may be grounds to deny the absentee the privilege of working in the hospital. Any member of the Active Medical Staff compelled to be absent from a meeting should submit to the President of the Medical Staff the reason for such absence. An excused absence may be granted by the President of the Medical Staff for practitioners who are unable to attend meetings due to vacation, being out of town, illness or an emergency. Alternative methods for attendance including telephone and internet attendance will be acceptable forms of attendance.

2. Honorary and Courtesy members of the Medical Staff shall not be required to attend meetings.

3. A member of the Medical Staff who has attended a case that is to be presented for discussion at any meeting shall be notified and shall be expected to be present.

4. Failure by a Practitioner to attend any meeting with respect to which he/she was given notice that attendance was mandatory, unless excused by the Medical Staff Committee upon a showing of good cause, shall be grounds for automatic suspension of all or such portion of the Practitioner's clinical privileges in accordance with Article X, as the Medical Staff Committee may direct. Such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary. In all other cases, if the Practitioner shall make a timely request for postponement supported by adequate showing that his/her absence will be unavoidable, such presentation may be postponed by the Medical Staff Committee until no later than the next regular meeting, otherwise the pertinent clinical information shall be presented and discussed as scheduled.

Section 5 Reserve Powers for Physicians Holding Active Medical Staff Status

Physicians (MD/DO) who maintain Active Staff status are granted Reserve Powers for voting on a select group Medical Staff agenda items. "Reserve Power" refers to items that can be voted upon exclusively by physicians who serve as Active Medical Staff when a quorum is present. A simple majority vote is required for items identified as "Reserved Power" agenda items.

Reserve Power is granted for the following Medical Staff Action Items:

A. Medical Staff Bylaws – approval, change, adoption of the following Medical Staff Bylaws Sections:

- i. Bylaws Manual
- ii. Credentialing and Privileging Manual
- iii. Judicial Review Manual

B. Credentialing of Medical Staff - All decisions made related to membership on the Medical Staff and granting of medical staff privileges. Application and re-credentialing packets may be reviewed by any practitioner of like specialty or license and input/comments from the entire medical staff will be considered prior to final action by physician staff.

C. Matters related to Judicial Action of Medical Staff Members

D. Elect, re-elect, appoint, reappoint and remove any Officer of the Medical Staff

Section 6 Quorum

At least three physician providers must be present at any Medical Staff meeting in order to constitute a quorum. Allied Health Professional attendance does not affect the definition of "quorum". In the absence of a quorum, Active Physician staff may elect to vote by providing written authorization with signature that defines in writing their favor or disfavor of action items identified on the agenda. The written record of each Medical Staff Committee member's "vote" will be attached to the original minutes and maintained according to the Hospital's Record Retention Policy. The minutes of the meeting will reflect the use of written vote procedure in absence of a quorum in attendance at the meeting.

SECTION 7 Voting

When a quorum is present, all active medical staff members, both Physicians and Allied Health Professionals, are granted voting privileges for all agenda items with the exception of the Reserve Powers identified in Section 5 "Reserve Powers for Physicians Holding Active Medical Staff Status". Physicians holding active medical staff privileges will vote on the agenda items listed in the Reserve Power section.

SECTION 7 Minutes

Minutes of all meeting shall be prepared and shall include a record of those attending, the vote taken on each matter and follow-up action required. The minutes shall be approved and signed by the Presiding Officer, and presented for review and approval by the voting members at the next meeting. After such approval, a permanent file of all minutes shall be maintained.

SECTION 8 Conduct of Business

The rules contained in Robert's Rules of Order shall govern all meeting in all cases in which they are applicable and consistent with the Guttenberg Municipal Hospital Medical Staff Bylaws.

ARTICLE X

CORRECTIVE ACTION, SUMMARY SUSPENSION AND AUTOMATIC SUSPENSION

Section 1 Procedure

1. Whenever the activities, clinical judgment or professional conduct of any Practitioner with clinical privileges is considered to be lower than the standards of patient care or aims of the Medical Staff or thought to be disruptive of the operation of the Hospital, corrective action/investigation against such Practitioner may be requested:

   a. By any member of the medical staff;
   b. By the chairperson of any standing committee of the medical staff;
   c. By the President of the Medical Staff ;
   d. By any member of the Board of Trustees; or,
   e. By the Hospital CEO or his/her designee.

   All requests for corrective action/investigation shall be in writing, shall be made to the Medical Staff President or Vice President and shall be supported by reference to the specific activities or conduct, which constitutes the grounds for request.

   This is a confidential professional peer review and quality assessment and improvement process. Unauthorized disclosure is prohibited. It is protected from disclosure pursuant to the provision of Iowa Statutes ICA 22.7; 135.40-135.42, 147.135.

2. Whenever the corrective action could be a reduction or suspension of clinical privileges, the President of the Medical Staff shall immediately appoint an ad hoc committee to investigate the matter, consisting of the President and Vice President of the Medical Staff, a surgeon and two members of the Courtesy Medical Staff, one of which shall be selected to serve as the Chairperson of the ad hoc committee. When possible, this ad hoc committee should consist of members of the Medical Staff Committee with the greatest regards for a broad spectrum of individuals who are not directly or indirectly connected with the guiding correspondent or the defendant.

   Ad Hoc Committee members shall be objective, and consider and make recommendations with good faith objectivity

   The Hospital may be represented by a member of Administration appointed by the Hospital CEO , or his/her designee in consultation with the Medical Staff President.

   The Ad Hoc Committee will work with the affected Practitioner and the person requesting corrective action to informally resolve the problems that have led to the request for corrective action. The Affected Practitioner against whom investigation or corrective action has been requested shall have an opportunity for an interview with the Ad Hoc Investigation Committee. At such interview, he/she shall be informed of the general nature of the charges against him/her, 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 Medical Staff Bylaws with respect to a hearing shall apply thereto. A record of such interview shall be made and included with its report to the Medical Staff Committee, along with the appropriate recommendations.

With mutual consent of the Affected Practitioner and the Committee, a tape recording of the proceedings of this meeting may be made.

3. Within thirty (30) days after the ad hoc committee's receipt of the request for investigation or corrective action, the ad hoc committee shall make a report to the Medical Staff Committee. The thirty (30) day restriction stated at the beginning of this subparagraph "C" may be extended if circumstances are such that scheduling the meeting is not possible because the appropriate staff members are unavailable to meet within the required time.

4. If corrective action is requested, the Medical Staff's Committee action may be to reject or modify the request, to issue a warning, a letter of admonition (mild censure) or a letter of reprimand (severe censure); to impose terms of probation or a requirement for consultation; to recommend reduction, suspension or revocation of clinical privileges; to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained; or to recommend that the Affected Practitioner's staff membership be suspended or revoked.

5. Any recommendation by the Medical Staff Committee for reduction, suspension or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff, shall entitle the Affected Practitioner to the procedural rights provided in the Judicial Review Process outlined in these Bylaws.

6. The procedure for reapplication after an adverse final recommendation by the Board of Trustees shall be followed as provided in Article XX.

7. Corrective actions will be reported according to State of Iowa law and National Practitioner Data Bank (NPDB) reporting guidelines.

Section 2 Summary Suspension

1. Any one of the following:
   a. The President of the Medical Staff;
   b. The Hospital Chief Executive Officer;
   c. The Board of Trustees,

   shall have the authority, whenever action must be taken immediately in the best interest of patient care in the hospital, to summarily suspend all or any portion of the clinical privileges of a Practitioner and such summary suspension shall become effective immediately upon imposition. The President of the Medical Staff shall make the necessary arrangements to provide for proper and necessary patient care during the period of suspension. The suspended Practitioner is expected to confer with the Practitioner who has been designated to replace him/her to the extent necessary to safeguard the patient.

2. A Practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the Medical Staff Committee hold a hearing on the matter within such reasonable time period thereafter as the Medical Staff Committee may be convened in accordance with the Hearing and Appeal Procedure of these Bylaws.

3. The Medical Staff Committee may recommend modification, continuance or termination of the terms of the summary suspension. If the Medical Staff Committee does not recommend immediate termination of the summary suspension, the Affected Practitioner shall be entitled to request an appellate review by the Board of Trustees, but the terms of the summary suspension as sustained or as modified by the Medical Staff Committee shall remain in effect pending a final decision by the Board of Trustees.

Section 3 Automatic Suspension/Revocation

1. A temporary suspension in the form of withdrawal of a practitioner's admitting and surgical scheduling privileges, effective until medical records are completed, shall be imposed for excessive medical record delinquencies per Medical Staff Policy Procedure: Medical Record Completion.

2. Action by the Iowa State Board of Examiners dealing with the respective profession/division revoking or suspending a Practitioner's license, shall automatically suspend all of his/her hospital privileges. Action by the same Boards of Examiners placing a Practitioner on probation, may, depending on the grounds for probation, be cause for suspension of privileges.

3. Practitioners who do not maintain the levels of malpractice liability insurance ($1,000,000) as outlined will be automatically suspended from all hospital privileges.

4. Failure of a Practitioner to attend any meeting with respect to which he/she was given notice that attendance was mandatory, unless excused by the Medical Staff Committee upon a showing of good cause, shall be grounds for automatic suspension of all or such portion of the Practitioner"s clinical privileges as the Medical Staff Committee may direct, and such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary. In all other cases, if the Practitioner shall make a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, such presentation may be postponed by the medical Staff Committee, until no later than the next regular meeting, otherwise the pertinent clinical information shall be presented and discussed as scheduled.

5. Upon conviction of a felony of a staff member in any court of the United States, either federal or state, the member's staff appointment is automatically revoked. Revocation pursuant to this section of the Bylaws does not preclude the staff member from subsequently applying for staff appointment.

6. Failure of a Practitioner to comply with the request by the President of the Medical Staff or Hospital Chief Executive Officer to subject himself/herself to drug testing as outlined below shall be grounds for automatic suspension.

7. It shall be the duty of the President of the Medical Staff to cooperate with the Hospital Chief Executive Officer in enforcing all automatic suspensions.

Section 4 Prohibition Against The Use Of Alcohol/Controlled Substance While On Duty.

The President of the Medical Staff or the Hospital Chief Executive Officer may require that a Practitioner be subjected to drug testing when the following conditions are met:

1. When there is probable cause to believe that a Practitioner's faculties are impaired, and

2. When the Practitioner is in a position where such impairment presents a danger to the hospital patients, hospital employees or property of the hospital.

The test sample withdrawn from the Practitioner shall be analyzed by a laboratory or testing facility that has been approved under rules adopted by the Department of Public Health. If a test is conducted and the results indicate that the Practitioner is under the influence of alcohol or a controlled substance or indicate the presence of alcohol at a level that has potential for impairment, a second test using an alternative method of analysis shall be conducted. When possible and practical, the second test shall use a portion of the same test sample withdrawn from the Practitioner for use in the first test. If the results of the drug test indicate that the Practitioner is under the influence of alcohol or a controlled substance or indicate the presence of alcohol at a level that has potential for impairment, the Practitioner's clinical privileges will be summarily suspended as previously outlined, and the Practitioner will be afforded the right to a hearing. Failure of the Practitioner to comply with the above request will result in automatic suspension of privileges as previously. As used in this Section, "Drug Test" means any blood, urine, saliva or chemical test conducted for the purpose of detecting the presence of a controlled substance in an individual. Failure of a Practitioner to comply with the request by the President of the Medical Staff or the Hospital Chief Executive Officer to subject himself/herself to drug testing shall be subject to automatic suspension of staff membership, privileges and prerogatives. The Policy and Procedure - Impaired Practitioner will be utilized for initial and continuing follow-up.

ARTICLE XI

IMMUNITY FROM LIABILITY

Since the Board of Trustees has the overall responsibility for the conduct of the hospital in a manner consonant with the hospital's objective of making available high quality patient care, and since the organized medical staff has the overall responsibility for the quality of all medical care provided to patients and for the ethical conduct and professional practices of its members, as well as for accounting therefore to the Board of Trustees, it is of the greatest importance that the most careful consideration be given to appointments and reappointments to the Medical Staff and to the granting of clinical privileges. In these matters, complete candor is required. Also, every hospital, through its medical staff and management, owes a duty to other hospitals and health care institutions to respond candidly to requests for references and evaluations of Practitioners, Allied Health Professionals, and of other health care personnel practicing, employed, or trained at the hospital. However, it is often the case that those charged with performing or contributing to such evaluation and education activities fear that true vigilance may expose them to monetary liability. This fear has adverse consequences upon the entire evaluation and education process. Actually, where they are acting in good faith, without malice and have made reasonable efforts to ascertain the truthfulness of the information being disclosed or relied upon, the law should, but in some jurisdiction may not, afford protection from civil liability. It is, therefore, important to assure protection to the fullest extent permitted by law and by clear, unequivocal Medical Staff Bylaws provisions.

The following shall apply as express conditions to any Practitioner's application for, or exercise of, clinical privileges at this hospital.

First, that any act, communication, report, recommendation or disclosure, with respect to any such Practitioner, performed or made in good faith and without malice, and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

Second, that such privilege shall extend to members of the hospital's medical staff and to its Board of Trustees, its Hospital CEO and his/her representatives and to third parties, who supply information to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this Article, the term "third parties" means both individuals and organizations from whom information has been requested by authorized representative of the Board of Trustees or the medical staff.

Third, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation or disclosure, even where the information involved would otherwise be deemed privileged.

Fourth, that such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to: (1) applications for appointment or clinical privileges; (2) periodic reappraisals for reappointment or clinical privileges; (3) corrective action, including summary suspension; (4) judicial review; (5) medical care evaluations; (6) utilization reviews; (7) other hospital departmental service or committee activities related to quality patient care and inter-professional conduct.

Fifth, that the acts, communications, reports, recommendations and disclosures referred to in this Article may relate to a Practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly have an effect on patient care.

Sixth, that in furtherance of the foregoing, each practitioner shall, upon request of the hospital, execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations specified in paragraph "Second", subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.

Seventh that the consents, authorizations, releases, rights, privileges and immunities provided by these Bylaws for the protection of this hospital's Practitioners and other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XI.

ARTICLE XII

JUDICIAL REVIEW PROCEDURE MANUAL

The Judicial Review Procedure Manual is by reference incorporated here in as part of these Bylaws. This manual may be amended from time to time as provided in Article XVI of these Bylaws. Revised texts of amendments and revisions to the Judicial Review Procedures are provided to the Medical Staff members.

ARTICLE XIII

POLICIES AND PROCEDURES

The Medical Staff shall adopt such policies and procedures as may be necessary for the proper conduct of its work subject to approval of the Hospital Board of Trustees. A Policies and Procedure Manual is by reference incorporated herein as part of these Bylaws. The Policies and Procedures Manual may be amended by an affirmative vote of a majority of the voting members of the Medical Staff Committee present at a meeting in which a quorum is present. Such amendments and/or revisions shall become effective when approved by the Board of Trustees of the Hospital. Revised texts of amendments/revisions to the Policies and Procedures are provided to the Medical Staff members who have delineated clinical privileges.

ARTICLE XIV

AMENDMENTS

These Medical Staff Bylaws shall be reviewed at least every three (3) years and amended as needed. These Medical Staff Bylaws may be amended, in whole or part, by an affirmative two-thirds (2/3) of the Medical Staff present at a regular meeting called for said purpose in which a quorum is present, or by, permitting as an alternative, a mailing to the Medical Staff inviting comments on proposed Medical Staff Bylaws changes, followed by review of these comments by the Medical Staff Committee, followed by a binding ballot. If there is opposition to an amendment, the opposition will be circulated via an additional mailing sponsored by the Hospital to the Medical Staff. A period of thirty (30) days will be allowed for review of these comments prior to the binding ballot. A return of a two-thirds (2/3) affirmative vote by a quorum of the Active Medical Staff would be required for adoption of each amendment to the Medical Staff Bylaws. Any amendments approved by the Medical Staff in accordance with these Medical Staff Bylaws shall not become effective until approved by the Board of Trustees of the Hospital. Revised texts of amendments/revisions to the Medical Staff Bylaws are provided to Medical Staff members and other individuals who have delineated clinical privileges.

ARTICLE XV

ADOPTION

These Medical Staff Bylaws, shall be adopted at any regular meeting of the Active Medical Staff, shall replace any previous Medical Staff Bylaws and shall become effective when approved by the Board of Trustees. They shall, when adopted and approved, be equally binding on the Board of Trustees and the Medical Staff.

TITLE: **(POL) CREDENTIALING AND PRIVILEDGING MANUAL**

AFFECTS: Medical Staff

OBJECTIVE:

Any change to this document needs first to be presented at Medical Staff meeting for approval before final approval in Policy Tech. See meeting minutes for documentation.

CREDENTIALING AND PRIVILEGING MANUAL

ARTICLE XIX

PURPOSE

The Credentialing and Privileging Manual outlines the process and procedures in handling the Guttenberg Municipal Hospital credentialing program. It is the intent of the Guttenberg Municipal Hospital to comply with state and federal regulations, including the Healthcare Quality Improvement Act of 1986, as well as standards established by The Joint Commission (TJC), the Accreditation body for healthcare organizations.

ARTICLE XX

APPOINTMENT AND REAPPOINTMENT

Section I Initial Application

1. An individual making initial application for Medical Staff membership shall submit a written application on a prescribed form to the Guttenberg Municipal Hospital. By virtue of submitting an application, the applicant:

    a. Accepts the obligation of providing all information requested in support of the applicant's application;

    b. Authorizes the Guttenberg Municipal Hospital to consult with appointees of medical staff, hospital administration and other professional contacts with whom the applicant has been previously associated;

    c. Consents to the hospital's inspection of all records and documents such as medical school diplomas, state licenses, specialty board certificates and certificates of membership in professional societies and organizations; and

    d. Signifies their willingness to appear for interviews in regard to their application.

2. The application shall include, at a minimum, the following information:

a. A complete history of the applicant's professional education and training and valid picture identification. Residency completion in practicing specialty is required before start date;

b. A complete history of the applicant's professional experience; work history gaps greater than six months require explanation;

c. Other professional qualifications including specialty board membership or active candidate status;

d. Documented evidence of current Iowa license, and federal DEA and state CSA (controlled substances certification);

e. The names of at least two practitioners who are currently knowledgeable about the applicants professional competence and ethical character;

f. If applicable, a letter of reference containing information regarding the number and type of cases performed from the chief of the clinical service or department of a hospital where the practitioner has or has had clinical privileges;

g. Any instance in which the applicant has been subjected to legal action based upon an allegation of medical malpractice including a summary of the allegation, the names of the person or persons making such allegation, the State and County in which the alleged incident took place, the date of the incident and the disposition of the allegation against the practitioner;

h. The license number of each state or provincial license ever held, and any instance of suspension, challenge or voluntary/involuntary relinquishment of a state or provincial license or registration in any jurisdiction;

i. Whether the applicant has ever been refused the granting or renewal of staff privileges or suffered a revocation, suspension, or reduction of staff privileges at any other institution, either voluntary or involuntary;

j. A specific request for particular staff assignments and delineated clinical privileges;

k. Whether the applicant has ever voluntarily or involuntarily terminated medical staff membership at any other institution;

l. Certification that the amount of professional liability insurance maintained in force by the applicant is equal to or greater than the minimal amount required by Guttenberg Municipal Hospital as required by Article III, Section 2 (5) of these Bylaws;

m. Information relating to the applicant's ability to perform the essential functions of the clinical privileges requested;

n. Any history of drug or alcohol abuse;

o. Agreement to provide for the continuous care of the applicants patients while they are undergoing treatment at Guttenberg Municipal Hospital including documentation of appropriate backup coverage for Courtesy Medical Staff applicants who are requesting admitting privileges and do not live within a reasonable distance of the hospital (30 minutes);

p. Acknowledgment of the immunity from liability provision of Article XI of these Bylaws;

q. Agreement to abide by those regulations imposed on the hospital by regulatory agencies and law;

r. Applicants requesting privileges to practice in the ED setting will be required to submit evidence of current ACLS certification or evidence plans to attend a certification course within six months of application.

s. The applicant must sign the application statement that s/he has received and the Bylaws, Policies and Procedures of the Medical Staff, and they agree to be bound by the terms thereof if granted medical staff membership.

t. An initial application fee will be collected for all initial application requests.

u. Board Certification in a medical specialty obtained within a reasonable time frame following residency or fellowship completion is preferred. Current Medical Staff Members that are not board certified will be considered "grandfathered" into the board certification requirement. Special consideration to foreign trained physicians will be considered on an individual basis.

Section 2 Action On Initial Appointment

1. Upon receipt of an application for Medical Staff membership and clinical privileges, Guttenberg Municipal Hospital staff or the Network Hospital Medical Staff Services Office (MSSO) staff shall review the application for completeness. An incomplete application shall be returned to the applicant for completion and re-submission. The process will be discontinued if a completed application and all supporting documents have not been received within 180 days from the date the application is initially received by the network hospital's Medical Staff Services Office.

2. Upon determining that an application is complete, GMH and/or the MSSO shall begin the document verification process. Document verification will be obtained from the primary source(s) regarding the following:

   a. Current licensure via the appropriate state licensing board(s);
   b. Relevant training or experience, including professional schools, residency and post-doctoral programs.
   c. Current competence from health care professionals personally acquainted with the applicant's professional and clinical performance; and
   d. The applicant's ability to perform the clinical privileges requested (i.e. from the director of a training program or the chief of staff at another hospital where the applicant holds privileges
   e. External agencies that are also queried as applicable include:

1. The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of education regarding foreign medical graduates;
2. The National Practitioner Data Bank (NPDB), as required by the "Healthcare Quality Improvement Act of 1986", at the time of initial appointment and granting clinical privileges, advancement after the Provisional period and every two (2) years thereafter. Staff monitors sanctions and/or limitation by receiving ongoing reports from the NPDB and obtaining routine reports from the appropriate state licensing boards. Reports are reviewed within 30 days of their release. When a sanction or citation is identified, the practitioner is forwarded to the Medical Staff Committee for review. When a quality of care concern or identified adverse event is identified, the practitioner is forwarded to the Medical Staff Committee for review ; and
3. The Federation of State medical Boards (FSMB), which is a secondary source used to supplement the external agency information that is obtained to fully evaluate each applicant.
4. Office of Inspector General (OIG) Sanction list
5. General Service Administration (GSA) list of parties excluded from federal program participation.

3. GMH and the Network Hospital agree that no applicant will be appointed to the Medical Staff or granted specific clinical privileges unless the applicant's credentials file contains verified information and supporting data demonstrating current clinical competence. Any request for special privileges (additional to those identified on the published GMH list of privileges) will be considered on an individual basis by the Network Hospital's Credentials Committee and the GMH Medical Staff Committee based upon the applicant's ability to demonstrate training and clinical competence.

4. The Network Hospital's MSSO forwards the completed application packet to Network Hospital's Credential Committee. Upon receipt of a completed application, the Network Hospital's Credentials Committee shall expeditiously proceed to:
   a. Review and investigate the character, evidence of the applicant's ability to perform the essential functions of the privileges requested, qualifications, professional competence and ethical standing of the applicant; and the Hospital's current capability to provide the resources necessary for the physician to perform the privileges.
   b. Verify the accuracy of the information contained in the application. Evaluate for any evidence of an unusual pattern or an excessive number of professional liability actions resulting in final judgment.

5. Unless the applicant consents to a longer period of time, within thirty (30) of receipt of the completed application, the Network Hospital's Credentials Committee shall make a written report of its review to the GMH Medical Staff Committee. Such report shall include a recommendation that the applicant be:

   a. Appointed to the Medical Staff; or
   b. Rejected for Medical Staff membership.
   c. Deferred / delayed pending further documentation or clarification of information

   The recommendation of the Network Hospital's Credentials Committee shall include specific recommendations for delineating the applicants clinical privileges.

6. Any application withdrawn prior to completion of the full credentialing process cannot be re-initiated for 12 months.

Section 3 GMH Medical Staff Committee Action On Initial Appointment

1. At the next regular GMH Medical Staff Committee Meeting after the Network Hospital's Credentials Committee forwards its report, the Medical Staff Committee will consider the report of the Network Hospital's Credentials Committee and determine their recommendation to be made to the GMH Board of Trustees of the hospital.

2. If the recommendation of the GMH Medical Staff Committee is that the applicant should be appointed to the Medical Staff, the GMH Medical Staff Committee shall also specifically recommend the clinical privileges to be granted, including any limitations to be imposed upon such clinical privileges.

3. If the recommendation of the GMH Medical Staff Committee is to defer action on the application for further consideration, the GMH Medical Staff Committee must specify the specific procedures and time limits that will be used to make a subsequent recommendation on the applicant′s acceptance, rejection or limitation of privileges.

4. If the GMH Medical Staff Committee's recommendation is that the applicant should be rejected for Medical Staff Membership, or that the clinical privileges should be less than requested by the applicant, the CEO shall promptly notify the applicant within 10 days by certified mail, return receipt requested, of the Medical Staff Committee's recommendation. No such adverse recommendation shall be transmitted to the Board until the applicant has exercised or has been deemed to waive his/her rights of appeal pursuant to Article XII of these Bylaws.

5. If Judicial Review has been pursued, the Medical Staff Committee will review the hearing record, report and recommendation, and provide a reconsidered recommendation. If the reconsidered recommendation is favorable to the practitioner, the Hospital CEO shall promptly forward it, together with all supporting documentation, to the Board of Trustees.

6. If such recommendation continues to be adverse, the Hospital CEO shall forward such recommendation and documentation to the Board of Trustees, but the Board of Trustess shall not take action thereon until after the practitioner has exercised or has been deemed to have waived his/her right to an appellate review by the Board of Directors as provided in Article XII of these Bylaws.

Section 4 Action Of GMH Board Of Trustees On Initial Application

1. The GMH Board of Trustees, at its next regular meeting after receipt of a favorable recommendation, shall act on the matter. If the GMH's Board of Trustees' decision is adverse to the practitioner with respect to either appointment or clinical privileges, the CEO shall notify him/her of such adverse decision within 10 days by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been

deemed to have waived his/her rights under Article XII of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

2. The GMH Board of Trustees shall act on the matter at its regular meeting after all of the practitioners rights under Article XII of these Bylaws have been exhausted or waived. The GMH Board of Trustee's decision shall be conclusive, except that the GMH Board of Trustees may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the GMH Board of Trustees shall be made, and may include a directive that an initial hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation and new evidence in the matter, if any, the GMH Board of Trustees shall make a decision either to provisionally appoint the practitioner to the staff or to reject him/her for staff membership. All decisions to appoint shall be communicated to the applicant in writing within 14 days and will include a delineation of the clinical privileges which the practitioner may exercise, and an orientation packet.

3. Whenever the GMH Board of Trustees' decision will be contrary to the recommendation of the GMH Medical Staff Committee pertaining to the granting or curtailment of clinical privileges, the Board of Trustees shall submit the matter to an Ad hoc committee consisting of two (2) members of the Board of Trustees, two (2) members of the Active Medical Staff, appointed by the President of the Medical Staff, for review and recommendation and shall consider such recommendation before the Board of trustees makes its final decision.

4. When the Board of Trustees' decision in final, it shall send notice of such decision through the Hospital CEO to the Medical Staff President and the Medical Staff Committee (as a whole) and by certified mail, return receipt requested, to the practitioner within 14 days.

Section 5 Reapplication After Adverse Decision.

A practitioner seeking appointment or reappointment, who has received a final adverse decision by the GMH Board of Trustees, shall not be eligible to reapply to the staff for a period of one (1) year, unless a decision provides otherwise. Any such re-application shall be processed as an initial application and the applicant shall submit such additional information as the GMH Medical Staff Committee or the GMH Board of Trustees may require in demonstration that the basis for the earlier adverse action no longer exists.

Section 6 Term Of Appointment And File Maintenance.

1. The GMH Board of Trustees will make all appointments to the Medical Staff. Upon initial appointment, the practitioner member will serve in a Provisional status for a minimum of 12 months to allow sufficient time for evaluation. The 12-month Provisional period begins with the signature of the Board Secretary. During this Provisional period, his/her professional competence, and ethical and moral conduct shall be observed by the active members of the GMH Medical Staff. Prior to the end of the 12-month Provisional period, the practitioner shall supply, in writing, at least the following information:

   a. Any change from the information provided by the practitioner in the initial application;

b. Any change in privileges requested by the practitioner;
c. The basis for any request for a change in privileges;
d. The extent of the practitioner's continuing education efforts, since their initial application;
e. The practitioner's malpractice insurance coverage.

Simultaneously, the following documentation will be obtained:

a. Primary source verification of current licensure with the appropriate state licensing board(s) for each state license currently held;
b. Current competence from two (2) peers[1] who are currently knowledgeable about the practitioner's professional competence and ethical character;

   [1]Peer is defined an any practitioner of similar or like discipline, or any practitioner with the same education and expertise. In the GMH rural setting, if no similar "specialist" is on active staff, the competence assessment will be judged by family practitioners observing outcomes.

c. National Practitioner Data Bank query;
d. Appropriate backup coverage for Courtesy Medical Staff holding admitting privileges that do not reside within 30 minutes of the Hospital;
e. Current competence and ethical character from hospitals where Courtesy Medical Staff members hold Active Medical Staff status;
f. Whether the practitioner has exhibited any behaviors that would indicate that she/he is unable to perform the essential functions of the privileges requested to care for patients in Guttenberg Municipal Hospital;
g. When applicable, the practitioner's attendance at required medical staff meetings;
h. The practitioner's service on Hospital and Medical staff committees when requested;
i. Whether the practitioner has had any periods of suspension due to incomplete medical records;
j. The practitioner's patterns of care, as demonstrated by reviews and evaluations conducted by committees (such as Utilization Review or Medical Record or Infection Control committee) or external peer reviews.
k. Quality Improvement and risk management information; and
l. Any other relevant factors.

The interval information form, along with the documentation outlined above, will be transmitted for review to the Network Hospital Credentialing Committee and then the GMH Medical Staff Committee. Each will indicate their recommendation for full appointment, or whether the Provisional period should be extended. A recommendation to extend the Provisional period should indicate the recommended period of time. Thereafter, the practitioner will be subject to reappointment as set forth in Section 7 of this document.

2. Notwithstanding the provisions of this Section 6, the clinical privileges and Medical Staff membership of any practitioner may be suspended or revoked at any time pursuant to Article X of these Bylaws, and the applicable provisions of the governing documents of The Guttenberg Municipal Hospital.

3. Each credentialed practitioner shall have an individual confidential credential file of all documentation gathered during their initial appointment and any subsequent reappointments. Throughout the period of appointment, the Hospital will ensure that each file contains primary

source verification of renewal for all state licenses currently held, copies of current state and federal controlled substances certifications, specialty board certifications (if applicable), malpractice insurance certification and any other applicable certifications (ACLS, ATLS, etc). All credential files are kept secured in a locked office.

4. Access to credential files is limited to the following individuals for peer review purposes:

   a. Identified administrative staff;
   b. Medical Staff support personnel;
   c. Physicians who are members of the GMH Medical Staff Committee who demonstrate a professional "need to know".

   The practitioner is allowed access to his or her credentialing file; however, the practitioner must sign a release acknowledging the restrictions of Iowa Code 147.135.

Section 7 Reappraisal And Reappointment.

1. Reappointments by the GMH Board of Trustees shall be for two (2) years, based upon a recommendation of the GMH Medical Staff Committee and Network Hospital's Credentials Committee.

2. The Network Hospital MSSO shall, during the birth month of the medical staff member, provide such staff member with an interval information form to use in considering reappointment. Each Staff member who desires reappointment shall, within 30 days, return their interval information form to the Network Hospital's MSSO.

3. The practitioner for reappointment shall supply, in writing, at least the following information:

   a. any change from the information provided by the member in the initial application;

   b. any change in the privileges requested by the Practitioner;

   c. the basis for any request for a change in privileges;

   d. the practitioner's malpractice insurance coverage; and

   e. The names of two (2) peer[1] references currently knowledgeable about the practitioner's professional competence and ethical character.

      [1]Peer is defined an any practitioner of similar discipline, or any practitioner with the same education and expertise. In the GMH rural setting, if no similar "specialist" is on active staff, the competence assessment will be judged by family practitioners observing outcomes.

   f. Copy of current Board Certification (if applicable)

   g. Allied Health Professionals must submit proof of continuing education as required by the Iowa Law which may be above and beyond the professional's state of origin

licensure as allowed or required by the nurse Licensure Compact enacted by the state of Iowa on July 1, 2000.

4. For licensed medical Practitioners, verification of maintenance of current Iowa Medical licensure since initial appointment or at the time of reappointment shall be considered proof of compliance with continuing education efforts as required by Iowa Law.

5. Upon receipt of the interval information form, the following documentation will be obtained:
    a. Primary source verification of current licensure with the appropriate state licensing board(s) for each state license currently held;

    b. Current competence from two (2) peers[1] who are currently knowledgeable about the practitioner's professional competence and ethical character;

        [1]Peer is defined an any practitioner of similar discipline, or any practitioner with the same education and expertise. In the GMH rural setting, if no similar "specialist" is on active staff, the competence assessment will be judged by family practitioners observing outcomes.

    c. National Practitioner Data Bank query;

    d. Appropriate backup coverage for Courtesy Medical Staff holding admitting privileges that do not reside within 30 minutes of the Hospital;

    e. Current competence and ethical character from hospitals where Courtesy Medical Staff members hold Active Medical Staff status;

    f. Whether the practitioner has exhibited any behaviors that would indicate that she/he is unable to perform the essential functions of the privileges requested to care for patients in Guttenberg Municipal Hospital;

    g. The practitioner's attendance at required medical staff meetings;

    h. The practitioner's service on Hospital and Medical staff committees when requested;

    i. Whether the practitioner has had any periods of suspension due to incomplete medical records;

    j. The practitioner's patterns of care, as demonstrated by reviews and evaluations conducted by committees (such as Utilization Review or Medical Record or Infection Control committee) or external peer reviews.

    k. Quality Improvement and risk management information;

    l. Evaluate whether the practitioner has had any evidence of unusual practice patterns or an excessive number of professional liability actions resulting in a final judgment against the applicant;

    m. Any other relevant factors.

The interval information form, along with the documentation outlined above, will be transmitted for review to the Network Hospital Credentialing Committee and then the GMH Medical Staff Committee.

5. Within 60 days of receipt of the completed interval information, the Network Hospital Credential Committee will review the information and recommend relative to the reappointment of Medical Staff members and renewal or revision of their privileges for the reappointment period.

6. Unless the applicant consents to a longer period of time, within 30 days of receipt of the completed application, the Network Hospital Credential Committee will make a written report of its review to the GMH Medical Staff Committee. Such report shall include a recommendation that the applicant be:
   1. Reappointed to the Medical Staff; or
   2. Rejected for reappointment
   3. Defer/delay pending further documentation or clarification of information

   The recommendation will be forwarded to the GMH Medical Staff.

6. The GMH Medical Staff Committee shall make written recommendations to the GMH Board of Trustees concerning reappointment, non-appointment and/or revision of clinical privileges of each practitioner. The written recommendation shall be discussed at the GMH Board of Trustees first monthly meeting following the Medical Staff Committee's meeting at which said practitioner was discussed.

7. Thereafter, the procedure provided in Sections 3 and 4 of this Article XX relating to the recommendations on application for initial appointment shall be followed.

Section 8 Leave Of Absence

When a written request for a voluntary leave of absence, in accordance with Article III, Section5, is submitted to the President of the Medical Staff, s/he will forward the request to the Hospital CEO and Medical Staff Committee for review.

A leave of absence may be granted by the Board of Trustees upon a recommendation of the Medical Staff Committee, subject to such conditions or limitations as the Medical Staff Committee should determine to be appropriate.

During the period of a leave, the Practitioner's privileges and prerogatives shall not be exercised.

At least 30 days prior to the termination of the leave, or at any earlier time, the Practitioner may request reinstatement of his/her privileges and prerogatives by submitting a written notice to that effect to the Medical Staff President. The Medical Staff President will forward the request in turn to the Hospital CEO and Medical Staff Committee for review. The Practitioner or Allied Health Professional shall submit a written summary of his/her activities during the leave, and may be required to submit a medical certification or other documentation of ability to return to work, as deemed necessary by the Medical Staff Committee. The conditions for reinstatement vary depending on the reason for the leave, use of time during the leave, and any new factors that may have changed the individual's ability

to perform effectively in the position held prior to the leave.

The Board of Trustees upon a recommendation of the Medical Staff Committee may grant reinstatement of the Practitioner's privileges and prerogatives.

Failure without good cause, to request reinstatement or to provide a summary of activities as noted above prior to termination of the leave shall result in an automatic suspension of Medical Staff membership, privileges and prerogatives without right of hearing or appellate review as outlined in Article XVI. A request for Medical Staff membership subsequently received from a Practitioner so suspended shall be submitted and processed in the manner specified for applications for initial appointments.

If the Medical Staff Committee makes an adverse recommendation, and the appointee has adhered to the above conditions, the appointee shall be entitled to the procedural rights outlined in the Judicial Review Procedure.

ARTICLE XXI

CLINICAL PRIVILEGES

Section 1 Limitation Of Clinical Privileges

1. Every Medical Staff member permitted by law and by the Guttenberg Municipal Hospital to provide patient care services independently in the hospital shall have delineated clinical privileges specifically granted by the GMH Board of Trustees with the exception of the temporary privilege process (refer to Section 4 of this article).

2. Privileges granted to members of the Medical Staff shall be based on their education, training, experience and demonstrated competence. The scope and extent of procedures shall be specifically delineated.

   As permitted by state law, the Medical Staff, by policy, may choose to allow qualified individuals who are not licensed independent physicians to perform part or all of a patient's medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified physician. The specific qualified physician retains accountability for the patient's medical history and physical examination.

3. Periodic re-determination of clinical privileges and the increases or curtailment of the same shall be based on the direct observation of care provided, review of the records of patients treated in this hospital and review of the records of the medical staff which document the evaluation of the member's participation in the delivery of medical care, continuous quality improvement findings, references, continuing education units, physical and mental health status to perform the essential functions of the privileges requested and any other relevant information.

Section 2 Delineation Of Clinical Privileges

1. All clinical privileges granted to practitioners shall be delineated with sufficient specificity to insure that a practitioner does not treat a patient in the Guttenberg Municipal Hospital outside the practitioner's area of demonstrated competence. An individual privilege listing is maintained for each practitioner on staff as an electronic file that is accessible by the appropriate hospital staff via the hospital information system. These files are updated on an ongoing basis as changes occur.

Section 3 Determination Of Privileges

1. Each practitioner shall have the responsibility of establishing his or her qualifications and competency for the clinical privileges requested.

2. Determination of initial privileges is based upon the applicant's education, training, experience, demonstrated current competence, references, current physical and mental health to perform the essential functions of the privileges requested and any other relevant information.

3. Determination of the retention or extension of clinical privileges to members of the Medical Staff is based upon the member's education, training, experience, demonstrated current competence, continuing education effort, current physical and mental health to perform the essential functions of the privileges requested, the observations of the Medical Staff and any other relevant information.

4. On occasion, there may be certain practitioners of the "Healthcare professionals" not on the medical staff who petition for use of hospital services, such as x-ray, laboratory, pulmonary function testing, etc., but who do not desire staff privileges. The Hospital will verify a current medical license and UPIN number on these practitioners. See policy and procedure: Practitioners Not On GMH Medical Staff Who Petition For Ancillary Department Services. The granting of such permission is understood to furnish a specific service to the individual concerned and in no way conveys the status of membership or any other privileges of medical staff members.

5. When privileges are applied for which require consultation, the staff member must designate by mutual agreement, a specified consultant (or consultants) credentialed for the privilege, which requires consultation. Before the requested privilege can be granted, the consultant must document in writing the agreement to provide supervision and emergency coverage. Failure to arrange such mutually agreed upon consultant relationship will constitute grounds for denial of the requested clinical privilege. These privileges will be contingent at all times on maintaining this coverage.

Section 4 Additional Privileges

Applications for additional clinical privileges must be in writing to the Hospital Administrator. Such applications should be processed in the same manner as applications for initial appointment and must include an inquiry of the NPDB and approved the Board of Directors before the requested privileges are used by the Practitioner. To assure uniformity, they should be submitted on a prescribed form, on which the type of clinical privileges desired and documented proof of the applicant's relevant and approved by the Board of Directors before the requested privileges are used by the Practitioner. To assure uniformity, they should be submitted on a prescribed form, on which the type of clinical privilege(s) desired and documented proof of the applicant's relevant recent training and/or experience must be provided. Such applications are processed in the same manner as applications for initial appointment. Temporary privileges are not granted for additional privileges.

Section 5 Temporary Privileges

1. Temporary privileges may be granted on an individual basis at the discretion of the President of the Medical Staff to address a specific patient care need or when an applicant with a complete application that reveals no challenges to licensure of registration, no involuntary termination from the medical staff or another organization and no history of limited, reduced, denied or lost clinical privileges is awaiting review and approval of the Medical Staff Committee and Board of Trustees.

2. Upon receipt of a complete application for Medical Staff membership from an appropriately licensed practitioner, the CEO or designee with the written concurrence of the President of the Medical Staff may grant temporary privileges to the applicant for a limited period of time, not

to exceed 120 days, provided there is verification of the following:

a. Unchallenged current licensure;

b. Relevant training or experience (includes medical school and residency)

c. Current competence (documented by residency director or current department Chairperson);

d. The ability to perform the requested privileges;

e. Appropriate malpractice insurance coverage;

f. No incidents of involuntary termination from the medical staff at another organization;

g. No history of limited, reduced, denied or lost clinical privileges; and

h. Non-controversial information from the National Practitioner Data Bank (NPDB).

In exercising such privileges, the applicant shall act under the supervision of a medical staff member.

If privileges are requested that are not contained on the current list of privileges from the applicant's assigned Department, written concurrence will also be obtained from the Medical Staff President. Differences in opinion between the applicant and the President of the Medical Staff will be discussed at the Medical Staff Committee. If the resolution is not to the satisfaction of the applicant requesting the privileges, the Judicial Review Procedure (Article XVIII) of these Bylaws may be utilized.

3. Locum tenens may be granted by the CEO and Chief of Staff to an appropriately licensed practitioner at the request of a member of the Medical Staff. A practitioner receiving locum tenens may attend patients without applying for membership on the Medical Staff for a period of not to exceed 120 days, providing all credentials have first been approved by the CEO and Chief of Staff on the basis of the following information, which has been verified with the primary source and may reasonably be relied upon as to the competence and ethical standing of the applicant:

a. Unchallenged current licensure;

b. Relevant training or experience;

c. Documentation of current competence;

d. The ability to perform the requested privileges;

e. Appropriate malpractice insurance coverage;

f. No incidents of involuntary termination from the medical staff at another organization;

g. No history of limited, reduced, denied or lost clinical privileges; and

h. Non-controversial information from the NPDB is obtained.

Practitioners serving as a locum tenens from more than 120 days will be required to submit an application for Courtesy Medical Staff membership as outlined in Article XX Appointment and Reappointment.

4. Residents in training who are enrolled in an approved medical or osteopathic residency may apply for temporary clinical privileges only if they:

a. Are licensed in the State of Iowa;

b. Complete an application for privileges as required for locum tenens physicians;

c. Are sponsored by an active or courtesy staff member;

d. Agree to be directly supervised by that staff member or his or her designee;

e. Agree to exercise only those specific privileges authorized for their experience level; and

f. Agree that privileges are conditioned upon the residency and shall be limited to the term of the residency with no procedural or fair hearing rights upon termination or denial of reappointment.

5. Special requirements of supervision and reporting may be imposed by the President of the Medical Staff regarding any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the CEO upon notice of any failure by the practitioner to comply with such special conditions.

6. The CEO and Chief of Staff, at any time, upon the recommendation of the Medical Staff Committee, may terminate a practitioner's temporary privileges effective with the discharge from the hospital of the practitioner's patient(s) being cared for in the hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to Article X Section 2 of these Bylaws, and the same shall be immediately effective. The President of the Medical Staff shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the hospital. The wishes of the patient (s) shall be considered where feasible in selection of a substitute practitioner.

7. A practitioner shall not be entitled to the procedural rights afforded under Articles X and XIII because of his/her inability to obtain temporary privileges or because of any termination or suspension of temporary privileges.

Section 6 Emergency Privileges

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

2. In the case of an emergency, any practitioner, to the degree permitted by the practitioner's license, shall be permitted and assisted to do everything possible to treat a patient, including the use of any necessary facilities of The Guttenberg Municipal Hospital and the calling of any consultation necessary or desirable.

3. When an emergency situation no longer exists, the practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or the practitioner does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff.

Section 7 Temporary Privileging in a Disaster Situation

Eligible volunteer Practitioners and Allied Health Professionals (AHPs) who do not possess Medical Staff privileges may be granted disaster privileges when the Emergency Management Plan has been activated and the organization is unable to meet immediate patient care needs.

The option to grant disaster privileges to eligible volunteer Practitioners and AHPs is made on a case-by-case basis in accordance with the needs of the organization and its patients, and based upon the qualifications of its eligible volunteer Practitioners and AHPs.

Eligible volunteer Practitioners and AHPs presenting to Guttenberg Municipal Hospital during a disaster will be directed to the Emergency Operations Center for processing. Prior to caring for patients volunteer practitioners and AHPs must complete the Emergency Credentialing Application and provide, at a minimum, a valid government issued photo ID, and one other identification mechanism as listed in (TJC) GRANTING TEMPORARY CLINICAL AND STAFF PRIVILEGES IN A DISASTER EVENT . Refer to Policy for further procedural definitions.

Section 8 Medical Residents

Medical Residents who are enrolled in an approved medical or osteopathic residency may apply for locum tenens privileges only and if they:

1. Are licensed in the State of Iowa;

2. Completed an application for privileges as required for locum tenens physicians;

3. Are sponsored by an active staff member;

4. Agree to be directly supervised by that staff member or his or her designee;

5. Agree to exercise only those specific privileges authorized for their experience level; and

6. Agree that privileges are conditioned upon the residency and shall be limited to the term of the residency with no procedural or fair hearing rights upon termination or denial of reappointment.

Section 9 Medical Students

Students enrolled in a professional healthcare program may function under limited circumstances if:

1. A written application from an active staff member is submitted outlining the specific requested responsibilities;
2. A written documentation that the student is covered by malpractice insurance;
3. The request is approved by the Chief of Staff; and
4. The sponsoring physician or his/her physician designee is physically present when the student performs his or her responsibilities.

Section 10 New Or Newly Learned Technical Procedures

Each medical staff member requesting privileges for new or newly learned procedures will be considered on an individual basis by the Medical Staff Committee. The review process will be the same for appointment and reappointment.

ARTICLE XXII

ALLIED HEALTH PROFESSIONALS
Midlevel Practitioners: Physician Assistants & Advanced Registered Nurse Practitioners

Section 1 General

1. An Allied Health Professional is an individual who (1) possesses a license, certificate or other credential required by Iowa law; (2) is qualified to provide patient care services in a hospital setting, as approved by the Board.

2. Allied Health Professionals may apply for specific privileges commensurate with documented license, certification, other credential, training and experience.

3. Allied Health Professionals must:

    a. Provide patient′s with care at the generally recognized professional level of quality and efficiency;

    b. Abide by the relevant sections of the Medical Staff Bylaws and by all other standards, policies and rules of the Guttenberg Municipal Hospital

    c. Discharge such staff, department, committee and hospital functions for which s/he is responsible by staff category assignment, appointment, election or otherwise;

    d. Prepare and complete in a timely fashion any documentation relevant to patient care provided;

e. Abide by the ethical and moral principles of the relevant profession; and

f. Meet the same basic responsibilities as requested of Medical Staff members in Article III, Section 2 (A), 2 (D) of these Bylaws.

4. Allied Health Professionals may:

   a. Provide specified patient care services upon direct order and under the sponsorship, supervision and direction of a member of The Guttenberg Municipal Hospital Active and Courtesy Medical Staff. Privileges will be contingent at all times on maintaining this coverage.

   b. Allied Health Professionals may write orders but not beyond the scope of the Allied Health Professional's license, certificate or other credentials and provided the sponsoring physician countersigns the order;

   c. Serve on staff, department and hospital committees

   d. Attend meetings of committees/departments

   e. Exercise such other prerogatives as shall be, by resolution or written policy, duly adopted by any Medical Staff committees and approved by the Medical Staff Committee and the GMH Board of Trustees accorded to Allied Health Professionals.

<u>Section 2 Appointment And Reappointment</u>.

1. An Allied Health Professional making initial application shall submit a written application on a prescribed form to the Guttenberg Municipal Hospital.

   a. The applicant shall accept the obligation of providing all information requested in support of the applicant's application.

   b. The applicant shall authorize Guttenberg Municipal Hospital to consult with appointees of medical staffs, hospital administrations, and other professional contacts with whom the applicant has been previously associated.

   c. The applicant shall consent to the inspection of all records and documents such as school diplomas, state licenses, and certificates of membership in professional societies and organizations.

2. The application shall include, at a minimum, the following information:

   a. Professional education and training;
   b. Professional experience;
   c. Other professional qualifications;
   d. Documented evidence of current Iowa license (or equivalent according to the State of Iowa Licensure Compact Laws), certificate or other legal credentials required by Iowa

law;

e. Letters of reference from at least one practitioner and two peers who are currently knowledgeable about the applicant's professional competence and ethical character.
f. Any instance in the previous 10 years in which the applicant has been subject to a claim based upon an allegation of medical malpractice, including a summary of the allegation, the names of the person or persons making such allegation, and the disposition of the allegation against the Allied Health Professional;
g. Any instance in which the Allied Health Professional's license, certificate or other legal credential has ever been suspended or challenged by a state licensing board in any jurisdiction;
h. Whether the applicant has ever been refused admission, renewal or suffered a revocation, suspension, or reduction of practice privileges at any other institution.
i. A specific request for particular hospital assignments and delineated practice privileges;
j. Certification that the amount of professional liability insurance maintained in force by the applicant is equal to or greater than the minimal amount required by Guttenberg Municipal Hospital;
k. Information relating to the applicant's current physical and mental ability to perform the essential functions of the clinical privileges requested;
l. Agreement to observe all of the profession's ethical principles;
m. Acknowledgment of the immunity from liability provisions in Article XI of these Bylaws; and
n. Agreement to abide by those regulations imposed on the hospital by regulatory agencies and law.

Section 3 – Temporary Privileges

1. Temporary privileges may be granted on an individual basis at the discretion of the President of the Medical Staff to address a specific patient care need or when an applicant with a complete application that reveals no challenges to licensure of registration, no involuntary termination from the medical staff or another organization and no history of limited, reduced, denied or lost clinical privileges is awaiting review and approval of the Medical Staff Committee and Board of Trustees.

2. Upon receipt of a complete application for Allied Health Professional Staff membership, the CEO with the written concurrence of the President of the Medical Staff may grant temporary privileges to the applicant for a limited period of time, not to exceed 180 days, provided there is verification of the following:

    a. Unchallenged current licensure (if applicable);

    b. Relevant training or experience;

    c. Appropriate malpractice insurance coverage;

    d. Requested privileges delineated.

    In exercising such privileges, the applicant shall act under the supervision of a medical staff member.

3. Locum tenens may be granted by the CEO and Chief of Staff to an appropriately Licensed Allied Health Practitioners at the request of a member of the Medical Staff. An AHP receiving locum tenens may attend patients without applying for Allied Health membership for a period of not to exceed 120 days, providing all credentials have first been approved by the CEO and Chief of Staff on the basis of the following information, which has been verified with the primary source and may reasonably be relied upon as to the competence and ethical standing of the applicant:

    a. Unchallenged current licensure (if applicable);

    b. Relevant training or experience;

    c. Documentation of current competence;

    d. The ability to perform the requested privileges;

    e. Appropriate malpractice insurance coverage;

    f. No incidents of involuntary termination from the medical staff at another organization;

    g. No history of limited, reduced, denied or lost clinical privileges; and

    h. Non-controversial information from the NPDB is obtained.

   Practitioners serving as a locum tenens from more than 120 days will be required to submit an application for Alllied Health Professional Staff membership.

Section 4 Additional Privileges

Applications for additional clinical privileges must be in writing to the Hospital CEO and approved by the Board of Trustees before the requested privileges are used by the Allied Health Professional. To assure uniformity, requests should be submitted on a prescribed form on which the type of clinical privileges desired are documented and proof of the applicant's relevant recent training and/or experience must be provided. Such applications should be processed in the same manner as applications for initial appointment. Temporary privileges are not granted for additional privileges.

Section 5 Action On Initial Appointment

1. Upon receipt of an application from an Allied Health Professional, GMH staff or the Network Hospital's Medical Staff Services Office (MSSO) shall review the application for completeness. An incomplete application shall be returned to the applicant for completion and resubmission. Upon determining that an application is complete GMH or the Network Hospital MSSO shall document verification from the primary sources listed on the application. Once an Allied Health Professional's application information has been verified the application is transmitted to the Network Hospital's Medical Staff Service Office (MSSO). The network hospital's MMSO office will review and investigate the character, health, qualifications and professional competence of the applicant and also verify the accuracy of the information

contained in the application. Once the MSSO is confident that the primary source verification and application information is complete;

2. The Network Hospital's MSSO forwards the completed application packet to the Network Hospital's Credential Committee. Upon receipt of a completed application, the Network Hospital's Credentials Committee shall expeditiously (within 90 days) proceed to:

    a. Review and investigate the character, evidence of the applicant's ability to perform the essential functions of the privileges requested, qualifications and professional competence of the applicant;
    b. Verify the accuracy of the information contained in the application;
    c. Request the opinion of the sponsoring physician as to the applicant's ability to perform the requested clinical privileges, and the appropriateness of the scope of privileges requested.

3. Unless the applicant consents to longer period of time, within one hundred eighty (180) days of receipt of the completed application the Network Hospital's Credentials Committee shall make a written report of its review to the GMH Medical Staff Committee. Such report shall include a recommendation that the applicant be:

    a. Appointed as an Allied Health Professional;
    b. Be deferred for further consideration; or clarification of information
    c. Rejected as an Allied Health Professional.

4. The recommendation of the Network Hospital's Credentials Committee shall include specific recommendations for delineating the applicant's practice privileges.

Section 6. Medical Staff Committee Action On Initial Appointment

1. At the next regular GMH Medical Staff Committee meeting which is held after the Network Hospital's Credentials Committee forwards its report to the GMH Medical Staff Committee, the Medical Staff Committee will consider the report of the Network Hospital's Credentials Committee and determine the recommendation to be made to the GMH Board of Trustees.

2. If the recommendation of the GMH Medical Staff Committee is that the applicant should be appointed, the GMH Medical Staff Committee shall also be specifically recommend the practice privileges to be granted, including any limitations to be imposed on such practice privileges.

3. If the recommendation of the GMH Medial Staff Committee is to defer action on the application for further consideration, the GMH Medial Staff Committee must specify the specific procedures and time limits that will be used to make a subsequent recommendation on the applicant's acceptance, rejection, or limitation of practice privileges.

4. If the GMH Medial Staff Committee's recommendation is that the applicant should be rejected or that the practice privileges granted to the applicant should be less than requested by the applicant, the CEO shall notify the applicant within 10 days by certified mail, return receipt requested, of the GMH Medial Staff Committee's recommendation. No such adverse recommendation shall be transmitted to the GMH Board of Trustees until the applicant has

exercised or has been deemed to waive his or her rights for department review under Article XVII, Section 3. Waiver by Failure to Request a Judicial Review of the Judicial Review Procedures Manual.

Section 7 Term Of Appointment

1. The GMH Board of Trustees will make all Allied Health Professional appointments. All decisions to appoint shall include a delineation of the clinical privileges, which the Allied Health Professional may exercise, and an orientation packet.

2. All Allied Health Professionals shall be assigned to a department and supervised by a sponsoring physician. All clinical privileges granted to practitioners shall be delineated with sufficient specificity to ensure that an Allied Health Professional does not treat a patient at GMH outside his/her area of demonstrated competence. To insure that all AHP's with clinical privileges only provide services within his/her scope of privileges, individual privilege lists are maintained as electronic files that are accessible by the appropriate hospital staff via the hospital's information system. The files are updated on an ongoing basis as changes occur.

3. Notwithstanding the provisions of this Section 5, the privileges and membership of any Allied Health Professional may be suspended or revoked at any time pursuant to Article X of these Bylaws and the applicable provisions of the governing documents of the Guttenberg Municipal Hospital.

4. Each credentialed AHP shall have an individual confidential credentials file of all documentation gathered during his/her initial appointment and any subsequent reappointment. Throughout the period of appointment, the Hospital will ensure that each AHP's credentials file contains documentation of primary source verification, if applicable, of renewal of all state licenses held and copied of current state and federal controlled substances certifications, specialty board certifications (i.e. CRNA, ACLS, etc). All credentials files are kept in secured and confidential files.

Section 8 Provisional Period

Upon initial appointment, Allied Health Professionals will serve in a provisional status for a minimum of twelve (12) months to allow sufficient time for evaluation. The twelve (12) month provisional period begins with the date of the signature of the Board Secretary. During this provisional period their professional competence, ethical and moral conduct shall be observed by the assigned Active/Courtesy Medical Staff member who sponsored the individual.

Prior to the end of the twelve month provisional period, the AHP will provide the following information:

1. Any change from the information provided in the initial application;
2. Any change in the privileges requested by the Allied Health Professional;
3. The basis for any request for change in privileges;
4. The extent of the AHP's continuing education efforts, as required by State of Iowa law since his/her initial appointment. (NOTE: This may be above and beyond what is

required by the AHP's state of origin for licensure allowed by the Nurse Licensure Compact enacted in the State of Iowa on July 1, 2000.)

5. The AHP's malpractice insurance coverage.

Simultaneously, the following documentation will be obtained:

1. Primary source verification of current licensure with the appropriate state licensing board(s) for each state license currently held;
2. Current competence from the sponsoring physician and one peer who are currently knowledgeable about the AHP's professional competence and ethical character;
3. Whether the AHP has exhibited any behaviors that would indicate she/he is unable to perform the essential functions of the privileges requested to care for patient at GMH;
4. Quality Improvement and risk management information; and
5. Any other relevant factors.

The interval information form, along with the documentation outlined above, will be reviewed by the GMH Medical Staff Committee. The GMH Medical Staff Committee will formulate a recommendation to either recommend full appointment or extend the provisional period. A recommendation to extend the provisional period will also include the period of time for the extension. The Medical Staff Committee's recommendation will be reviewed by the GMH Board of Trustees who will determine final action. Thereafter, the AHP will be subject to reappointment as set forth in Section 9.

Section 9 Reappraisal and Reappointment

1. Reappointment by the Board shall be for two (2) years, based upon a recommendation of the Board.
2. Reappointments of Allied Health Professionals shall follow the process identified in Article XX, Section 7.

Section 10 Allied Health Professional Students

Students enrolled in professional health care programs may function under limited circumstances if:

1. A written application form from a Medical Staff or Allied Health member is submitted outlining the specific requested responsibilities;
2. The request is approved by the appropriate sponsoring medical staff member – Active, Courtesy, or Allied Health
3. The sponsoring physician, or his/her designee, is physically present when the student performs his/her responsibilities.

TITLE: **(PRO) JUDICAL REVIEW MANUAL**

AFFECTS: Medical Staff

OBJECTIVE:

Any change to this document needs first to be presented at Medical Staff meeting for approval before final approval in Policy Tech. See meeting minutes for documentation.

JUDICIAL REVIEW PROCEDURE MANUAL

ARTICLE XVI

APPLICATION OF REVIEW PROCEDURES

Section 1 Scope

In all cases where a Practitioner receives notice of a recommendation of the Medical Staff Committee that, if ratified by the Board of Trustees, will result in any of the following actions:

- Rejection for initial Medical Staff membership,
- Limitation of clinical privileges requested by the applicant,
- Reduction, suspension or revocation of clinical privileges, or
- Non-reappointment or reduction in previously granted privileges;

then such Practitioners shall be entitled to a hearing by a Judicial Review Committee appointed by the Medical Staff Committee.

The Practitioner must submit his/her request for a hearing to the Chief Executive Officer within 21 days of receipt of said notice.

Results of Judicial Review procedures will be processed according to State of Iowa Law and National Practitioner Data Bank (NPDB) reporting guidelines.

This is a confidential professional/peer review and quality assessment and improvement process. Unauthorized disclosure is prohibited pursuant to the provisions of Iowa Statures ICA 22.7; 135.40-135.42, 147.135.

Section 2 Definitions

The following definitions shall apply to this Procedure:

"Administration″ means Hospital Administration.

"Practitioner" means a licensed Physician (MD or DO) or Midlevel Practitioner (PA, ARNP)]

"Affected Practitioner" means a Staff Member or Initial Applicant as to whom a Staff or Board recommendation was made or action taken

"Board" means the Board of Trustees of the Hospital.

"Bylaws" means the Bylaws of the Medical Staff.

"CEO" means the chief executive officer of the Hospital or a person from Administration designated in writing to act on his/her behalf for the purpose of hearing proceedings under this Plan.

"Days" means calendar days.

"Initial Applicant" means a Practitioner making application for initial appointment to Medical Staff.

"Chief of Staff" means the President of the Medical Staff.

"Special Notice" means written notification by registered mail or certified mail, return receipt requested, or personal delivery by a Hospital employee designated by the CEO.

"Staff″ means the organized Medical Staff of the Hospital.

"Staff Member" means a Practitioner who is a member of the staff.

"Network Hospital & Staff" means by Agreement the hospital and medical staff that provide assistance & quality oversight as well as credentialing oversight to a Critical Access Hospital, i.e. Finley Hospital, Dubuque\GMH.

ARTICLE XVII

ADVERSE RECOMMENDATION OR ACTION

Section 1 Notice Of Recommendation Or Action

When a recommendation is made or action taken by the Medical Staff Committee or the Board which, according to this Procedure, entitles an Affected Practitioner to a judicial review prior to a final decision of the Board on that recommendation or action, the Affected Practitioner shall be given Special Notice within 10 days by the CEO. This Special Notice shall contain:

1. A statement of the recommendation made and the general reasons for it;
2. A statement that the Affected Practitioner has the right to request a judicial review on the recommendation within twenty one (21) days of his receipt of the notice;
3. A copy of these Judicial Review Procedures, unless it has already been provided to the Affected Practitioner.

Section 2 Request For Judicial Review

The Affected Practitioner shall have twenty-one (21) days following the date of the receipt of such notice within which to request a Judicial Review. The request shall be made in writing and delivered in person or by certified mail to the CEO.

Section 3 Waiver By Failure To Request A Judicial Review

An affected practitioner who fails to request a formal judicial review within the time and in the manner specified in Section 2 waives any right to such review and to any possible appellate review. When such waiver is in connection with:

1. A proposed or actual adverse action by the Board of Trustees, it shall constitute acceptance of the action which shall thereupon become effective as the final decision of the Board of trustees;
2. An adverse recommendation of action by the Medical Staff Committee, it shall constitute acceptance of that recommendation which shall thereupon become and remain effective pending the final decision of the Board of Trustees. In this event, the Board of Trustees shall consider the Medical Staff Committee's recommendation at its next regular meeting following the effective date of such waiver. In its deliberations, the Board shall review and consider the recommendation and supporting documentation of the Medical Staff Committee and may consider any other relevant information received from any source. The Board of Trustee's action on the matter shall constitute the final decision of the Board of Trustees.

ARTICLE XVIII

JUDICIAL REVIEW PROCEDURES

Section 1 Application Of Judicial Review Procedures

The judicial review procedures apply to the following recommendations or actions:

1. Automatic suspension of Staff Membership or clinical privileges due to loss of licensure; limitations of privileges imposed by governmental prescribing authorities; or conviction of any felony or any crime arising out of professional practice.

2. Denial of a request of a Practitioner to obtain clinical privileges, which are not ordinarily possessed by professionals of like training, experience, Staff category and Staff membership duration.

3. Denial of a requested change in Staff category;

4. Issuance of a letter of reprimand (severe censure) without any reduction or limitation on the exercise of clinical privileges;

5. Non-reappointment to the Staff by reason of failure to document financial responsibility/professional liability insurance requirement compliance. (However, a hearing based on this action shall be limited to the issue of whether financial responsibility compliance has been documented by the Staff Member).

6. Denial of an initial application for appointment to the Staff, because the application is incomplete; the application contains material inaccuracies; the application does not contain documentation of competence for the privileges requested, as determined by the Medical Staff; the application contains evidence of professional misconduct; or for any reason unrelated to the competence or professional conduct of the Initial Applicant.

Section 2 Notice Of Time And Place For Judicial Review

Upon receipt of a timely and proper request for a judicial review, the CEO shall, after consultation with the Chief of Staff and the Board, promptly schedule and arrange for the judicial review. At least seven (7) days prior to the review date, the CEO shall, after consultation with the Chief of Staff or Board of Trustees depending on the body whose recommendation or action prompted the request for judicial review, notify the Affected Practitioner of the date, time and place of the commencement of the review by special notice. The review date ordinarily should not be less than thirty (30) days nor more than forty five (45) days from the date of receipt of the request for review.

Section 3 Appointments Of Judicial Review Committee

1. A judicial review shall be conducted by formulating a Judicial Review Subcommittee.

2. The Judicial Review Committee shall be composed of two (2) members of the GMH Board, one (1) member of the Medical Staff Committee, and one (1) member from the Network Hospital Medical Staff either the VP of Medical Affairs a physician currently serving on the Network Hospital's Credential Committee. The Chairperson of the Board, who shall not be a member of the judicial review committee, shall designate a member of the review committee to serve as its chair.

3. Service on Judicial Review Committee A Medical Staff member shall be disqualified from serving on a Judicial Review Committee if he/she participated in initiating or investigating the underlying matter at issue or because he/she served on the initial Ad Hoc Committee identified in Article X (Correction Action, Summary Suspension, and Automatic Suspension). In the event a member of the Judicial Review Committee feels that his/her prior knowledge of the facts or involvement with the case will not allow him/her to serve as an objective member of the Committee, that individual should request to be excused from service on the Judicial Review Committee. In any event, all members of the Judicial Review Committee will be required to consider and decide the case with good faith objectivity.

4. Notice to Affected Practitioner The CEO shall notify the Affected Practitioner of the hearing committee's composition.

Section 4 Appearance And Representation

1. Appearance of Affected Practitioner The Affected Practitioner requesting the judicial review must be present for the review. His/Her failure to appear at the date and time set forth in the notice shall constitute a waiver of the right to a judicial review. Under extenuating circumstances, the Affected Practitioner may request written permission for a delay in the judicial review from the Chief of Staff, or his/her designee.

2. Representation
    a. The Affected Practitioner shall represent him/herself and/or may be represented by counsel.

    b. The Hospital may be represented by a member of Administration and/or counsel.

Section 5 Judicial Review Conduct And Evidence

1. Judicial Review Conduct. The chairman of the review committee shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the review have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall determine the order of procedure during the review and ensure the considerations of evidence.

   The judicial review shall be conducted in such a manner that the affected practitioner has an opportunity to have his/her position fairly heard and considered. Members of the review committee may ask questions of the Affected Practitioner or witnesses.

2. Evidence The Affected Practitioner, Hospital and their counsel may submit to the review committee for consideration:

    1. Written statements, letter and documents, which are relevant to the subject matter of the hearing, including relevant portions of the file maintained by the Hospital regarding the affected practitioner.

    2. Oral statements by the affected Practitioner or the Hospital.

    3. During the review, each of the parties shall have the right to:

        a. Call and examine witnesses;

        b. Cross-examine witnesses called by the other party;

        c. Introduce exhibits;

        d. Rebut any evidence.

       If the Affected Practitioner does not testify, s/he may be called and examined as if under cross-examination.

    4. Evidence admitted in the judicial review need not strictly meet the requirements of admissibility of a court of law, and the review committee may consider any evidence customarily relied upon by responsible persons in the conduct of serious affairs.

Section 6 Burden Of Proof

The Affected Practitioner shall have the burden of proof and must demonstrate that the action of recommendation is:

1. Arbitrary;
2. Capricious; and/or
3. Based on inaccurate or insufficient information through no fault of the Affected Practitioner.

Section 7 Recording Of Judicial Review

The judicial review shall be recorded by minutes prepared by a certified court recorder provided by the hospital.

Section 8 Decision

After all parties have presented all information the committee will entertain actions via motions from the Judicial Review Committee members. All action requiring a vote shall be done by voicing either a "Aye" or "Nay" on each motion. If the chairperson is unable to determine a majority vote, members may be asked for a show of hands or a paper ballot tabulation after which a tally of votes will be taken and the action entered into the meeting transcript.

Section 9 Recommendation

Notice. Within twenty-one (21) days after completion of the judicial review, the review committee shall meet, deliberate, and then issue its report in writing to the CEO. The report shall be submitted by the CEO to the Chief of Staff or Board of Trustees (as appropriate), the counsel (if any), and to the Affected Practitioner (by Special Notice).

Section 10 Notice And Effect Of Results

Effect and Action Upon Favorable Judicial Review Committee Report If the judicial review committee's report is favorable to the Affected Practitioner, the CEO shall promptly forward it, together with all supporting documentation, to the Board for its final action.

1. The Board may, before taking final action thereon, refer the matter back to the review committee or the Medical Staff Committee for further consideration or information. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board must be made and may include a directive that an additional hearing or other review be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action.

2. If the Board's action on the matter is favorable to the Affected Practitioner it shall become the final decision of the Board, and the matter shall be closed.

3. If the Board's action is contrary to a favorable Judicial Review Committee report and would result in any of the recommendations or actions listed in Article X, the Special Notice shall inform the affected Practitioner of a right to request an appellate review by the Board as provided in this Article XVIII Section 12 of these Judicial Review Procedures.

4. <u>Effect of Adverse Judicial Review Committee Report</u> If the report and recommendation of the Judicial Review committee is adverse to the Affected Practitioner in any of the respects listed in Article XVI Section 1, Special Notice shall be given of the report and recommendation and his/her right to request appellate review by the Board as provided in Article XVIII Section 11 of these Judicial review Procedures.

Section 11 Appeal

If, following a judicial review pursuant to this Article XVIII, the Affected Practitioner believes that the judicial review committee's recommendation was arbitrary, capricious, or lacks any evidence in support, which shall be sole grounds for appeal, s/he may, within twenty one (21) days of receipt of notice of the recommendation, submit a written appeal of the recommendation to the CEO. If an appeal request is filed, the judicial review committee or a representative thereof may submit a written response in opposition to the request, to the CEO, within twenty one (21) days after the request is received. The appeal request shall be considered by the Board, which shall, within forty five (45) days after receipt of the appeal request, take one of the following actions:

1. Refer the matter back to the judicial review committee for further review or supplemental findings; if this is done, the judicial review committee shall respond in writing to the Board request within twenty one (21) days of request, and the Board shall then take the actions in (2), (3) or (4) below within twenty one (21) days after receipt of the response; or

2. Uphold the recommendation of the judicial review committee and take final action accordingly; or

3. Reverse or modify the recommendations of the judicial review committee with or without the requirement that further reviews be conducted by the judicial review committee; or

4. Reverse or modify the recommendation of the judicial review committee and require a special review be held in accordance with the provisions of this Article XVIII these Judicial Review Procedures.

The CEO shall advise the Affected Practitioner in writing by Special Notice of the outcome of the appeal. The Boards action on the matter shall constitute the final decision of the Board.

Final Board action that adversely affects a Practitioner shall be reported by the Hospital according to State of Iowa Law and National Practitioner Data Bank (NPDB) reporting guidelines.

Section 12 Privileged Communications

To the fullest extent possible, matters reported, investigated and heard under this Section shall be deemed "peer review records." Said records are privileged and confidential and are not subject to discovery, subpoena, or other means of legal compulsion. Said records are not admissible into evidence in a judicial or administrative proceeding, other than a proceeding involving licensee discipline. To the fullest extent possible, a person's service on a judicial review committee shall be considered as service on a peer review committee, and said person shall not be civilly liable as a result of acts, omissions or decisions made in connection with the person's service on said committee. Such immunity from civil liability shall not apply if an act, omission or decision is made with malice. By accepting membership on the Medical Staff, each member thereof waives any right of personal redress against other members of the Medical Staff, Hospital, or it's officers, directors, trustees, employees and agents, to include any and all members of the Judicial Review Committee, for actions taken in good faith under this Article XVIII.

This is a confidential professional/peer review and quality assessment and improvement process. Unauthorized disclosure is prohibited pursuant to the provisions of Iowa Statutes ICA 22.7; 135.40-135.42, 147.135.