



<b>Current Status:</b> <i>Active</i>		<b>PolicyStat ID:</b> 9460856
	<b>Origination:</b>	03/2017
	<b>Effective:</b>	03/2021
	<b>Last Approved:</b>	03/2021
	<b>Last Revised:</b>	03/2021
	<b>Next Review:</b>	03/2024
	<b>Owner:</b>	<i>Suzan Brunes</i>
	<b>Area:</b>	<i>P Provider Services - Policies/ Bylaws/Credentialin</i>
	<b>References:</b>	
	<b>Applicability:</b>	<i>MercyOne North Iowa Medical Center</i>

## Medical Staff by Laws

### PART I: DEFINITIONS

**Administration:** The executive and administrative organization of the Mercy Medical Center – North Iowa (Medical Center.)

**Admitting Privileges:** Authority issued to admit patients to Medical Center. Individuals with admitting privileges may practice only within the scope of the clinical privileges granted by the Board.

**Advance Directive:** A document or documentation allowing a person to give directions about future medical care or to designate another person(s) to make medical decisions if the individual loses decision-making capacity. Advance directives may include living wills, durable powers of attorney, do-not-resuscitate (DNR) orders, right to die, or similar documents expressing the individual's preferences as specified in the Patient Self-Determination Act.

**Advocate:** A person who may be appointed in the Fair Hearing process to represent the position adverse to the Affected Practitioner.

**Affected Practitioner:** A Medical Staff member, non-physician health care practitioner or initial applicant to whom a Medical Staff or Ministry Organization Board recommendation was made or an action taken.

**Advanced Registered Nurse Practitioner (ARNP):** An individual who is not a member of the Medical Staff, but is qualified by training and by licensure, to assist, facilitate, and/or complement the work of physicians, dentists, podiatrists. ARNPs are allowed to perform defined patient evaluations and/or treatments approved by the Board. A registered nurse who has completed all requirements to practice as an advanced registered nurse practitioner and who is registered with the Iowa Board of Nursing to practice shall use the title ARNP. The specialty areas of nursing practice for the ARNP include: Certified Clinical Nurse Specialists (CCNS), Certified Nurse-Midwife (CNM), Certified Nurse Practitioner (CNP), and Certified Registered Nurse Anesthetists (CRNA).

**Advanced Registered Nurse Practitioner (ARNP) Staff:** A group of advanced registered nurse practitioners who are granted appointment by the Board. ARNP staff includes Certified Clinical Nurse Specialists (CCNS), Certified Nurse-Midwife (CNM), Certified Nurse Practitioner (CNP), and Certified Registered Nurse Anesthetists (CRNA).

**Attending Physician:** The practitioner who is responsible for the management, coordination and quality of a patient's care, treatment and services, and the clinical accuracy of the medical record

- When an intervention, surgery, or a procedure is performed on the patient, the physician providing the service is the attending physician. (Clarification – if a patient is admitted for elective surgery or intervention and it is determined before or shortly after admission, the surgeon or interventional practitioner is the attending physician. If a patient is admitted for complex medical problems and is followed throughout the hospital stay by the medical physician, the medical physician is considered the attending physician, even though a surgical or

invasive consultation or intervention occurs.)

- In OB, the physician present at delivery is the attending physician. If a primary physician calls in an obstetrician for consultation, the primary care attending physician remains the attending physician. If the obstetric consultation results in a C-Section the obstetrician assumes care of the patient. He/she becomes the attending physician.
- The discharging provider documents in the discharge order, who the attending physician is at the time of discharge. In cases where no surgery is performed, the physician providing the "majority of care" is considered the attending physician, unless the care of the patient was transferred to another physician.
- The Patient Registration department is notified when there is a change in the attending physician.
- On-call physicians complete an order to "designate the attending physician."
- Physicians transferring care to another physician complete an order to "change attending physician."
- A Fellow, Resident, or Non-Physician Health Care Practitioner cannot be designated as an attending physician in the electronic medical record. A Fellow, Resident, or NPHCP can only be assigned attending privileges in the electronic registration application for the purposes of ordering tests.

**Board:** Mercy Medical Center-North Iowa Board of Directors or Ministry Organization Board - MOB

**Certified Clinical Nurse Specialist (CCNS):** An ARNP prepared at the master's or doctoral level who possesses evidence of current advanced level certification as a clinical specialist in an area of nursing practice by a national professional nursing certifying body as approved by the Iowa Board of Nursing.

**Certified Nurse-Midwife (CNM):** An ARNP educated in the disciplines of nursing that has advanced knowledge of nursing, physical and psychosocial assessment, appropriate interventions, and management of health care, and who possesses evidence of current certification by a national professional nursing certifying body approved by the Iowa Board of Nursing. The CNM is authorized to manage the care of normal newborns and women, antepartally, intrapartally, postpartally, or gynecologically.

**Certified Nurse Practitioner (CNP):** An ARNP educated in the disciplines of nursing that has advanced knowledge of nursing, physical and psychosocial assessment, appropriate interventions, and management of health care, and who possesses evidence of current certification by a national professional nursing certifying body approved by the Iowa Board of Nursing.

**Certified Registered Nurse Anesthetist (CRNA):** An ARNP educated in the disciplines of nursing and anesthesia that possesses evidence of current advanced level certification or recertification, as applicable, by a national professional nursing certifying body approved by the Iowa Board of Nursing.

**Chief Executive Officer (CEO):** the individual appointed by the Board to act on its behalf in the overall leadership of the Medical Center. The term "Chief Executive Officer" includes a duly appointed acting administrator to serve when the Chief Executive Officer is away from the Medical Center. The Medical Staff and the NPHCP Staff may rely upon all actions of the CEO as being the actions of the Board taken pursuant to a proper delegation of authority from the Board. In a Fair Hearing, the CEO may designate, in writing, a person from administration to act on his/her behalf for the purpose of hearing proceedings.

**Code of Conduct:** A policy intended to set forth a procedure for resolution of complaints of disruptive conduct and / or sexual harassment brought by Hospital employees, Practitioners, patients or others about a Practitioner.

**Confidentiality:** The restriction of access to data and information to individuals who have a need, a reason, and permission for such access. An individual's right, within the law, to personal and informational privacy, including his or her health care records.

**Consult:** The consulting physician does not take over as the attending physician unless another physician completes an order to "change attending physician" or transfer care. The completion of a consultation may require multiple encounters. After the initial consultation evaluation and follow-up consultation, the consultant may be excused from the responsibility of the care of the patient or may share with the primary attending physician in

current care.

**Continuing Education:** Education beyond initial professional preparation that is relevant to the type of care delivered in an organization, that provides current knowledge relevant to an individual's field of practice or service responsibilities, and that may be related to findings from performance-improvement activities.

**Credentials:** Documented evidence of licensure, education, training, experience, or other qualifications.

**Credentialing:** The process of obtaining, verifying and assessing the qualifications of a health care practitioner to provide patient care services in or for a health care organization.

**Delinquent Medical Record:** A patient record at 25 days post discharge, which does not include all required elements.

**Department:** A structural unit of the Medical Staff in which the Department Chair is responsible for recommending privileges for individuals within the Department.

**D & O:** Directors and Officers

**Economic Credentialing** – the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges.

**EHR - Electronic Health Record**

**EMTALA** – Emergency Medical Treatment and Labor Act

**Extended Family Member** – An extended family member includes the physician's and the physician's spouse's or domestic partner's: parents, stepparents or grandparents; any child's spouse, domestic partner, or children; the siblings of the physician or the physician's spouse or domestic partner and the sibling's spouse or domestic partner.

**GMEC** – Graduate Medical Education Committee

**Hearing, Basic** - For use in the Fair Hearing, a formal hearing conducted by the Executive Committee, a subcommittee of the Executive Committee, or a committee appointed by the Board. The Basic Hearing uses simplified rules of procedure.

**Hearing, Special** - For use in the Fair Hearing, a formal hearing conducted by a specially appointed ad hoc committee or a hearing officer.

**HIPAA** - Health Insurance Portability and Accountability Act

**IBM** - Iowa Board of Medicine

**Immediate Family Member** – Immediate Family Member – An immediate family member includes the physician's spouse or domestic partner the physician's natural or adopted children or stepchildren or anyone else living with the physician.

**In Good Standing** – A Medical Staff Member or NPHCP member who is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policy of the medical staff.

**Incomplete Medical Record** - A patient record that, at the time of patient discharge, does not include all required elements, including a discharge summary and the final diagnosis (unless a final lab result is pending – in which case a note is made in the final progress note).

**Initial Applicant** - A physician, dentist, podiatrist, NPHCP making application for initial appointment to the Medical Staff.

**Investigation** – A process specifically initiated by the Medical Staff Executive Committee to determine the validity,

if any, of a concern or complaint rose against a medical staff or **NPHCP** staff member, excluding activity of the Practitioner Health Committee.

**TJC** - The Joint Commission

**Licensed Independent Practitioner (LIP)** - Any individual permitted by law and by the organization to provide care, treatment, and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted privileges.

**Medical Staff (MS)** - A group of self-governed Licensed Independent Practitioners (LIPs) who are granted appointment by the Ministry Organization Board (MOB). The Medical Staff reports to and is accountable to the Board for the quality of care, treatment and services provided to patients by practitioners with privileges. Medical Staff includes Doctors of Medicine, Doctors of Osteopathy, Doctors of Optometry, Dentists and Podiatrists.

**Medical Staff Conduct Evaluation Committee** – The organizational body established for the purpose of investigation and review of potential conduct issues of Medical Staff Members.

**Medical Staff Department** - The structured unit of the medical staff in which the Department Chair is responsible for recommending privileges in the department to the Executive Committee.

**Medical Staff Executive Committee (MSEC)** - The committee responsible for all Medical Staff affairs of the Medical Center. It serves as the primary liaison between the Medical Staff and the CEO within the context of organizational functions of governance, leadership, monitoring, and performance improvement.

**Medical Staff Member** - Any practitioner appointed to, and maintaining membership in, any category of the Medical Staff in accordance with these Bylaws, including specifically licensed allopathic physicians, osteopathic physicians, dentists, optometrists, and podiatrists who are privileged to attend patients in this Medical Center.

**Medical Staff President** – (MSP)

**Medical Staff Services** - The department of the Medical Center that includes the personnel who process all credentialing functions for the Medical Staff and NPHCP Staff.

**Ministry Organization Board (Board)** - The group responsible for conducting the ordinary business affairs of Medical Center which, for the purposes of these Bylaws and except as the context otherwise requires, is deemed to act through the authorized actions of the officers of the corporation and through the Chief Executive Officer of the Medical Center.

**Non-Physician Health Care Practitioner (NPHCP):** An individual who is not a member of the Medical Staff, but is qualified by training, and frequently by licensure, to assist, facilitate, and/or complement the work of physicians, dentists, podiatrists, and other health care professionals. NPHCP are allowed to perform defined patient evaluations and/or treatments approved by the Board.

**Non-Physician Health Care Practitioner Staff:** A group of health care professionals who are granted appointment by the Board. NPHCP Staff include specifically Advanced Registered Nurse Practitioners (ARNP) i.e. Certified Clinical Nurse Specialists (CCNS), Certified Nurse-Midwife (CNM), Certified Nurse Practitioner (CNP), Certified Registered Nurse Anesthetists (CRNA), Licensed Medical Social Workers, Licensed Marriage and Family Therapists, Licensed Mental Health Counselors, Physician Assistants, EAP Counselors, and Psychologists.

**Non-Physician Health Care Practitioner (NPHCP) Staff Member:** A professional appointed to, and maintaining membership in any category of the Non-Physician Health Care Practitioner Staff in accordance with these Bylaws who is privileged to attend patients in this Medical Center.

**Non-Physician Health Care Practitioner Student;** A person enrolled in an accredited physician assistant or advance practice nursing program and is supervised by a designated preceptor or teaching physician.

**OIG** – Office of the Inspector General

**PA** - Physician Assistant

**Patient** - Any person undergoing diagnostic evaluation or receiving medical treatment or other services under the auspices of the Medical Center.

**Patient Contact** - Any form of consultation with a patient including referral for inpatient or outpatient care.

**Policies and Procedures** – Basic principles and guidelines, approved by the Medical Staff, to direct affairs of the Medical Staff.

**Practitioner** – The Licensed Independent Practitioner (LIP) as defined above.

**Primary Source Verification** - The process by which information is obtained from the originating source.

**Practitioner Health Committee** – An ad hoc group of professionals identified per the Provider Health-Impaired Provider Medical Staff Policy.

**Privileges (clinical)** - The authorization granted by the Board to a practitioner to provide specific patient care services within defined limits, based on the individual practitioner's license, education, training, experience, health status/ability to perform, and judgment. Clinical privileges include reasonable, unrestricted access to those Medical Center resources (including equipment, facilities and Medical Center personnel), which are necessary to effectively exercise those privileges. All individuals who are permitted by law and by the Medical Center to provide patient care independently in the Medical Center are required to have delineated clinical privileges.

**Referral** – The physician to whom the patient is referred becomes the attending physician. As in the case of referrals to physician specialists or referrals to limited practitioners, the referral should be based on the individual's ability to perform the services needed by the patient.

**Resident** - A physician in specialized training. This training qualifies a physician to practice one or more specialties.

**Rules and Regulations**- The formal, approved description of how the Board, Leadership, or clinical care processes are defined, organized, and carried out.

**Senior Leadership Team** – The group of organizational Senior Leaders, who, in conjunction with the governing body, are responsible for planning, management, operational activities, and strategic planning consistent with carrying out the mission of the organization. The group may include, but is not limited to, the Chief Executive Officer, the Chief Medical Officer, the Chief Nursing Officer, Chief Operating Officer, and the Chief Financial Officer.

**Service Line** – An organized grouping of like or complimentary services.

**Special Notice** - Written notice by registered mail or certified mail, return receipt requested, or personal delivery by a Medical Center employee designated by the CEO.

**Staff** - The organized Medical Staff or NPHCP staff of the Medical Center.

**Staff Member** - A member of the Medical Staff or NPHCP staff who has been granted delineated clinical privileges.

**Telemedicine Privileges** – Authorization granted by the Medical Center to render a diagnosis or otherwise provide clinical treatment to a patient at the Medical Center through the use of electronic communication or other communication technologies.

**Temporary Privileges** - Privileges recommended by a Department Chair and granted by the CEO, or designee, for a specified, limited period of time, not greater than 120 days. The circumstances for granting temporary privileges are:

- To fulfill an important patient care, treatment, or service need; or
- When a new applicant submits a complete application that raises no concerns, and is awaiting review and approval of the MSEC and the Board. The provider can provide patient care as credentialing and privileging

processes are completed.

## **PART II: MEDICAL STAFF COMPOSITION AND FUNCTION**

MERCY MEDICAL CENTER – NORTH IOWA

### **ARTICLE I: PURPOSE**

#### **Purpose of the Medical Staff Bylaws:**

- A. Provide the framework by which the practitioner promotes and provides competent patient care at the Medical Center.
- B. Create a system of mutual rights and responsibilities between members of the Medical Staff and the Medical Center.
- C. Establish a framework for self-governance of medical staff activities and accountability to the Board.

### **ARTICLE II: MEDICAL STAFF MEMBERSHIP**

#### **Section 1. Medical Staff Membership**

- A. Appointment to the Medical Staff of the Medical Center is a privilege that is extended only to competent professionals who continuously meet the qualification standards and requirements set forth in these Bylaws and the associated policies of the Medical Staff and Medical Center.
- B. The organized Medical Staff develop criteria for Medical Staff membership, designed to assure that patients will receive competent treatment and services.
- C. A hospital-employed practitioner's employment may not be adversely affected by exercising Medical Staff duties as governed by the Medical Staff By Laws.
- D. These bylaws are intended to be binding upon the Medical Center, the Medical Staff, its members and applicants.

#### **Section 2. Qualification for Membership**

- A. Medical staff may not rely solely on licensure/certification in making a judgment on medical staff membership. Qualifications of a candidate for membership/privileges, in order for the Medical Staff to recommend a candidate be approved by the governing body, must include consideration to the individual practitioners individual character, individual competence, individual training, individual experience and individual judgment.
- B. Only physicians with a Doctor of Medicine, Doctor of Osteopathy, Doctor of dental surgery or of dental medicine, Doctor of optometry, or Doctor of podiatric medicine degree holding a license to practice in the state of Iowa, who can document their background, experience, training, judgment, individual character, demonstrated competence, physical and mental capabilities, adherence to the ethics of their profession, and ability to work with others with sufficient adequacy to assure the Medical Staff and Board that any patient treated by them in the Medical Center will be given patient care in accordance with professional standards is qualified for appointment to the Medical Staff. Each member must abide by the Organizational Integrity Program, including without limitation the Mercy Standards of Conduct as it applies to any related education, training or clinical practice requirements.
- C. Licensure to practice in Iowa or any other state, certification, fellowship or membership in any professional organization, does not entitle any professional to membership in the Medical Staff nor the ability to exercise any particular clinical privilege in the Medical Center.



- D. Medical Staff membership or clinical privileges are not to be conditioned or determined on the basis of an individual's participation or nonparticipation in a particular medical group, IPA, PPO, PHO, Medical Center-sponsored foundation or other organization or in contracts with a third party which contracts with the Medical Center.
- E. Economic credentialing is not used in medical staff membership or privileging decisions. Medical staff membership, participation in medical staff activities, clinical privileges, and access to resources or patients will not be restricted or terminated or denied because the member's financial or professional interests or plans compete with those of the hospital or system.
- F. No applicant who is currently excluded by sanction from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, or who has a recent conviction of a criminal offense related to health care, is eligible or qualified for Medical Staff membership.
- G. Documentation of completion of an approved residency is required except for special instances where privileges are granted to individuals who have:
  - 1. Exhibited a high level of expertise; and
  - 2. Experience, which is documented and has been corroborated.
- H. Only the Board makes exceptions to qualifications for membership to the Medical Staff, after recommendation from the Medical Staff Credentials Committee and the MSEC.
- I. The current Medical Staff Development Plan is amended from time to time and is considered in making appointments.

### **Section 3. Nondiscrimination**

The Medical Center does not discriminate in granting staff appointment and/or clinical privileges on the basis of age, gender, sexual orientation, race, creed, color, ethnic origin, disability, other health care organization affiliation, or other protected class against whom discrimination is prohibited by law.

### **Section 4. Conditions and Duration of Appointment**

- A. The Board makes initial appointments, reappointments, and granting of privileges to the NPHCP Staff.
- B. The Board acts on appointments and recommendations only after there has been a recommendation from the MSEC in accordance with the provisions of these Bylaws and after consideration of the Medical Staff Development Plan.
- C. Appointments to the Medical Staff are for no more than 24 calendar months.
- D. Appointment to the Medical Staff shall confer on the appointees only such clinical privileges as have been granted in accordance with the Credentials Manual.
- E. Appointment to the Medical Staff requires completion of a general orientation process or alternative orientation within 30 days of appointment or start of practice – whichever comes first.

### **Section 5. Staff Assessments**

Active Medical Staff Members are required to pay medical staff dues upon reappointment. Periodically there may be a monetary assessment of Medical Staff members which is payable upon request to the Medical Staff.

### **Section 6. Responsibilities of Membership**

Each staff member:

- A. Manages the patient's general medical condition, directs the care of her/his patients and supervises the work of any residents and/or NPHCP staff under his/her direction. (Does not apply to Resident Staff members)
- B. Provides medical assessment and treatment of patients. Performs operative and other procedures within those

areas of competence indicated by their delineated privileges

- C. Assists the Medical Center in fulfilling its responsibilities for providing emergency care, as defined by EMTALA.
- D. Assists the Medical Center in fulfilling its responsibilities for providing charitable care.
- E. Assists other practitioners in the care of their patients when asked.
- F. Is subject to all sections of the Medical Staff Bylaws.
- G. Acts in an ethical, professional, and courteous manner, and abides by the principles of ethics set forth by their specific professional association and the Medical Center Code of Conduct outlined in the Medical Staff Conduct Evaluation policy.
- H. Acts in an ethical, professional and courteous manner and abides by the Principles of Medical Ethics of the American Medical Association, the Principles of Ethics of the American Osteopathic Association, the Code of Ethics of the American Podiatry Association or by the Principles of Ethics of the American Dental Association, whichever is applicable and the Ethical and Religious Directives for Catholic Health Care Facilities.
- I. Agrees to appear before the Medical Staff Conduct Evaluation Committee, the Medical Staff Executive Committee or designated subcommittee, upon receiving a formal notice to do so. Failure to participate in such a conference will result in a suspension from the Medical Staff with complete loss of privileges until required discussions are held.
- J. Immediately notifies the Medical Center's CEO by telephone and in writing upon receiving notice of any proposed or actual exclusion or any pending investigation from any health care program or pending criminal charges related to any health care program funded in whole or in part by the federal government or by any law enforcement agency.
- K. Is immediately removed from direct responsibility for, or involvement in, any federal health care program upon notice of criminal charges related to health care, pending resolution of such charges.
- L. At least 30 days prior to the intended effective date, notifies the President of the Medical Staff or the SVP of Physician Integration of reduction or suspension of liability coverage.
- M. Will not prescribe controlled substances for him/her, extended family members, or immediate family members.
- N. Will not order diagnostic tests or procedures on him/her or immediate family members.
- O. Will not treat himself/herself or members of his/her immediate family except in an emergency setting or an isolated setting when no other qualified MS member is available.
- P. Communicates information to the CEO, the Sr. VP of Physician Integration, the Medical Staff President (MSP), or the Chair of the MS Credentials Committee regarding potential health status of self or other practitioner that would potentially compromise patient care. (Refer also to Provider Health / Impaired Provider Policies and Procedures).
- Q. Immediately notifies the Medical Staff President or the SVP of Physician Integration of any potential conflicts of interest.
- R. Maintains and routinely monitors an active e-mail account for purposes of communication with the Medical Staff Office, with the organized Medical Staff Governing Body (MSEC), and with the Credentials Committee. Shares current preferred e-mail address and any address changes to the preferred address with the Medical Staff Office. Provider Communication Guidelines will be utilized to determine the most appropriate method(s) to disseminate information. [Provider Communication Guidelines](#)

#### **Section 7. Leave of Absence (LOA)**

- A. For absences greater than 45 days, but not to exceed one year, members of the Medical Staff must apply to the MSEC for a leave of absence renewable under appropriate conditions.



- B. Privileges are suspended for the duration of the LOA.
- C. Reinstatement of staff privileges may be requested through the MSEC without formal application.

### **Section 8. Termination or Suspension of Medical Staff Membership**

Indications for recommending termination or suspension of medical staff membership include but are not limited to:

- A. Inability to provide patient care in accordance with professional standards
- B. Failure to abide by the Organizational Integrity Program
- C. Failure to abide by the Mercy Standards of Conduct
- D. Failure to maintain education, training or clinical practice requirements
- E. Failure to maintain licensure to practice in Iowa
- F. Failure to complete medical records as required by the By Laws

Refer to Bylaws Part V: Plan for Fair Hearing, for the suspension or termination process.

## **ARTICLE III: MEDICAL STAFF FUNCTIONS**

(Does not apply to Resident Staff members)

### **Section 1. Performance of Medical Staff Functions**

Effective performance of the staff functions required by the Medical Staff Bylaws or by resolution of the MSEC with Board approval is accomplished by assignment to departments, staff committees, staff officers or designees, or interdisciplinary Medical Center committees. Medical Staff Functions include:

- A. Initiate, develop, approve, enforce, and comply with Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures.
- B. Define the Medical Staff structure with Administration to assist the Board in assuring ultimate quality care for all patients. The Medical Staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the Medical Staff process.
- C. Monitor and evaluate care provided in and assist in the development of clinical policy for all patient care areas including acute care, Outpatient Areas, SNU, Acute Rehab Unit, Home Care, Hospice, and clinics.
- D. Monitors repeated and/or significant departures from established patterns of clinical practice.
- E. Oversee quality and safety activities and ensure a standard of quality of patient care. Provides leadership for process measurement, assessment, improvement and reviews; appropriateness, clinical protocols, blood usage, drug usage evaluation, medical records, quality of medical histories and physical examinations, resource utilization, invasive procedures, infection control, patient satisfaction and others.
- F. Ensures that MS and NPHCP staff members participate in the measurement, assessment and improvement of relevant patient care processes (i.e. education of patients and families, coordination of care with other practitioners and Medical Center personnel.)
- G. Conduct or coordinate credentials investigation for staff membership and makes recommendations to the governing body for each candidate for medical staff membership/privileges that are specific to type of appointment and extent of the individual practitioner's specific clinical privilege.
- H. At least every 24 months appraise the qualifications of all practitioners appointed to the medical staff/granted medical staff privileges. Based on the reappraisal of individual members, the medical staff makes recommendations to the governing body to continue, revise, discontinue, limit or revoke some or all of the practitioner's privileges.

- I. Review and agree upon the mechanisms for supervision of residents and the circumstances in which they apply.
- J. Assure the provision for continuing education opportunities responsive to quality assessment/ improvement activities, new state-of-the-art developments and other perceived needs.
- K. Provide Medical Staff input to the plans for disaster preparation.
- L. Direct staff organization activities including staff bylaws review and revision; staff officer and committee nominations; liaison with the Board and Medical Center Administration; and review and comply with all Medical Center regulatory and accreditation agencies.
- M. Assure compliance with EMTALA, CMS Conditions of Participation, Joint Commission Accreditation Standards and HIPAA Standards.
- N. Assure the coordination among Medical Staff, Patient Services and other Departments for quality patient care.
- O. Engage in other functions reasonably requested by the MSEC and Board.

## **ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF**

[SEE TABLE I: CATEGORIES OF MEDICAL STAFF](#)

## **ARTICLE V: OFFICERS**

### **Section 1. Officers of the Medical Staff**

The officers of the Medical Staff are:

- A. President
- B. President-Elect
- C. Secretary/Treasurer

### **Section 2. Qualifications of the Officers**

- A. Officers must be members of the active MS at the time of nomination and election.
- B. Officers must remain members of the active MS in good standing during their terms of office.

### **Section 3. Election of Officers**

- A. Officers are elected at the annual meeting of the MS. Only the active members on MS are eligible to vote.
- B. The Nominating Committee is appointed by the MSEC. Members include the three most recent past presidents of the Medical Staff, with the immediate past president as Chair.
- C. Nominations may also be made by petition to the nominating committee signed by at least ten percent of the active and provisional active members of the Medical Staff. Such a petition must be submitted to the MSEC at least 15 days prior to the annual Medical Staff meeting.

### **Section 4. Term of Office**

The President, President-Elect, and Secretary/Treasurer assume office on the first day of the calendar year and each serve a term of two years.

### **Section 5. Vacancies in Office**

- A. Vacancies in term of office, except for the office of President, are filled by the MSEC.
- B. The President-Elect, for the remainder of the term, fills a vacancy in the office of President.

## **Section 6. Duties of Officers**

### **A. President:**

The President serves as Chief Administrative Officer of the Medical Staff and fulfills those duties specified in the Bylaws, Fair Hearing, Credentialing, and Medical Staff Policy and Procedure manuals.

### **B. President-Elect:**

In the absence of the President, the President-Elect assumes the duties and authority of the President. This individual performs such further duties to assist the President as requested.

### **C. Secretary/Treasurer:**

The Secretary/Treasurer assures that accurate and complete minutes of all Medical Staff meetings are kept, calls Medical Staff meetings by order of the President, attends to all correspondence, sees to the administration of staff expenditures, the collection of assessments and performs such other duties as ordinarily pertain to his/her office. He/she serves as the Chairperson of the Credentials Committee.

## **Section 7. Medical Staff members as Agents of the Medical Center**

Medical Staff members, acting as agents of the Medical Center, performing activities at the request of the Medical Center or Medical Staff as Medical Staff Officers or Directors, appointees to committees—whether they are employees or not, are covered by the Medical Center's Directors' & Officers' insurance coverage.

## **Section 8. Removal from Office**

### **A. The MSEC, by a two-thirds vote, may remove any MS officer for:**

1. Failure to accept responsibilities assigned by these Bylaws, Fair Hearing Manual, Credentialing Manual, Code of Conduct, and/or the Medical Staff Rules and Regulations.
2. If the officer is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office.

### **B. Notice of the meeting, at which such action will be decided, is given in writing to the officer at least 10 days prior to the date of the meeting. The officer is afforded the opportunity to speak prior to any vote.**

### **C. An officer who is found by the MSEC to no longer meet all of the qualifications for officers set forth in these bylaws shall automatically relinquish his/her office.**

# **ARTICLE VI: DEPARTMENTS**

## **Section 1. Organization of Departments**

### **A. The Medical Staff is organized into four departments:**

1. Family Medicine
2. Medicine
3. Surgery
4. Maternal and Child Health

### **B. All MS and all NPHCP staff members are assigned to a department, dependent on their discipline and, at times, personal request.**

## **Section 2. Qualifications, Selection, and Tenure of Department Chairpersons**

### **A. Each Chairperson:**

1. Is an Active member of the Medical Staff.
2. Is willing and able to discharge the functions of his/her office.

3. Is certified by a Board in a specialty relevant to the services provided by the Department (American Board of Medical Specialties or the American Osteopathic Association).
  4. He/she must meet the qualifications and perform the functions specified in the Bylaws, Credentials Manual, Fair Hearing Manual, and Policy and Procedure Manual.
- B. Clinical privileges within any clinical Department are subject to the Policies and Procedures of that Department and to the authority of the Department Chair.
- C. Department Chairpersons are selected by their individual departments and are submitted to the MSEC.
- D. Department Chairpersons may be removed from office by a two-thirds vote of the entire voting MSEC for:
1. Failure to accept responsibilities assigned by these Bylaws, Fair Hearing Manual, Credentialing Manual, Code of Conduct, and/or the Medical Staff Rules and Regulations.
  2. If the department chairperson is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office.
- E. Notice of the meeting at which such action will be decided is given in writing to the department chairperson at least 10 days prior to the date of the meeting. The department chairperson is afforded the opportunity to speak prior to any vote.
- F. A department chairperson who is found by the MSEC to no longer meet all of the qualifications for department chairs set forth in these bylaws shall automatically relinquish his/her office.
- G. Department Chairpersons assume office on the first day of the calendar year and serve a term of two years, with no limit on the number of terms that can be served.
- H. The Medicine and Maternal/Child Health Department Chairpersons are selected in years ending in even numbers. Surgery and Family Medicine Department Chairpersons are selected in years ending in odd numbers.
- I. Responsibilities of Department Chairpersons:
1. Member of the Medical Staff Executive Committee.
  2. All clinically related activities of the department.
  3. All administratively related activities of the department except those provided for by the Medical Center.
  4. Continuing surveillance of the professional performance of all individuals in the department with delineated privileges as outlined in the Medical Staff Professional Practice Evaluation policy.
  5. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided by members within the department.
  6. Recommending clinical privileges for each member of the department.
  7. Assessing and making recommendations to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.
  8. The integration of the department into the primary functions of the organization.
  9. The coordination and integration of interdepartmental and intradepartmental services.
  10. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
  11. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.
  12. The determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care.

13. The continuous assessment and improvement of the quality of care, treatment, and services.
14. The maintenance of quality control programs, as appropriate.
15. The orientation and continuing education of all persons in the department or service
16. Recommendations for space and other resources needed by the department or service

### **Section 3. Functions of Departments**

Each Department:

- A. Assures participation in the organization's quality improvement teams and supports the Quality Plan of the Medical Center approved by the MSEC.
- B. Conducts the necessary business of the department.
- C. Makes recommendations to Administration regarding strategic planning, budgeting, and capital requests.
- D. Participates in and maintains compliance with Joint Commission regulations and other regulatory agencies, and cooperates with these survey processes.
- E. Establishes credentialing criteria for appointment, reappointment, and privilege delineation of department members.
- F. Reviews candidate applications for conformance with credentialing criteria and reports findings to the Credentials Committee.

## **ARTICLE VII: COMMITTEES**

[See TABLE II: MEDICAL STAFF COMMITTEES AND MEETINGS](#)

### **Section 1. Medical Staff Committees Determination**

- A. A Medical Staff committee is one that requires a medical staff member to serve as a chairperson:
  1. Medical Staff Executive Committee
  2. Medical Staff Credentials Committee
  3. Medical Staff Conduct Evaluation Committee
- B. Additional committees deemed necessary but not required by the Joint Commission may be designated as Medical Staff Committees:
  1. NPHCP Credentials Sub-Committee
  2. Oncology Committee
  3. Trauma Committee
- C. Any Medical Director of a Service Line, or representative from a Service Line, with approval of the Medical Director, may attend a MSEC meeting when an issue directly relating to the Service Line is on the agenda. The Medical Director or representative has the right to participate in the discussion but cannot vote.

## **ARTICLE VIII: MEDICAL STAFF MEETINGS**

[SEE TABLE II: MEDICAL STAFF COMMITTEES AND MEETINGS](#)

### **Section 1. Meeting Attendance by Non-Medical Staff Members**

The CEO and any representative assigned by the CEO may attend committee meetings, department meetings, or the Medical Staff meeting.

## **Section 2. Meeting Format**

When questions arise regarding voting/selection procedure or other topics, the authority will be Robert's Rules of Order.

## **Section 3. Meeting Record**

A Meeting Record of each regular and special meeting of a committee or department is prepared. The meeting record is signed by the designated secretary/recorder and copies are submitted to the MSEC. Minutes of each committee and department meeting are maintained in a permanent file.

# **ARTICLE IX: RIGHTS OF MEDICAL STAFF MEMBERS**

(Does not apply to Resident Staff members)

## **Section 1. Right to Meet with the MSEC**

Each Medical Staff member has a right to meet with the MSEC. In the event a Medical Staff member is unable to resolve a difficulty working with his/her respective department chair, that Medical Staff member may, upon presentation of written notice, meet with the MSEC to discuss the issue.

## **Section 2. Calling a General Staff Meeting**

Any Medical Staff member may call a General Staff meeting upon presentation of a petition signed by not less than 20% of the active staff. The MSEC will schedule a General Staff meeting for the specific purpose addressed by the petition written notice. No business other than that in the petition written notice may be transacted.

## **Section 3. Challenge**

Any Medical Staff member may raise a challenge to any rule or policy established by the MSEC. In the event a rule, regulation or policy is felt to be inappropriate, any Medical Staff member may submit a petition signed by no less than 20% of the members of the active staff. When such a petition has been received by the MSEC, it will either: (1) provide the petitioner(s) with information clarifying the intent of such rule, regulation, or policy and/or (2) schedule a meeting with the petitioner(s) to discuss the issue.

## **Section 4. Department Meeting Requests**

Any subspecialty group may request a department meeting when a majority of the members believe the department has not acted appropriately.

## **Section 5. Exclusions**

This Article does not pertain to issues involving conduct, disciplinary action, and denial of requests for appointment, clinical privileges, or any other matter relating to individual "credentialing" actions. The Plan for Fair Hearing provides recourse in these matters.

## **Section 6. Fair Hearing**

Any Active or Affiliate MS member has the right to the procedural protections set out in the Plan for Fair Hearing.

# **ARTICLE X: IMMUNITY FROM LIABILITY**

The following shall be conditions expressed to any Medical Staff member's application for or exercise of clinical privileges at this Medical Center.

## **Section 1. Quality Patient Care**

Any act, communication, report, recommendation, or disclosure, with respect to any Medical Staff member,



performed or made in good faith 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.

## **Section 2. Identified Individuals**

Such privileges extend to members of the Medical Staff and Board, the 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 Article X, the term "third parties" means both individuals and organizations from which an authorized representative of the Board or of the Medical Staff has requested information.

## **Section 3. Civil Liability**

There shall be, to the fullest extent permitted by law, 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.

## **Section 4. Credentialing and Review**

Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this health care institution's activities related, but not limited to: (A through G below do not apply to Resident Staff members)

- A. Applications for appointment or clinical privileges.
- B. Periodic reappraisals for reappointment or clinical privileges, including information for peer review.
- C. Corrective action, including summary suspension.
- D. Hearings and appellate reviews.
- E. Medical care evaluations.
- F. Utilization reviews.
- G. Other Medical Center, departmental, service or committee activities related to quality patient care and inter-professional conduct.

## **Section 5. Rights of Medical Staff Members**

The acts, communications, reports, recommendations and disclosures referred to in Article IX may relate to a Medical Staff member'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.

## **Section 6. Releases**

That in furtherance of the foregoing, each Medical Staff member shall, upon request of the Medical Center, execute releases in accordance with the tenor and import of Article X in favor of the individuals and organizations specified in Section 2, 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.

## **Section 7. Applications for Initial Appointment** (Does not apply to Resident Staff members)

The consents, authorizations, releases, rights, privileges, and immunities provided by Article I, Sections 1 and 2, of the Credentials Manual of the Bylaws for the protection of Medical Staff members, other appropriate Medical Center 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 Article X.

# ARTICLE XI:

## Section 1: Conflict Management

The organized medical staff utilizes Administrative Policy, "Conflict Management for Leadership Groups" to manage conflict between the Medical Staff and the MSEC on issues including, but not limited to, proposals to adopt a rule, regulation or policy, or an amendment. The Board has ultimate authority to resolve conflict.

# ARTICLE XII:

## Section 1: Requirements for Completing and Documenting Medical History and Physical Examination

- A. Who can perform history and physical (H & P)?
  - Medical history and physical pertinent to the patient's general health: MD, DO, ARNPs, and PAs that are privileged to do so at the Medical Center. Part of an H & P can be appropriately delegated to a qualified non-LIP as long as the H & P is authenticated and co-signed by a MS member.
  - Detailed dental H & P: DDS
  - Detailed podiatric H & P: DPM
- B. Nature and Scope of H&P is determined by the MS
- C. Elements of an H&P for Admission must include:
  - Chief complaint
  - Details of the present illness
  - Relevant past medical history
  - Social and family histories
  - Patient's emotional, behavioral and social status, when appropriate
  - All pertinent findings resulting from a comprehensive, current assessment of all body systems
- D. Extent of an H&P for outpatient procedures is determined by level of anesthesia.
  - Topical, local, regional or no anesthesia requires mental assessment and a physical exam specific to the planned procedure.
  - IV Sedation: requires mental assessment and a physical exam specific to the planned procedure PLUS an exam of the heart and lungs by auscultation.
  - General, Spinal or Epidural: requires mental assessment and a physical exam specific to the planned procedure PLUS an exam of the heart and lungs by auscultation PLUS assessment and written statement about the patient's general condition.
- E. Timing
  - An H & P is recorded in the medical record within 24 hours of admission.
  - An H & P must be completed prior to the performance of any surgery, invasive procedure or potentially hazardous diagnostic procedure. If, at the time of the procedure, a valid H&P is not on the chart and the patient is not in a designated inpatient status, the physician may complete a predetermined H&P form. If the patient status becomes inpatient, a complete H&P for admission must be documented through dictation, or by documenting directly into the Electronic Medical Record.
- F. Use of Previous H & P or Non-Medical Center H & P
  - A previous (within 30 days) H & P may be used. H & P's over 30 days old are not valid, thus requiring a

new H & P to be performed. For an H & P that was completed within 30 days, an update documenting any changes in the patient's condition is completed within 24 hours prior to surgery or a procedure requiring anesthesia services. H & P's submitted by non-Medical Center privileged providers must be reviewed, updated and signed by the attending physician. Use of the Medical Center's H & P update form can be used for this purpose.

## **ARTICLE XIII: ADOPTION AND AMENDMENT OF THE BYLAWS**

### **Section 1. Adoption**

All sections of these Medical Staff Bylaws (Definitions, Medical Staff Bylaws, NPHCP Bylaws, Credentials, and Fair Hearing) shall be adopted at any regular or special meeting of the Medical Staff, shall replace any previous Bylaws, and shall become effective following approval of the Board. Adoption or amendment of the Bylaws cannot be delegated by the organized Medical Staff unless an emergent amendment process is required as outlined by Article XIII, Section 2 (B).

### **Section 2. Bylaws Amendment**

#### **A. Non Urgent Amendment / Approval Process**

1. Any suggested non urgent amendment to the bylaws will be discussed and approved at the annual meeting of the organized Medical Staff requiring an affirmative 50% plus 1 vote cast by active members present.
  - a. If a voting member of either the organized Medical Staff or MSEC proposes to adopt a rule, regulation, or amendment, it will be electronically communicated to each other at least two weeks prior to the annual meeting. This communication will outline the verbiage changes to the existing document, displaying the present and proposed changes.
  - b. Notification of any proposed amendments will be electronically communicated to all Active, Affiliate, Provisional, Fellow, and Resident members of the Medical Staff and all members of the NPHCP Staff.
2. Amendments so made shall be effective when approved by the Board.

#### **B. Urgent Amendment / Approval Process**

In the event an urgent amendment is necessary to comply with law or regulation, the MSEC is delegated the ability by the voting members of the organized medical staff, This provision allows the MSEC to provisionally adopt and the governing body to provisionally approve the urgent amendment without prior notification of the medical staff. In such a case, the medical staff will be immediately notified by the MSEC. The Medical Staff then has the opportunity for retrospective review and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MSEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the MSEC is implemented. If necessary, a revised amendment is then submitted to the governing body for action. All urgent amendments approved throughout the year will be discussed and approved by the annual meeting of the organized Medical Staff.

C. All sections of the Medical Staff Bylaws are integral components of the Medical Staff Bylaws subject to the amendment and adoption provisions.

D. All sections of the Medical Staff Bylaws are revised and amended as frequently as necessary to reflect the Medical Center's current practice with respect to Medical Staff organizational functions or at least every three years.

E. All sections of the Medical Staff Bylaws will not conflict with the policies and bylaws of the Board. Any

administrative policies and procedures referenced in the Medical Staff Bylaws will be approved by the MSEC.

**Section 3. Access to Medical Staff Bylaws**

All sections of the Medical Staff Bylaws are available on the Medical Center's Intranet. An electronic copy is offered to each new medical staff member at time of initial appointment.

**ARTICLE XIV: ADOPTION AND AMENDMENT OF MEDICAL STAFF RULES AND REGULATIONS**

**Section 1. Adoption and Amendment**

- A. If the voting members of either the organized Medical Staff or MSEC propose to adopt or change a policy or procedure the proposed change discussed at any regular or special meeting of the MSEC. MSEC has the authority to amend or adopt any Medical Staff Rule or Regulation. Newly approved Rules and Regulations, shall replace any previous Rules and Regulations, and shall become effective when approved by the MSEC. Notifications of all changes are electronically communicated to all Active, Affiliate, Provisional, Fellow, and Resident members of the Medical Staff and all members of the NPHCPStaff. The approved document will be posted on the Medical Center's intranet.
- B. The Medical Staff Policies and Procedures are revised and amended as frequently as necessary to reflect the Medical Center's current practice OR at least every three years.
- C. The Rules and Regulations will not conflict with the policies and bylaws of the Board.
- D. Any administrative policies and procedures referenced in the Medical Staff Policies and Procedures need to be approved by the MSEC.

**Section 2. Access to Medical Staff Rules and Regulations**

All sections of the Medical Staff Bylaws are available on the Medical Center's Intranet. An electronic copy is offered to each new medical staff member at time of initial appointment.

**ARTICLE IV TABLE I: CATEGORIES OF MEDICAL STAFF**

	<b>QUALIFICATIONS</b>	<b>PREROGATIVES</b>	<b>RESPONSIBILITIES</b>
ACTIVE	Involved in a minimum of 10 patient contacts annually. <b>AND</b> Has completed the initial Focused Professional Practice Evaluation requirement <b>AND</b> Has written documentation by the department chair or designee of satisfactory performance.	<ul style="list-style-type: none"> <li>• May exercise the privileges granted without limitations except as otherwise provided in the Medical Staff Rules and Regulations or by specific privilege restriction.</li> <li>• May vote on all matters presented at general and special meetings of the Medical Staff and of Departments and Committees to which he/she is appointed.</li> <li>• May hold office and sit on or chair any committee unless otherwise specified in these Bylaws.</li> <li>• May be appointed on a</li> </ul>	<ul style="list-style-type: none"> <li>• Must contribute to the organizational administrative affairs of the Medical Staff.</li> <li>• Must actively participate in recognized functions of staff appointment including quality improvement, other monitoring activities, and other staff functions as may be required from time to time.</li> <li>• Must participate in Emergency Center and</li> </ul>

	QUALIFICATIONS	PREROGATIVES	RESPONSIBILITIES
		temporary basis.	<p>other specialty coverage programs, as determined by the MSEC.</p> <ul style="list-style-type: none"> <li>• Will comply with EMTALA.</li> </ul>
AFFILIATE	<p>Interested in the clinical affairs of the Medical Center. OR Admits or otherwise is involved in the care and treatment of patients. OR Refers patients to Medical Center Staff physicians. OR Orders diagnostic or therapeutic services at the Medical Center. AND Has completed the initial Focused Professional Practice Evaluation requirement AND Has written documentation by the department chair or designee of satisfactory performance.</p>	<ul style="list-style-type: none"> <li>• May exercise privileges the same as Active status.</li> <li>• May attend meetings of the Medical Staff, meetings of the department he/she is appointed to, and educational programs.</li> <li>• May NOT vote at meetings of the Medical Staff and Departments.</li> <li>• May vote at meetings of Committees to which he/she is assigned.</li> <li>• May be appointed on an interim or temporary basis.</li> </ul>	<ul style="list-style-type: none"> <li>• Must participate in Emergency Center and other specialty coverage programs as determined by the MSEC.</li> <li>• Will comply with EMTALA.</li> </ul>
PROVISIONAL ACTIVE AND AFFILIATE	<p>All initial appointments to any category of the Medical Staff are Provisional until:</p> <ol style="list-style-type: none"> <li>1. Involved in a minimum of 10 patient contacts annually <b>AND</b></li> </ol>	<ul style="list-style-type: none"> <li>• Is assigned to a department where his /her performance is observed by the department chair or designee to determine eligibility for active or affiliate staff membership and for exercising the clinical privileges provisionally granted to him/her.</li> <li>• Provisional-Affiliates may NOT</li> </ul>	<ul style="list-style-type: none"> <li>• Must participate in Emergency Center and other specialty coverage programs as determined by the MSEC.</li> <li>• Will comply with EMTALA.</li> </ul>

	QUALIFICATIONS	PREROGATIVES	RESPONSIBILITIES
	<p>2. Has completed the initial Focused Professional Practice Evaluation requirement</p> <p><b>AND</b></p> <p>3. Has written documentation by the department chair or designee of satisfactory performance for a minimum of twelve months.</p> <p>Can be reappointed to Provisional status but total may NOT exceed two years.</p> <p>Failure to advance to Active or Affiliate Staff is deemed a termination of his/her appointment.</p>	<p>vote at general and special meetings of the Medical Staff, or meetings of the department, but may vote at committees to which he/she has been appointed.</p> <ul style="list-style-type: none"> <li>• A provisional appointee is not eligible for the Fair Hearing process.</li> </ul>	
HONORARY	<ul style="list-style-type: none"> <li>• Restricted to retirees and/or those that the Medical Staff wish to honor.</li> </ul>	<ul style="list-style-type: none"> <li>• May NOT admit patients or exercise clinical privileges in the Medical Center.</li> <li>• May attend Medical Staff meetings and/or department meetings, educational and social events.</li> <li>• Does NOT vote at Medical Staff meetings, department meetings or committee meetings.</li> </ul>	
RESIDENT	<ul style="list-style-type: none"> <li>• A physician in specialized training, qualifying the physician to</li> </ul>	<ul style="list-style-type: none"> <li>• May attend Medical Staff meetings and/or department meetings.</li> <li>• Does NOT vote at Medical Staff meetings or department</li> </ul>	



	<b>QUALIFICATIONS</b>	<b>PREROGATIVES</b>	<b>RESPONSIBILITIES</b>
	practice in one or more specialties.	meetings. <ul style="list-style-type: none"> <li>• May vote at committees to which he/she has been appointed.</li> <li>• Is not eligible for Fair Hearing, but is entitled to "Due Process" as defined within the Medical Center's Family Medicine Residency program and the GMEC.</li> </ul>	
FELLOW	<ul style="list-style-type: none"> <li>• A physician in specialized training, qualifying the physician to practice in one or more specialties.</li> </ul>	<ul style="list-style-type: none"> <li>• May attend Medical Staff meetings and/or department meetings.</li> <li>• Does NOT vote at Medical Staff meetings or department meetings.</li> <li>• May vote at committees to which he/she has been appointed.</li> <li>• Is not eligible for Fair Hearing, but is entitled to "Due Process" as defined by the GMEC and MSEC.</li> </ul>	
ORDER ONLY: DIAGNOSTIC TESTS AND REHABILITATIVE SERVICES	<ul style="list-style-type: none"> <li>• Licensed MD, DO, DPM, DC, or DDS in any U.S. state.</li> </ul>	<ul style="list-style-type: none"> <li>• Not eligible for Fair Hearing.</li> </ul>	<ul style="list-style-type: none"> <li>• Must provide full name and address in order that current licensure can be verified.</li> <li>• Must provide location and means to transmit the test result(s).</li> </ul>
DICTATE H & P'S ONLY:	<ul style="list-style-type: none"> <li>• Licensed MD, DO, DPM or DDS in any U.S. state.</li> </ul>	<ul style="list-style-type: none"> <li>• Not eligible for Fair Hearing.</li> </ul>	<ul style="list-style-type: none"> <li>• Must provide full name and address in order that current licensure can be verified.</li> </ul>
REFER AND FOLLOW	<ul style="list-style-type: none"> <li>• Licensed MD, DO, DPM or DDS in any U.S. state.</li> </ul>	<ul style="list-style-type: none"> <li>• After referral of a patient to a Medical Center Active or Affiliate MS member, may visit and follow the patient without provision of direct patient care.</li> <li>• Does not attend or vote at Medical Staff meetings.</li> <li>• Not eligible for Fair Hearing process.</li> <li>• Is not the Attending Physician.</li> </ul>	

# ARTICLE VII

## TABLE II: MEDICAL STAFF COMMITTEES AND MEETINGS

	MEMBERSHIP / TERM	ATTENDANCE	Functions
MEDICAL STAFF	<b>As defined in ARTICLE II: MEDICAL STAFF MEMBERSHIP</b>	<p><b>MEDICAL STAFF ANNUAL MEETING</b></p> <p><b>Meeting Frequency -</b> Annually - At least 20 days before end of calendar year.</p> <p><b>Meeting Notice</b> Written notice sent to all categories of members and/or conspicuously posted at least seven days prior to the meeting</p> <p><b>Attendance</b> Members of the Medical Staff are encouraged to attend; attendance records are not used by the Credentials Committee in evaluation of members for reappointment</p> <p><b>Quorum</b> Those active members present and voting. The President may vote</p> <p><b>Meeting Documentation</b> Permanent meeting record maintained</p>	<ul style="list-style-type: none"> <li>• To report on the activities of the staff.</li> <li>• To conduct other business on the agenda.</li> <li>• Elect officers, if necessary</li> </ul>
	<b>As defined in ARTICLE II: MEDICAL STAFF MEMBERSHIP</b>	<p><b>MEDICAL STAFF SPECIAL MEETING</b></p> <p><b>Meeting Frequency</b> Called by President at any time, OR Within 20 days after the receipt of a written request signed by not less than 20% of the active medical staff, OR</p>	<ul style="list-style-type: none"> <li>• To transact ONLY the business that is stated in the notice</li> </ul>

		<p>Upon a resolution of the Medical Executive Committee.</p> <p><b>Meeting Notice</b> The request or resolution must state the purpose of the meeting. The President designates the time and place. Written notice sent to all categories of members and/or conspicuously posted at least seven days before the meeting.</p> <p><b>Attendance</b> Members of the Medical Staff are encouraged to attend; attendance records are not used by the Credentials Committee in evaluation of members for reappointment</p> <p><b>Quorum</b></p> <ul style="list-style-type: none"> <li>• Quorum is those active members present and voting.</li> <li>• Absentee ballots may be used at the discretion of the President; if used the quorum is all those voting.</li> <li>• The President may vote.</li> </ul> <p><b>Meeting Documentation</b> Permanent meeting record maintained</p>		
	<p><b>As defined in ARTICLE II: MEDICAL STAFF MEMBERSHIP</b></p>	<p>DEPARTMENT REGULAR</p> <p><b>Meeting Frequency</b> The Chair designates frequency, time, and place.</p> <p><b>Meeting Notice</b> Written notice sent to all categories of members and/or conspicuously posted at least seven days before the meeting.</p> <p><b>Attendance</b></p>	<p>Is responsible for carrying out necessary business of the department and making recommendations to administration regarding strategic planning, budgeting, capital requests, maintaining compliance with Joint Commission and other regulatory agencies and cooperation with the survey process.</p>	

		<p>Members of the Medical Staff are encouraged to attend; attendance records are not used by the Credentials Committee in evaluation of members for reappointment.</p> <p><b>Quorum</b> Quorum is those active members present and voting. The Chairperson may vote.</p> <p><b>Meeting Documentation</b> Permanent meeting record maintained</p>		
	<p>As defined in ARTICLE II: MEDICAL STAFF MEMBERSHIP</p>	<p><b>DEPARTMENT SPECIAL Meeting Frequency</b> Called by or at the request of the Chair or by the President. The Chair or President designates time and place.</p> <p><b>Meeting Notice</b> Written notice sent to all categories of members and/or conspicuously posted at least seven days before the meeting</p> <p><b>Attendance</b> Any Medical Director of a Service Line, or representative from a Service Line, with approval of the Medical Director, may attend a Medical Executive Committee meeting when an issue directly relating to the Service Line is on the agenda.</p> <p>Members of the Medical Staff are encouraged to attend; attendance records are not used by the Credentials Committee in evaluation of members for reappointment.</p> <p><b>Quorum</b> Quorum is those active</p>	<p>To transact ONLY the business that is stated in the notice</p>	

		<p>members present and voting. The Chairperson may vote.</p> <p><b>Meeting Documentation</b> Permanent meeting record maintained</p>	
<p>MEDICAL STAFF EXECUTIVE COMMITTEE (MSEC)</p>	<p><b>Term</b> All appointments are for a two-year term</p> <p><b>Membership</b></p> <ul style="list-style-type: none"> <li>• President of Medical Staff (Chairperson).</li> <li>• Past President.</li> <li>• President-Elect.</li> <li>• Secretary/Treasurer.</li> <li>• Chairperson of each department.</li> <li>• Senior Vice President of Physician Integration (ex-officio with no vote).</li> <li>• President/CEO or his/her designee (ex-officio with no vote).</li> <li>• Chief Nursing Officer</li> </ul> <p>All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the medical staff executive committee.</p> <p>May include other</p>	<p><b>MEDICAL STAFF EXECUTIVE COMMITTEE</b></p> <p><b>Meeting Frequency</b> Monthly - The Chair designates time and place.</p> <p><b>Meeting Notice</b> Written notice sent to all categories of members and/or conspicuously posted at least seven days before the meeting.</p> <p><b>Attendance</b> Members are expected to attend at least 50% of the meetings held.</p> <p><b>Quorum</b> Quorum is 50% of the voting members on the committee.</p> <p>The Chairperson may vote. The Medical Director or representative of a Service Line has the right to participate in the discussion but does not vote.</p> <p><b>Meeting Documentation</b> Permanent meeting record maintained</p>	<ul style="list-style-type: none"> <li>• The MSEC has authority for the below activities, given to it by the MS, through the MS election of Department Chair Persons and officers, who make up the MSEC. This authority may be delegated or removed through normal bylaw amendment process.</li> <li>• Responsible for all Medical Staff affairs of the Medical Center.</li> <li>• Primary liaison between the Medical Staff, Board and CEO within the context of organizational functions of governance, leadership monitoring and performance improvement.</li> <li>• Has delegated authority for Process Improvements of professional services provided by privileged individuals.</li> <li>• Reviews credentials and requested privileges of applicants to MS and NPHCP staff</li> <li>• Makes recommendations directly to the governing body on: <ul style="list-style-type: none"> <li>a. Medical staff membership</li> <li>b. The organized medical staff's structure</li> <li>c. The process used to review credentials and delineate privileges</li> <li>d. The delineation of privileges for each practitioner privileged through the medical staff process</li> <li>e. The executive committee's</li> </ul> </li> </ul>
<p>MSEC (CONTINUED)</p>			

	<p>licensed independent practitioners.</p> <p>All voting medical staff executive committee members are fully licensed physicians actively practicing in the hospital</p> <p>Additional ex-officio members without vote may be designated by the MSEC.</p>		<p>review and actions on reports of medical staff committees, departments, and other assigned activity groups</p> <ul style="list-style-type: none"> <li>• Makes policy recommendations to the Board and Medical Center administration of issues relating to the quality and delivery of patient care, credentialing and privileging processes and the Medical Staff structure and functions.</li> <li>• Investigates any reported breach of ethics.</li> <li>• Has oversight responsibility for the four departments and designated medical staff committees and subcommittees.</li> <li>• Is empowered to act for the Medical Staff in intervals between Medical Staff meetings within the scope of its responsibilities, as defined by the organized medical staff.</li> <li>• Reviews periodically all information available regarding professional performance and competency of staff members presented to them and makes recommendations for granting changes in privileging, reappointments, terminations and any other appropriate action.</li> <li>• Requests evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested.</li> <li>• May request a MS or NPHCP staff member to appear before the MSEC or designated subcommittee and may enact a suspension upon refusal to appear.</li> <li>• The medical staff recommends</li> </ul>	
--	---	--	--	--



			<p>which clinical services are appropriately delivered by licensed independent practitioners through telemedicine. -</p> <ul style="list-style-type: none"> <li>• Consults with administration on the quality aspects of contracts for patient care services with entities outside of Mercy</li> </ul>
MEDICAL STAFF CREDENTIALS COMMITTEE	<p><b>Term</b> All appointments are for a two-year term. There is no limit to the number of terms served.</p> <p><b>Accountability</b> Accountable to the MSEC</p> <p><b>Membership</b></p> <ul style="list-style-type: none"> <li>• Secretary/ Treasurer of the Medical Staff (Chair).</li> <li>• Chairperson of each department.</li> <li>• Senior Vice President of Physician Integration.</li> <li>• Credentialing staff members (ex-officio without vote).</li> </ul>	<p><b>Meeting Frequency</b> At least quarterly. The Chair designates time and place.</p> <p><b>Meeting Notice</b> Written notice sent to all categories of members and/or conspicuously posted at least seven days before the meeting.</p> <p><b>Attendance</b> Members are expected to attend at least 50% of the meetings held</p> <p><b>Quorum</b> The Chairperson may vote. Quorum is those present and voting.</p> <p><b>Meeting Documentation</b> Permanent meeting record maintained</p>	<ul style="list-style-type: none"> <li>• Reviews Bylaw changes and make recommendations to the MSEC.</li> <li>• Reviews the credentials and requested privileges of applicants to the MS and NPHCP staff and make recommendations to MSEC.</li> <li>• Periodically reviews the credentials and all information available regarding professional performance.</li> <li>• Makes recommendations to MSEC for reappointment to Medical Staff.</li> <li>• Provides oversight for Medical Staff Professional Practice Evaluations (OPPE and FPPE).</li> </ul>
MEDICAL STAFF CONDUCT EVALUATION COMMITTEE	<p><b>Term</b> Appointment term unlimited</p> <p><b>Accountability</b> Accountable to the MSEC</p> <p><b>Membership</b></p> <ul style="list-style-type: none"> <li>• SVP Physician</li> </ul>	<p><b>Meeting Frequency</b> As needed for conduct evaluation</p> <p><b>Meeting Notice</b> Meeting notice is sent by the SVP-PI/CMO at least 24 hours before the meeting</p> <p><b>Attendance</b> Members as appointed by the</p>	<ul style="list-style-type: none"> <li>• Reviews reported practitioner conduct issues and determines actions according to the Medical Staff Code of Conduct Policy</li> <li>• Forwards issues deeming further investigation to MSEC</li> </ul>

	<p>Integration</p> <ul style="list-style-type: none"> <li>• Immediate Past President of the Medical Staff</li> <li>• Three physicians as appointed by the MSEC.</li> <li>• Vice President of Mission and Ethics (Non voting)</li> <li>• Risk Manager (Non voting)</li> <li>• Psychologist (Non voting)</li> </ul>	<p>MSEC with the expectation of full participation.</p> <p><b>Quorum</b> Decision making is by consensus of those participating.</p> <p><b>Meeting Documentation</b> Information gathered through the fact finding process.</p>		
<p>NPHCP CREDENTIALS SUB-COMMITTEE</p>	<p><b>Term</b> All appointments are for a two-year term. There is no limit to the number of terms served.</p> <p><b>Accountability</b> Accountable to the MS Credentials Committee.</p> <p><b>Membership</b></p> <ul style="list-style-type: none"> <li>• Secretary/ Treasurer of the Medical Staff (Chair).</li> <li>• 1 PA representing Medical Center/clinic.</li> <li>• 1 ARNP.</li> <li>• 1 CRNA.</li> <li>• 1 Behavioral Health professional representing psychology and social</li> </ul>	<p><b>Meeting Frequency</b> At least quarterly. The Chair designates time and place.</p> <p><b>Meeting Notice</b> Written notice sent to all members.</p> <p><b>Attendance</b> Members are expected to attend at least 50% of the meetings held</p> <p><b>Quorum</b> The Chairperson may vote. Quorum is those present and voting.</p> <p><b>Meeting Documentation</b> Permanent meeting record maintained</p>	<ul style="list-style-type: none"> <li>• Reviews Bylaw changes that impact NPHCPs.</li> <li>• Reviews the credentials and requested privileges of applicants to the NPHCP Staff and make recommendations to the MS Credentials Committee.</li> <li>• Periodically reviews the credentials and all information available regarding professional performance of NPHCP Staff; make recommendations to MS Credentials Committee for reappointment to NPHCP Staff.</li> </ul>	

	<p>work).</p> <ul style="list-style-type: none"> <li>• May include other NPHCP Staff</li> <li>• Credentialing Staff</li> <li>• Members (ex-officio without vote).</li> </ul>		
ONCOLOGY COMMITTEE	<p><b>Term</b> All appointments are for one year</p> <p><b>Accountability</b> <b>Accountable to MSEC</b></p> <p><b>Membership</b> Representative of specialties:</p> <ul style="list-style-type: none"> <li>• Surgery</li> <li>• Pathology</li> <li>• Diagnostic Radiology</li> <li>• Medical Oncology</li> <li>• Radiation Oncology</li> <li>• Cancer Liaison Physician</li> <li>• Palliative Care</li> </ul> <p>Additional representation:</p> <ul style="list-style-type: none"> <li>• Oncology Nurse</li> <li>• Research RN</li> <li>• Case Management</li> <li>• Cancer Registry</li> <li>• Quality</li> <li>• Hospice</li> <li>• Pharmacy</li> <li>• American Cancer Society</li> </ul>	<p><b>Meeting Frequency</b> At least quarterly</p> <p><b>Meeting Notice</b> Written notice sent to all categories of members and/or conspicuously posted at least seven days before the meeting.</p> <p><b>Attendance</b> Members are expected to attend at least 50% of the meetings held</p> <p><b>Quorum</b> The Chairperson may vote. Quorum is those present and voting.</p> <p><b>Meeting Documentation</b> Permanent meeting record maintained</p>	<ul style="list-style-type: none"> <li>• Overall responsibility and accountability for cancer program activities.</li> <li>• Reviews the entire spectrum of care for all cancer patients admitted (to encompass: diagnosis, treatment, rehabilitation, follow-up and end-results-reporting.)</li> <li>• Arrange for weekly multi-disciplinary cancer conferences.</li> <li>• Provided consultative services for specific problem cases.</li> <li>• Encourage clinical and/or basic research.</li> <li>• Prepares periodic Cancer Registry reports for the Medical Staff.</li> </ul>

	<ul style="list-style-type: none"> <li>• Cancer Center Director</li> <li>• Pastoral Care</li> <li>• NPHCP Staff</li> </ul>		
GENERAL TRAUMA COMMITTEE	<p><b>Term</b> Appointment term unlimited</p> <p><b>Accountability</b> <b>Accountable to MSEC</b></p> <p><b>Membership</b> Trauma Medical Director</p> <p>All general surgeons taking trauma call</p> <p>Physician Representatives from:</p> <ul style="list-style-type: none"> <li>• Emergency Medicine</li> <li>• Neurosurgery</li> <li>• Orthopedics</li> <li>• Anesthesia</li> <li>• Radiology</li> <li>• Critical Care</li> <li>• Rehabilitation Services</li> </ul> <p>Other Representation:</p> <ul style="list-style-type: none"> <li>• Rehabilitation Services</li> <li>• OR</li> <li>• Administration</li> <li>• Emergency Services</li> <li>• Practice/Quality</li> <li>• Air Med</li> <li>• Trauma Coordinator</li> </ul>	<p><b>Meeting Frequency</b> Monthly</p> <p><b>Meeting Notice</b> Written notice sent to all categories of members</p> <p><b>Attendance</b> Members are expected to attend at least 50% of total meetings per year</p> <p><b>Quorum</b> The Chairperson may vote. Quorum is those present and voting.</p> <p><b>Meeting Documentation</b> Permanent meeting record maintained</p>	<ul style="list-style-type: none"> <li>• Reviews trauma morbidity, mortality (selective cases), and complications.</li> <li>• Discusses trauma specific sentinel events in conjunction with Patient Safety and Quality.</li> <li>• Identifies and resolves problems or issues that are found through case review or practice patterns.</li> <li>• Identifies and resolves trauma program issues throughout the trauma continuum of care.</li> </ul>

# **PART III: NON PHYSICIAN HEALTH CARE PRACTITIONER (NPHCP) STAFF BYLAWS**

## **ARTICLE I: PURPOSE**

### **Purpose of the NON PHYSICIAN HEALTH CARE PRACTITIONER (NPHCP) Staff Bylaws**

- A. Provide the framework by which NPHCPs promote and provide competent patient care at Mercy Medical Center – North Iowa (Medical Center).
- B. Create a system of mutual rights and responsibilities among members of the NPHCP Staff, the MS and the Medical Center.
- C. Establish a framework of NPHCPs accountability to MSEC.

## **ARTICLE II: NON PHYSICIAN HEALTH CARE PRACTITIONER STAFF MEMBERSHIP**

### **Section 1. Non Physician Health Care Practitioner Staff Membership**

Appointment to the NPHCP Staff of the Medical Center is a privilege that is extended only to competent professionals who continuously meet the qualification standards and requirements set forth in these Bylaws and the associated policies of the Medical Staff and the Medical Center.

### **Section 2. Qualification for Membership**

- A. Non Physician Health Care Practitioners include Physician Assistants (PAs) and Surgical Assistants (SAs) and the following Licensed Independent Practitioners (LIPs):
  - 1. Certified Clinical Nurse Specialists
  - 2. Certified Nurse Midwives
  - 3. Certified Nurse Practitioners
  - 4. Certified Registered Nurse Anesthetists
  - 5. Employee Assistance Program Counselors
  - 6. Licensed Independent Social Workers
  - 7. Licensed Medical Social Workers
  - 8. Licensed Marriage and Family Therapists
  - 9. Licensed Mental Health Counselors
  - 10. Psychologists
- B. All NPHCPs must document their background, experience, training, judgment, individual character, demonstrated competence, physical and mental capabilities, adherence to the ethics of their profession, and ability to work with others with sufficient adequacy to assure the Medical Staff and Board that any patient treated by them in the Medical Center will be given patient care in accordance with professional standards and in accordance with the professional standards of the supervising physician for individuals practicing by delegated authority. Employee Assistance Program Counselors are processed utilizing a streamlined credentialing process – refer to the Credentials Section; Article I, Section 2, C.
- C. Licensure to practice in Iowa or any other state, or membership in any professional organization, does not entitle any professional to membership to the NPHCP Staff or the Medical Center, nor the right to exercise any

particular clinical privilege in the Medical Center.

- D. NPHCP Staff membership or clinical privileges are not to be conditioned or determined on the basis of an individual's participation or nonparticipation in a particular medical group, IPA, PPO, PHO, Medical Center-sponsored foundation or other organization or in contracts with a third party which contracts with the Medical Center.
- E. Exceptions to qualifications for membership of the NPHCP Staff are made only by the Board, after recommendation from the MSEC.
- F. The current Medical Staff Development Plan is amended periodically and is considered in making appointments.

### **Section 3. Nondiscrimination**

The Medical Center does not discriminate in granting staff appointment and/or clinical privileges on the basis of age, gender, sexual orientation, race, creed, color, ethnic origin, disability, other health care organization affiliation, or other protected class against whom discrimination is prohibited by law.

### **Section 4. Conditions and Duration of Appointment**

- A. The Board makes initial appointments, reappointments, and granting of privileges to the NPHCP Staff.
- B. The Board acts on appointments and recommendations only after there has been a recommendation from the MSEC in accordance with the provisions of these Bylaws and after consideration of the Medical Staff Development Plan.
- C. Appointments to the NPHCP Staff are for no more than 24 calendar months.
- D. Appointment to the NPHCP Staff shall confer on the appointees only such clinical privileges, as have been granted in accordance with the Credentials Section of these Bylaws. NPHCP Staff will only be granted privileges in which their supervising physician is credentialed.
- E. Initial appointment to the NPHCP staff requires completion of a general orientation process or alternative orientation within 30 days of appointment or start of practice - whichever comes first.

### **Section 5. Responsibilities of Membership**

Each NPHCP Staff Member:

- A. Manages the medical care of her/his patients under the supervising Medical Staff member when appropriate as designated in assigned privileges.
- B. Assists the Medical Center in fulfilling its responsibilities for providing emergency care, as defined by EMTALA.
- C. Assists the Medical Center in fulfilling its responsibilities for providing charitable care.
- D. Assists other practitioners in the care of their patients when asked.
- E. Is subject to all sections of the Medical Staff Bylaws. Acts in an ethical, professional, and courteous manner, and abides by the principles of ethics set forth by their specific professional association and the Medical Center's Code of Conduct outlined in the Medical Staff Conduct Evaluation policy.
- F. Agrees to appear before the Medical Staff Conduct Evaluation Committee, the Medical Staff Executive Committee or designated subcommittee, upon receiving a formal notice to do so. Failure to participate in such a conference will result in suspension from the NPHCP Staff with complete loss of privileges until required discussions are held.
- G. Immediately notifies the Medical Center's CEO by telephone and in writing upon receiving notice of any proposed or actual exclusion or any pending investigation from any health care program or pending criminal charges related to any health care program funded in whole or in part by the federal government or by any law



enforcement agency.

- H. Is immediately removed from direct responsibility for, or involvement in, any federal health care program upon notice of criminal charges related to health care, pending resolution of such charges.
- I. At least 30 days prior to the intended effective date, notifies the President of the Medical Staff or the SVP of Physician Integration of reduction or suspension of liability coverage.
- J. Will not prescribe controlled substances for him/her or immediate family members.
- K. Will not order diagnostic tests or procedures on him/her or immediate family members.
- L. Will not treat himself/herself or members of his/her immediate family except in an emergency setting or an isolated setting when no other qualified MS member is available.
- M. Communicates information to the Practitioner Health Committee regarding health status of self or other practitioner that would potentially compromise patient care. (Refer also to Provider Health / Impaired Provider Policies and Procedures)

#### **Section 6. Leave of Absence (LOA)**

- A. For absences greater than 45 days, but not to exceed one year, members of the NPHCP Staff must apply to the MSEC for a leave of absence, renewable under appropriate conditions.
- B. Privileges are suspended for the duration of the LOA.
- C. Reinstatement of staff privileges may be requested through the MSEC without formal application.

## **ARTICLE III: CATEGORIES OF THE NON PHYSICIAN HEALTH CARE PRACTITIONER STAFF**

*SEE TABLE I: CATEGORIES OF THE NPHCP STAFF*

## **ARTICLE IV: OFFICERS**

NPHCP Staff members do not hold office on the Medical Staff.

## **ARTICLE V: DEPARTMENTS**

### **Section 1. Organization of Departments**

- A. All NPHCP s are assigned to a Medical Staff Department, dependent upon their discipline and or that of the supervising MS member.
- B. The exercise of clinical privileges within any department is subject to the Policies and Procedures of that Department and to the authority of the Department's Chair.

### **Section 2. Qualifications, Selection, and Tenure of Department Chairperson**

NPHCP Staff members do not serve as Department Chairs.

### **Section 3. Functions of Departments**

Department Functions as outlined in the Medical Staff section of these Bylaws.

### **Section 4. NPHCPs as Agents of the Medical Center**

NPHCP Staff members, acting as agents of the Medical Center and performing activities, at the request of the Medical Center or Medical Staff as appointees to committees whether they are employees or not, are covered by the Medical Center's D & O insurance coverage.

# ARTICLE VI: COMMITTEES

## Section 1. NON PHYSICIAN HEALTH CARE PRACTITIONER Staff Committee Determination

NPHCP s are assigned to this Medical Staff Committee and may vote.

*Refer to Table II: Committees in Medical Staff Bylaws.*

## Section 2. NON PHYSICIAN HEALTH CARE PRACTITIONER Staff Functions

- A. Effective performance of the staff functions required by the Medical Staff Bylaws, the NPHCP Staff Bylaws, or by resolution of the MSEC with Board approval, is accomplished by assignments to departments, staff committees, staff officers or designees, or interdisciplinary Medical Center committees.
- B. NPHCP Staff functions include:
  - 1. Working through the NPHCP Staff structure with the MSEC and Administration to assist the Medical Center in assuring ultimate quality care for all patients.
  - 2. Conduct or coordinate credentials investigation for NPHCP Staff membership
  - 3. Recommendation to MS Credentials Committee of clinical privileges in specified services.
  - 4. Engage in other functions reasonably requested by the MSEC and Board.

# ARTICLE VII: RIGHTS OF NON PHYSICIAN HEALTH CARE PRACTITIONER STAFF MEMBERS

## Section 1. Right to Meet with the MSEC

Each NPHCP Staff member has the right to meet with the MSEC. In the event an NPHCP Staff member is unable to resolve a difficulty working with his/her respective department chair, that NPHCP staff member may, upon presentation of written notice, meet with the MSEC to discuss the issue.

## Section 2. Calling a General Staff Meeting

NPHCP Staff members do not have the right to call a General MS meeting.

## Section 3. Challenge

- A. Any NPHCP Staff member may raise a challenge to any rule or policy impacting NPHCP Staff members that has been established by the MSEC.
- B. In the event a rule, regulation or policy is felt to be inappropriate, an NPHCP Staff Member may submit a petition signed by no less than 20% of the active members of the NPHCP Staff.
- C. When such a petition has been received by the MSEC, it will either:
  - 1. Provide the petitioner(s) with information clarifying the intent of such rule, regulation, or policy and/or
  - 2. Schedule a meeting with the petitioner(s) to discuss the issue.
- D. PA's are not bound by any rule or policy which requires practice in a manner that conflicts with the MS-approved practice standards delegated by the supervising MS member or any rule or policy which impairs or prohibits the physician's authority to delegate approved medical services to a PA.

## Section 4. Department Meeting Requests

NPHCP Staff members do not have the right to call a department meeting.

## Section 5. Exclusions

This Article does not pertain to issues involving conduct, disciplinary action, and denial of requests for appointment, clinical privileges, or any other matter relating to individual "credentialing" actions. The Plan for Fair Hearing provides recourse in these matters.

### **Section 6. Fair Hearing**

Any Active or Affiliate NPHCP Staff member has the right to the procedural protections in the Plan for Fair Hearing. NPHCP s employed by the Medical Center access the Human Resource processes; non-employed AHPs access the Medical Staff Fair Hearing Process.

## **ARTICLE VIII: IMMUNITY FROM LIABILITY**

The following shall be conditions expressed to any NPHCP Staff member's application for or exercise of clinical privileges at this Medical Center:

### **Section 1. Quality Patient Care**

Any act, communication, report, recommendation, or disclosure, with respect to any NPHCP Staff member, performed or made in good faith 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.

### **Section 2. Identified Individuals**

Such privileges extend to members of the NPHCP Staff and Board, the 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 Article VIII, the term "third parties" means both individuals and organizations from which an authorized representative of the Board or of the NPHCP Staff has requested information.

### **Section 3. Civil Liability**

There shall be, to the fullest extent permitted by law, 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.

### **Section 4. Credentialing and Review**

Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this health care institution's activities related, but not limited to:

- A. Applications for appointment or clinical privileges.
- B. Periodic reappraisals for reappointment or clinical privileges, including information for peer review.
- C. Corrective action, including summary suspension.
- D. Hearings and appellate reviews.
- E. Medical care evaluations.
- F. Utilization reviews.
- G. Other Medical Center, departmental, service or committee activities related to quality patient care and inter-professional conduct.

### **Section 5. Rights of NPHCP Staff**

The acts, communications, reports, recommendations and disclosures referred to in Article VIII may relate to an NPHCP Staff member'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.

**Section 6. Releases**

That in furtherance of the foregoing, each NPHCP Staff member shall, upon request of the Medical Center, execute releases in accordance with the tenor and import of Article VIII in favor of the individuals and organizations specified in Section 2, 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.

**Section 7. Applications for Initial Appointment**

The consents, authorizations, releases, rights, privileges, and immunities provided by Article I, Sections 1 and 2, of the Credentials Manual of the Bylaws for the protection of NPHCP Staff members, other appropriate Medical Center 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 Article VII.

**TABLE I: CATEGORIES OF NPHCP STAFF**

	<b>QUALIFICATIONS</b>	<b>PREROGATIVES</b>	<b>RESPONSIBILITIES</b>
ACTIVE	<ol style="list-style-type: none"> <li>1. Involved in a minimum of 10 patient contacts annually AND</li> <li>2. Has completed the initial Focused Professional Practice Evaluation requirement AND</li> <li>3. Has written documentation by the department chair or designee of satisfactory performance</li> </ol>	<ul style="list-style-type: none"> <li>• May exercise the privileges granted without limitations except as otherwise provided in the Medical Staff Rules and Regulations or by specific privilege restriction.</li> <li>• May NOT vote at general and special meetings of the Medical Staff.</li> <li>• May vote at Department and Committee meetings to which he/she is appointed.</li> <li>• May be appointed on a temporary basis.</li> <li>• NPHCP Staff Members, who are employed by the Medical Center, access the Human Resource process rather than the Medical Staff Plan for Fair Hearing.</li> </ul>	<ul style="list-style-type: none"> <li>• Must actively participate in recognized functions of staff appointment including quality improvement, other monitoring activities and other NPHCP staff functions as may be required from time to time.</li> </ul>
AFFILIATE	<ul style="list-style-type: none"> <li>• Interested in the clinical affairs of the Medical Center OR</li> <li>• Refers patients to Medical Center Staff physicians OR</li> <li>• Orders diagnostic or therapeutic services at the Medical Center</li> </ul>	<ul style="list-style-type: none"> <li>• May exercise privileges the same as Active status.</li> <li>• May NOT vote at meetings of the Medical Staff and Departments.</li> <li>• May vote at meetings of Committees to which he/she is assigned.</li> <li>• May be appointed on a temporary basis.</li> <li>• NPHCP Staff Members, who are employed by the Medical Center, access the Human</li> </ul>	

	<b>QUALIFICATIONS</b>	<b>PREROGATIVES</b>	<b>RESPONSIBILITIES</b>
	<p>AND</p> <ul style="list-style-type: none"> <li>• Has completed the initial Focused Professional Practice Evaluation requirement</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>• Has written documentation by the department chair or designee of satisfactory performance</li> </ul>	<p>Resource process rather than the Medical Staff Plan for Fair Hearing.</p>	
<p>PROVISIONAL: ACTIVE AND AFFILIATE</p>	<p>All initial appointments to any category of the NPHCP Staff are Provisional until:</p> <ol style="list-style-type: none"> <li>1. Involved in a minimum of 10 patient contacts annually</li> </ol> <p>AND</p> <ol style="list-style-type: none"> <li>2. Has completed the initial Focused Professional Practice Evaluation requirement</li> </ol> <p>AND</p> <ol style="list-style-type: none"> <li>3. Has written documentation by the department chair or designee of satisfactory performance for a minimum of twelve months. <ul style="list-style-type: none"> <li>◦ Can be reappointed to Provisional status but total may</li> </ul> </li> </ol>	<ul style="list-style-type: none"> <li>• Is assigned to a department where his /her performance is observed by the department chair or designee to determine eligibility for active or affiliate staff membership and for exercising the clinical privileges provisionally granted to him/her.</li> <li>• May NOT vote at general and special or department meetings of the Medical Staff. May vote at committees to which he/she has been appointed.</li> </ul>	

	QUALIFICATIONS	PREROGATIVES	RESPONSIBILITIES
	<p>NOT exceed two full years.</p> <ul style="list-style-type: none"> <li>Failure to advance to Active or Affiliate Staff is deemed a termination of his/her appointment.</li> </ul>		
ORDER ONLY: DIAGNOSTIC TESTS AND REHABILITATIVE SERVICES	<ul style="list-style-type: none"> <li>Licensed ARNP i.e CCNS, CNP, CRNA, CNM or PA in any U.S. state.</li> </ul>	<ul style="list-style-type: none"> <li>Not eligible for Fair Hearing.</li> </ul>	<ul style="list-style-type: none"> <li>Must provide full name and address in order that current licensure can be verified.</li> <li>Must provide location and means to transmit the test result(s).</li> </ul>

## PART IV: CREDENTIALS

The credentials review process is the basis for making appointments to membership of the Medical Staff. It also provides information for granting privileges to LIPs and other practitioners credentialed and privileged through the Medical Center's Medical Staff process to ensure that patients receive care, treatment and services from qualified and competent providers.

The purpose of verifying credentials data is to ensure competent patient care:

- The individual requesting privileges is in fact the same individual who is identified in the credentialing documents
- The applicant has attained the credentials as stated
- The credentials are current
- There are no challenges to any of the credentials
- There is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege

## ARTICLE I: APPOINTMENT

### Section 1. Application for Initial Appointment

- A. Only complete applications are considered for appointment to the Medical Staff or NPHCP Staff. Applications are:
  1. In writing
  2. Signed by the applicant.
  3. Submitted on a form recommended by the MSEC and approved by the Board.
- B. Filed as separate records within Medical Staff Services.
- C. No applicant who is currently excluded by sanction from any health care program funded in whole or in part by

the federal government, including Medicare or Medicaid, or has a recent conviction of a criminal offense related to health care, is eligible or qualified for MS or NPHCP staff membership.

- D. The applicant has the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualifications and resolving any doubts about such qualifications.
- E. Individuals in administrative positions who desire MS membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges.
- F. By initiating a process for appointment to the MS or NPHCP Staff, each applicant thereby:
  - 1. Signifies his/her willingness to appear for interviews in regard to his/her application
  - 2. Authorizes the Medical Center to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her competence, health, character, and ethical qualifications
  - 3. Consents to the Medical Center's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, as well as his/her moral and ethical qualifications for Staff membership
  - 4. Releases all representatives of the Medical Center and its MS from any liability for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials during or at any time after the appointment process
  - 5. Releases from any liability all individuals and organizations who provide information to the Medical Center in good faith and without malice concerning the applicant's competence, ethics, health, character, and other qualifications for Staff appointment and clinical privileges, including otherwise privileged or confidential information.
- G. The application requires that the following be included:
  - 1. Detailed information concerning the applicant's professional qualifications.
  - 2. Names of at least three persons who have had extensive experience in observing and working with the applicant and who can provide adequate peer and/or non-peer references pertaining to the applicant's professional competence and ethical character. A peer reference is one from an appropriate practitioner in the same professional discipline as the applicant who has personal knowledge of the applicant.
  - 3. Information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced, or not renewed at any other hospital or institution.
  - 4. Information as to whether his/her membership in local, state or national medical societies, or his/her license to practice as a professional in any jurisdiction, has ever been suspended or terminated voluntarily or involuntarily.
  - 5. A photograph of himself/herself by providing either a current picture hospital ID card or a valid picture ID issued by a state or federal agency (driver's license or passport).
  - 6. Proof of current and continuous malpractice liability insurance of a minimum of one million dollars. Malpractice liability coverage must be provided by no less than an A-rated carrier in the amounts of \$1million/\$3 million coverage.
  - 7. A statement regarding health status.
  - 8. Immunization information.
  - 9. A completed form indicating the delineated clinical privileges he/she is requesting.
  - 10. Information regarding any litigation or malpractice actions or claims involving the applicant in the past five years.

11. Information as to whether his/her DEA number has ever been revoked.
12. Current Controlled Substance Registration Certificates.
13. Documentation of education.
14. Copy of Iowa state license.
15. A statement that the applicant has received or has been given the opportunity to read, the Medical Staff Bylaws, including sections on Definitions, Medical Staff Bylaws, NPHCP Staff Bylaws, Credentials, Plan for Fair Hearing, Rules and Regulations, Code of Conduct, and the Codes of Ethics. He/she agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges.

## **Section 2. Identification of Process for Initial Appointment**

### *SEE FLOWCHART FOR CREDENTIALING APPROVALS*

- A. Medical Staff Services reviews the information and determines which approval process is appropriate for the applicant based on established criteria.
  1. Regular Process:
    - a. Has submitted a complete application.
    - b. Credentialing staff obtains and verifies qualifications
    - c. Department Chair reviews and recommends
    - d. Medical Staff Credentials Committee reviews and recommends
    - e. Medical Staff Executive Committee reviews and recommends
    - f. Board gives final approval
  2. Temporary Process:
    - a. All temporary privileges are granted by the CEO or authorized designee upon the recommendation from the medical staff president or authorized designee and shall not exceed 120 days.
    - b. There are two circumstances in which temporary privileges may be granted:
      1. To fulfill an important patient care, treatment, or service need. When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence.
      2. When a new applicant submits a complete application that raises no concerns and is awaiting review and approval of the MSEC and the Board upon verification of the following:
        - Current licensure
        - Relevant training or experience
        - Current competence
        - Ability to perform the privileges requested
        - Other criteria required by the organized medical staff bylaws
        - A query and evaluation of the National Practitioner Data Bank (NPDB) information
        - A complete application
        - No current or previously successful challenge to licensure or registration
        - No subjection to involuntary termination of medical staff membership at another organization
        - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges



3. Streamlined Process

Employee Assistance Program (EAP) Counselors streamlined process requires the provider's license, diploma, certificate of insurance, abbreviated demographic information, and information from the National Practitioner Data Bank.

**Section 3. Process for Initial Appointment Application**

*SEE FLOWCHART FOR CREDENTIALING APPROVALS*

- A. The completed application is submitted to the Credentialing Staff of Medical Staff Services. The SVP-PI/CMO or designee may arrange an interview with the applicant at this time. All references and other materials deemed pertinent are collected and the accuracy of the information verified.
- B. In all instances, the need for services, as determined by the MS Development Plan, are considered regarding specialty and privileges.
- C. Medical Staff Services obtains the following:
  - 1. Verification of professional schools.
  - 2. Verification, in writing (in paper or electronic format), of Iowa state licensure, verified with the primary source.
  - 3. Verification of relevant training, in writing (in paper or electronic format), verified with the primary source.
  - 4. Evidence of physical ability to perform the requested privilege. The applicant's ability to perform privileges requested must be evaluated. This evaluation is documented in the individual's credentials file. Such documentation may include the applicant's statement that no health problems exist that could affect his or her practice. Documentation regarding an applicant's health status and his or her ability to practice should be confirmed. Initial applicants may have their health status confirmed by the director of a training program, the chief of services, or chief of staff at another hospital at which the applicant holds privileges, or a currently licensed physician approved by the organized medical staff. In instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff.
  - 5. Verification of specialty board certification (when appropriate).
  - 6. Information from the National Practitioner Data Bank when clinical privilege are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.
  - 7. Background Check Information
  - 8. OIG Database exclusions
  - 9. Data from professional practice review by an organization(s) that currently privilege the applicant (if available);
  - 10. References from past and current hospital affiliations.
  - 11. Verification of professional liability insurance coverage.
  - 12. The applicant's current competence; Peer and/or faculty recommendation; professional references from those who have personal knowledge of the applicant's clinical abilities, ethical character, health status, and ability to work cooperatively with others. This will include written information regarding the practitioner's current:
    - a. Medical / Clinical knowledge
    - b. Technical and clinical skills
    - c. Clinical Judgment

- d. Interpersonal skills
- e. Communication skills
- f. Professionalism

Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of practitioner-specific data collected from various sources for the purpose of validating current competence.

- D. Before recommending privileges, the organized medical staff also evaluates the following:
1. Challenges to any licensure or registration
  2. Voluntary or involuntary relinquishment of any license or registration
  3. Voluntary or involuntary termination of medical staff membership
  4. Voluntary or involuntary limitation, reduction, or loss of clinical privileges
  5. Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
  6. Documentation as to the applicant's health status
  7. Relevant practitioner-specific as compared to aggregate data, when available
  8. Morbidity and mortality data, when available
- E. The Department Chair reviews the completed application and required attachments and submits the information to the MS or **NPHCP** Credentials Committee with his/her written recommendations for determining initial appointment and for granting clinical privileges.
- F. The MS and NPHCP Credentials Committees meets at least quarterly, to review applications with attached documents, including recommendations from the Department Chair, for initial appointment and submits a verbal/written recommendation to the MSEC.
- G. The MSEC reviews the recommendations of the Credentials Committee, along with the recommendation of the Department Chair, and submits a written recommendation to the Board for initial appointment, non-appointment, and/or clinical privileges of each MS and NPHCP member. The MSEC has the right to review the application with attached documents in their entirety.
- H. The Board reviews the recommendation of the MSEC, and determines appointment, non-appointment, and/or clinical privileges of each MS/ NPHCP staff member. Where non-appointment or a change in clinical privileges is recommended, the reasons are stated and documented. All reviews are confirmed by indicating the date of approval, and are made part of the practitioner's permanent record within Medical Staff Services.
- I. The processing of all applications (from receipt by Medical Staff Services to decision by the Board) must be completed within 180 days.
- J. All initial appointments to any category of the Medical Staff are Provisional for a minimum of twelve months. Practitioners can be reappointed to Provisional status but total may NOT exceed two years. Failure to advance to Active or Affiliate Staff is deemed a termination of his/her appointment.
- K. A contracted agency may be used to collect and transfer the appointment information.
- L. Requesting practitioners are notified regarding the granting decision in writing.

#### **Section 4. Application Deferral for Further Consideration or Rejection**

- A. The SVP-PI/CMO, CEO, President of the Medical Staff, any Department. Chair, Chair of the MS Credentials Committee, or the Chair of the NPHCP Credentials Committee, can recommend to the MSEC that an application be deferred for further consideration or rejection, upon reasonable and informed request.

- B. When the recommendation of the MSEC is to defer the application for further consideration, it is reviewed within sixty days with a subsequent recommendation for appointment with specified clinical privileges or for rejection for Staff membership.
- C. When the recommendation of the MSEC is favorable to the applicant, Medical Staff Services promptly forwards it with all supporting documentation, to the Board.
- D. When the MSEC's recommendation is unfavorable to the applicant, either with respect to appointment or to some or all of the requested clinical privileges, the applicant is informed of the reason for denial and the recommendation is forwarded to the CEO. It does not go to the Board until the applicant has waived his or her right to a hearing or until after a hearing is held. The CEO notifies the applicant by certified mail, return receipt requested, of the unfavorable recommendation and of his or her right to a Fair Hearing and Appeal Process for adverse privileging decisions. If the applicant requests a hearing, procedures are followed as defined in the Plan for Fair Hearing Section.
- E. If the applicant does not request a hearing, the MSEC's original recommendation goes to the Board for action.
- F. If the MSEC's recommendation is that the applicant be appointed but that some of the requested privileges are not granted, the applicant has a right to request a hearing, but he or she should also be given the option of withdrawing the request for those privileges. Under the reporting requirements of the Health Care Quality Improvement Act of 1986, the withdrawal of the request would not have to be reported to the National Practitioner Data Bank; however, if certain privileges requested were ultimately denied, the denial would have to be reported to other entities as applicable by law.
- G. If after the MSEC has reviewed the hearing record and considered the report and recommendation of the Hearing Committee, the MSEC's reconsidered recommendation is favorable to the practitioner, it is processed per normal protocol.
- H. When the Board's decision is final, it sends notice of such decision through the CEO to Medical Staff Services, to the Chairperson of the MSEC, and by certified mail, return receipt requested, to the applicant.
- I. A practitioner seeking appointment who has received an adverse decision may not apply to the staff for a period of two years unless the decision provides otherwise. Any such reapplication is processed as an initial application. The applicant submits additional information as the MSEC or the Board requires demonstrating that the basis for the earlier adverse action no longer exists.

## **ARTICLE II: REAPPOINTMENT**

### **Section 1. Application for Reappointment**

- A. Only complete applications are considered for reappointment to the Medical Staff or NPHCP Staff. Applications are:
  - 1. In writing
  - 2. Signed by the applicant.
  - 3. Submitted on a form recommended by the MSEC and approved by the Board.
  - 4. Filed as separate records within Medical Staff Services.
- B. No applicant who is currently excluded by sanction from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, or has a recent conviction of a criminal offense related to health care, is eligible or qualified for Medical Staff membership
- C. The applicant has the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualifications and resolving any doubts about such qualifications. When requested, the applicant must provide evidence of clinical performance to allow for an appropriate assessment of continued qualifications for appointment and privileges.

- D. Recommendations for reappointment are considered by birth date on a quarterly basis. The appointment period does not exceed two years.
- E. Extensions of previous appointments or clinical privileges are not extended beyond the 2-year period.
- F. Failure to submit the required information within the required time for processing constitutes voluntary resignation. Denial of reappointment due to failure to submit a completed application shall not entitle the practitioner to a hearing or appeal or give rise to a report to the National Practitioner Data Bank or State Department of Health and Human Services Credentialing Division.
- G. MS and NPHCP staff members are required to report any final or pending judgments or settlements for professional liability and any health status that may impede the safe practice of existing privileges on the application. The process for addressing practitioner health concerns is included in the Policies and Procedures.
- H. The processing of all applications (from receipt by Medical Staff Services to decision by the Board) must be completed within 180 days.
- I. A contracted agency may be used to collect and transfer the reappointment information.

## **Section 2. Process for Reappointment**

- A. Medical Staff Services sends a reappointment application to each MS or NPHCP staff member who is to be considered for reappointment in the designated quarter. Employee Assistance Program Counselors are processed utilizing a streamlined reappointment process refer to the G. below.
- B. Medical Staff Services requests that the MS or NPHCP Staff member submit the completed application and required attachments to Medical Staff Services within 21 days.
- C. The application requires that the following be included:
  - 1. Names of peers (same professional discipline as the applicant with personal knowledge of the applicant's ability to practice) to who forms can be sent requesting letters of reference.
  - 2. Information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced, or not renewed at any other hospital or health care organization.
  - 3. Status at primary admitting hospital (as designated by the applicant).
  - 4. Information as to whether his/her membership in local, state or national medical societies, or his/her license to practice as a professional in any jurisdiction, has ever been suspended or terminated voluntarily or involuntarily.
  - 5. Proof of current and continuous malpractice liability insurance of a minimum of one million dollars. Malpractice liability coverage must be provided by no less than an A-rated carrier in the amounts of \$1million/\$3 million coverage.
  - 6. A statement regarding health status. (The process for addressing practitioner health concerns is included in the Policies and Procedures).
  - 7. A statement declaring no present illegal drug usage.
  - 8. A completed form indicating the delineated clinical privileges he/she is requesting.
  - 9. Currently pending or final judgments or settlements or currently pending professional liability actions.
  - 10. Current Controlled Substance Registration Certificates.
  - 11. Information as to whether his/her DEA number has ever been revoked.
  - 12. Attestation of participating in CME/CEU courses pertinent to primary specialty. Documentation of CME/CEU courses is obtained if required for requested privileges. The MSEC may require a practitioner to attend a CME program if prompted by the findings of process improvements or quality assessment activities.

13. Evidence of current competence.
14. Statement of ability to perform specifically related to the requested clinical privileges with or without accommodations.
15. Current Iowa state license
16. Evidence of Board Certification (when appropriate).

D. Medical Staff Services obtains the following:

1. Verification of Iowa state licensure, in writing or electronically, from the primary source.
2. Verification of specialty board certification (when appropriate).
3. Letters of peer review from a practitioner of like discipline to include written information regarding the practitioner's current:
  - a. Medical / Clinical knowledge
  - b. Technical and clinical skills
  - c. Clinical Judgment
  - d. Interpersonal skills
  - e. Communication skills
  - f. Professionalism

E. A reappraisal is conducted at the time of reappointment or renewal or revision of clinical privileges. The reappraisal includes review of all submitted documents, and confirmation of adherence to MS or NPHCP Staff membership requirements stated in the Bylaws, Rules and Regulations, and Policies and Procedures. Information regarding each practitioner's scope of privileges is updated as changes in clinical privileges for each practitioner are made.

The reappraisal includes consideration of the following:

1. Information from the National Practitioner Data Bank.
2. Verification of current licensure
3. Applicant's relevant training
4. Verification of liability insurance coverage/history
5. Professional competence within their scope of practice and clinical judgment in the treatment of patients.
6. Relevant practitioner-specific performance data from the Ongoing Professional Practice Evaluation reflecting the current quality and competency of the practitioner. Data may be obtained from, but not limited to, routine department quality indicators, mortality and morbidity case reviews, random chart reviews, direct observation of the clinical performance of Department members, or patient complaint(s).
7. Risk management data including sentinel events, significant incidents, or near misses
8. The individual's clinical/technical skills.
9. Ethics and conduct.
10. Peer recommendation. (Additional information regarding peer review and peer recommendation protocols is in the Policies and Procedure Section).
11. Participation in MS and hospital affairs.
12. Professional activities
13. Compliance with the Medical Center Bylaws, MS and/or NPHCP Bylaws, Rules and Regulations, and all

Policies and Procedures.

14. Relations with other practitioners.
  15. General attitude toward patients, the Medical Center, and the public.
  16. Cooperation with Medical Center personnel.
  17. Health status including physical and mental capabilities.
  18. In circumstances where there is insufficient practitioner specific information available, a peer recommendation may be used.
- F. Quality Reports are sent to the individual practitioner as feedback, and as a means to improve performance.
- G. The streamlined process for Employee Assistance Program (EAP) Counselors includes the following from the provider:
1. Abbreviated demographic information
  2. Current license
  3. Certificate of insurance
- H. Before recommending privileges, the organized medical staff also evaluates the following:
1. Challenges to any licensure or registration
  2. Voluntary or involuntary relinquishment of any license or registration
  3. Voluntary or involuntary termination of medical staff membership
  4. Voluntary or involuntary limitation, reduction, or loss of clinical privileges
  5. Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
  6. Documentation as to the applicant's health status
  7. Relevant practitioner-specific as compared to aggregate data, when available
  8. Morbidity and mortality data, when available
- I. The Department Chair reviews the completed application and required attachments and submits the information to the MS or NPHCP Credentials Committee with his/her written recommendations for determining reappointment and for granting clinical privileges for the ensuing period.
- J. The MS and NPHCP Credentials Committees meet quarterly to review applications with attached documents for reappointments and submit recommendations to the MSEC.
- K. The MS or the NPHCP Credentials Committee reviews the completed application and required attachments, along with the recommendation of the Department Chair, in order to develop a verbal/written recommendation for consideration by the MSEC.
- L. The MSEC, after review of the completed application and required attachments, along with the recommendation of the Department Chair and the Credentialing Committee, submits a written recommendation to the Board for reappointment, non-reappointment, and/or clinical privileges of each MS and NPHCP member.
- M. The Board reviews the recommendation of the MSEC, and determines reappointment, non-reappointment, and/or clinical privileges of each MS/ NPHCP staff member. Where non-reappointment or a change in clinical privileges is recommended, the reasons are stated and documented. All reviews are confirmed by indicating the date of approval, and are made part of the practitioner's permanent record within Medical Staff Services.

### **Section 3. Adverse Decision for Reappointment Application or Reduction of Clinical Privileges**

- A. When the MSEC's recommendation is unfavorable to the applicant, either with respect to reappointment or to

some or all of the requested clinical privileges, the applicant is informed of the reason for denial and the recommendation is forwarded to the CEO. It does not go to the Board until the applicant has waived his or her right to a hearing or until after a hearing is held. The CEO notifies the applicant by certified mail, return receipt requested, of the unfavorable recommendation and of his or her right to a Fair Hearing and Appeal process for adverse privileging decisions. If the applicant requests a hearing, procedures are followed as defined in the Plan for Fair Hearing Section.

- B. If the applicant does not request a hearing, the MSEC's original recommendation goes to the Board for action.
- C. If the MSEC's recommendation is that the applicant be appointed but that some of the requested privileges are not granted, the applicant has a right to request a hearing, but he or she should also be given the option of withdrawing the request for those privileges. Under the reporting requirements of the Health Care Quality Improvement Act of 1986, the withdrawal of the request would not have to be reported to the National Practitioner Data Bank; however, if certain privileges requested were ultimately denied, the denial would have to be reported to other entities as applicable by law.
- D. If after the MSEC has reviewed the hearing record and considered the report and recommendation of the Hearing Committee, the MSEC's reconsidered recommendation is favorable to the practitioner, it is processed per normal protocol.
- E. When the Board's adverse decision is final, notice is sent from the CEO to the Chair of the MSEC and to the applicant by certified mail, return receipt requested.
- F. A practitioner seeking appointment that has received a final adverse decision for MS or NPHCP staff membership may not reapply for a period of two years unless the decision provides otherwise. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the staff or the Board may require in demonstrating that the basis for the earlier adverse action no longer exists.

#### **Section 4. Monitoring and Evaluation of a Practitioner's Professional Performance**

- A. The MS has a clearly defined process for collecting, investigating, and evaluating professional practice and addressing concerns. [Ongoing Professional Practice Evaluation](#) / [Focused Professional Practice Evaluation](#).
- B. The MS develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality care are identified. Criteria are developed that determine the type of monitoring to be conducted.
- C. The measures employed to resolve performance issues are clearly defined in the Medical Staff Professional Practice Evaluation and the Medical Staff Focused Professional Practice Evaluation policies.
- D. The performance monitoring process includes each of the following elements:
  - 1. Criteria for conducting performance monitoring
  - 2. Methods for establishing a monitoring plan specific to requested privileges
  - 3. A method for determining the duration of performance monitoring
  - 4. Circumstances under which monitoring by an external source is required.

## **ARTICLE III: CLINICAL PRIVILEGES**

### **Section 1. Clinical Privileges Requests**

- A. Every MS and NPHCP staff member practicing by virtue of MS or NPHCP membership, employment or contract, in connection with such practice, is entitled to exercise only those delineated clinical privileges specifically granted to him/her by the Board to treat patients, except as provided in Section 4 of this Article III: Temporary Privileges.



- B. Granting of clinical privileges is setting specific (i.e. hospital, clinic, emergency room).
- C. An applicant is allowed to apply for clinical privileges in more than one clinical specialty area.
- D. The applicant has the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests. The clinical privileges granted are specific for each MS or NPHCP member.
- E. Board determines the delineation of an individual's privileges that define the scope to admit and treat patients or direct the course of treatment for the conditions for which patients were admitted.
- F. Every initial application for MS or NPHCP Staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon:
  - 1. Current licensure.
  - 2. Education.
  - 3. Training.
  - 4. Board certification, when appropriate.
  - 5. Documented experience (both inpatient and outpatient) in categories of treatment/procedures.
  - 6. Demonstrated competence.
  - 7. Results of treatment.
  - 8. The conclusions drawn from quality assessment and improvement activities when available.
  - 9. References.
  - 10. Health status.
  - 11. An appraisal by the department in which such privileges are sought.
  - 12. Other relevant information.

## **Section 2. Granting of Clinical Privileges**

- A. Medical Staff Services retains current lists for clinical privileges that are specific to:
  - 1. Specialty
  - 2. Care setting (clinic, hospital, and emergency room).
- B. All of the criteria used are consistently evaluated for all practitioners holding that privilege.
- C. Special privileges and/or procedures are to be interpreted specifically. Privileging forms will be provided to the clinician at the time of initial request for privileges, at time of reappointment and, at any other time, upon request.
- D. The MS or NPHCP member initiates the level of requested privileges, followed by a recommendation of the Department Chairperson, or, when appropriate, the SVP-PI/CMO. The appropriate Department will recommend requests for privileges that cross specialty lines. Limitations for patient care restricted "with consultation" may be applicable in any case. The recommendation of the Department Chair is forwarded to the Credentials Committee, which may request consultation from any Department Chairperson who is affected by the request for other than usual privileges. The recommendation is then submitted to the MSEC and the Board, which has the authority for approval.
- E. Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal. Provider specific professional practice evaluation information may consist of information related to performance data, the individual practitioner's role in sentinel events, significant incidents, or near misses, correspondence to practitioner regarding commendations, comments regarding practice performance, or corrective action.



- F. All requests for additional privileges are in writing and set forth the type of clinical privileges desired, and the applicant's recent relevant training and/or experience. Such requests are processed in the same manner as applications for initial appointment. Information regarding each practitioner's scope of privileges is updated as changes in clinical privileges are made.
- G. The delineation of an individual's clinical privileges includes the limitations, if any, on an individual's privileges to admit and treat patients or direct the course of treatment for the conditions for which the patient was admitted.
- H. Privileges granted to dentists and podiatrists shall be based on their current licensure, training, experience (both inpatient and outpatient), and demonstrated competence, judgment, and recommendations. The scope and extent of surgical procedures that each dentist and podiatrist may perform are granted in the same manner as all other surgical privileges. All dental and podiatric patients receive the same basic medical appraisals as patients admitted to other surgical services. A physician member of the MS shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.
- I. It is not necessary to have clinical privileges to act in an emergency situation. An emergency is deemed to exist when serious, permanent harm or aggravation of injury or disease is imminent, or the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. The clinician is obliged to act to the best of his/her ability to the benefit of that patient, to utilize appropriate consultative assistance when available, and to arrange for appropriate follow-up care.

### **Section 3. Early Case Reviews (Focused Professional Practice Evaluation)**

- A. A period of focused professional practice evaluation is implemented for all initially requested privileges through a standardized case review process. Ongoing professional practice evaluation information is factored into the decision to revise existing privilege(s) for practitioners requesting additional privileges. A standardized case review process is carried out to ensure competency with newly approved privileges.
- B. Every Provisional MS and NPHCP member has cases evaluated by proctoring methods as delineated in the FPPE process.
- C. The responsibility to obtain proctors belongs to the applicant. If a Family Medicine applicant requests obstetric privileges, Department Chair of Family Medicine and the Director of Obstetrics approve the reviewer.

### **Section 4. Temporary Privileges – Short Term**

#### **SEE FLOWCHART FOR CREDENTIALING APPROVALS**

- A. Upon receipt of an application for MS or NPHCP membership from a licensed practitioner, the CEO or authorized designee may upon the basis of information available which may reasonably be relied upon as to the competence and ethical standing of the applicant, grant temporary admitting and clinical privileges to the applicant as recommended by the Medical Staff President or authorized designee. In exercising such privileges, the applicant acts under the supervision of the chairperson of the department to which he/she is assigned. Such temporary privileges are good for a specified period of time but no more than 120 days.
- B. The termination of temporary privileges does not give rise to any hearing or appeal rights.
- C. Minimally, the following information must be present in order to grant temporary privileges:
  - 1. Completed application and Waiver/Signature page.
  - 2. Completed form indicating the delineated clinical privileges he/she is requesting.
  - 3. Verification, in writing (paper or electronic), of Iowa state licensure, verified with the primary source.
  - 4. Current Controlled Substance Registration Certificates.
  - 5. Proof of current and continuous malpractice liability insurance of a minimum of one million dollars. Malpractice liability coverage must be provided by no less than an A-rated carrier in the amounts of

\$1million/\$3 million coverage.

6. A query and evaluation of the National Practitioner Data Bank information.
  7. Verification of relevant training, – Medical School & Residency, in writing (paper/electronic), verified with the primary source.
  8. Current Competence – Letters of peer review from a practitioner of like discipline to include written information regarding the practitioner's current medical / clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, and communication skills.
  9. Letter from primary hospital stating practitioner is in good standing.
  10. One reference letter.
  11. If a resident, reference from the Medical Director or faculty physician.
  12. Department Chair review and recommendation.
  13. Verification of ability to perform the privileges requested
  14. No current or previously successful challenge to licensure or registration
  15. No subjection to involuntary termination of medical staff membership at another organization
  16. No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
- D. For the care of a specific patient, temporary clinical privileges may be granted by the CEO or Authorized Designee to a practitioner who is not an applicant for membership in the same manner and upon the same conditions as set forth in subparagraph A. of this Section 4, provided that there is first obtained the practitioner's signed acknowledgment that he/she has received copies of the MS Bylaws, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges. Such temporary privileges are restricted to the treatment of not more than ten patients in any one-year by any practitioner, after which the practitioner is required to apply for membership on the MS or NPHCP staff before being allowed to attend additional patients.
- E. The MSP or SVP-PI/CMO may impose special requirements of supervision and reporting on any practitioner granted temporary privileges.

**Section 5. Termination of Temporary Privileges**

CAUSE	WHO	EFFECTIVE TIMEFRAME	COMMENTS
Failure to comply with imposed conditions	CEO or SVP-PI/CMO	Immediately	The MSP, appropriate Dept. Chair or the SVP-PI/CMO assigns a MS member to assume responsibility for the care of the practitioner's patients until discharge. The wishes of the patient are considered, when feasible.
Recommendation from the MSP or other MSEC member	CEO or SVP-PI/CMO	Upon the discharge from the Medical Center of any of the practitioner's patients under his/her care	
Recommendation from the MSP or other MSEC member AND it is	CEO, MSP,	Immediately	The MSP, appropriate Dept. Chair or the SVP-PI/CMO assigns a MS member to

CAUSE	WHO	EFFECTIVE TIMEFRAME	COMMENTS
determined that the life or health of the practitioner's patients are endangered by the continued treatment by the practitioner.	or the Chair of the Board		assume responsibility for the care of the practitioner's patients until discharge. The wishes of the patient are considered, when feasible.

**Section 6. Disaster Privileges**

Disaster privileges may be granted when the Emergency Management Plan has been activated and the organization is unable to handle the immediate patient needs. Privileges to provide patient care during the disaster may be granted by the Chief Executive Officer (CEO) (or designee) or Sr. VP of Physician Integration (or designee). (See Administrative Policy #805) [Disaster Privileges](#)

**Section 7. Resident / Fellow Privileges**

- A. Graduates of a school of allopathic or osteopathic medicine, actively participating in an accredited residency (hereinafter called resident/fellow) may obtain training at the Medical Center. The resident/fellow abides by applicable bylaws, rules and regulations, and policies and procedures of the Medical Staff, of the Departments and Services, of the Medical Center and the resident's residency program. Termination of affiliation with the residency/fellowship program for any reason, or failure of the residency program itself to be accredited will result in termination of all privileges.
- B. The resident/fellow completes an approved application for Medical Staff membership and request for privileges and submits it to Medical Staff Services.
- C. Full-time resident/fellow physicians are required to have a valid Iowa resident physician license or an Iowa permanent physician license.
- D. Visiting resident/fellow physicians who come to Iowa to practice, as part of their resident/fellow training program must have a resident or permanent license in good standing in the home state of the resident/fellowship training program. An Iowa temporary license is required of a physician in training if the physician does not hold a resident/fellow or permanent physician license in good standing in the home state of the resident training program (IA Code 653-9.2(2)).
- E. The resident/fellow will be under the general supervision of a Licensed Independent Practitioner (LIP) with appropriate privileges. All patients are admitted under the name and direct responsibility of an Attending Physician (Active, Affiliate or Provisional Medical Staff member). The Attending Physician is the one who oversees all medical care of the hospitalized patient and is responsible for the clinical accuracy of the medical record. A resident/fellow cannot be an attending physician.
- F. The resident/fellow may evaluate patients, order and/or perform diagnostic tests, write orders and render medical care as directed by the attending or other Active, Affiliate or Provisional Medical Staff member as is common in accredited residency/fellowship programs. Written descriptions of the role, responsibilities, and patient care activities of the resident/fellow are developed by the faculty in the resident's residency/fellowship program in consultation with the Medical Staff members, under whom the resident serves, and/or the Departments and Services of the Medical Staff. These descriptions are provided to the Medical Staff. The practitioner will staff those procedures, which the resident/fellow is not privileged to perform without direct supervision.
- G. The resident/fellow may complete medical records. The ultimate responsibility for the medical record shall lie with the attending practitioner who is responsible for the accuracy of the medical record, verification of the final diagnosis and all relevant coding/billing information as reflected in the patient's medical record.
- H. The SVP-PI/CMO and the Residency Director/responsible site physician will serve as the liaison between the residency/fellowship program, the Medical Staff, and the Medical Center. The residency/fellowship program

and medical staff regularly communicate about the safety and quality of patient care provided by, and the related educational and supervisory needs of the resident/fellow. The residency/fellowship program and the governing body periodically communicate about the educational needs and performance of residents

- I. No resident/fellow actively participating in a residency will be eligible to become an Active or Affiliate Medical Staff member. However, Second-year and Third-year residents in the Medical Center program may be privileged to care for patients in the Urgent Care Center and the Emergency Center when a staff ER physician is present.

### **Section 8. Telemedicine Privileges**

The medical staffs at both the originating (the site where the patient is located at the time service is provided) and distant sites (the site where the practitioner providing the professional service is located) recommend the clinical services to be provided by licensed independent practitioners through a telemedicine link at their respective sites.

#### **A. Originating Site (the site where the patient is located at the time service is provided)**

1. The Medical Center retains responsibility for overseeing the safety and quality of services offered to its patients.
2. All licensed independent practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms:
  - a. The originating site fully privileges and credentials the practitioner
  - b. The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited organization.
  - c. The originating site uses the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:
    - The distant site is a Joint Commission–accredited hospital or ambulatory care organization.
    - The practitioner is privileged at the distant site for those services to be provided at the originating site.
    - The originating site has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site.

#### **B. Distant Site (the site where the practitioner providing the professional service is located)**

1. The Medical Staff, through the MSEC, recommends which clinical services the LIPs appropriately deliver via telemedicine.
2. Telemedicine clinical services are consistent with the quality standards of the Medical Center.

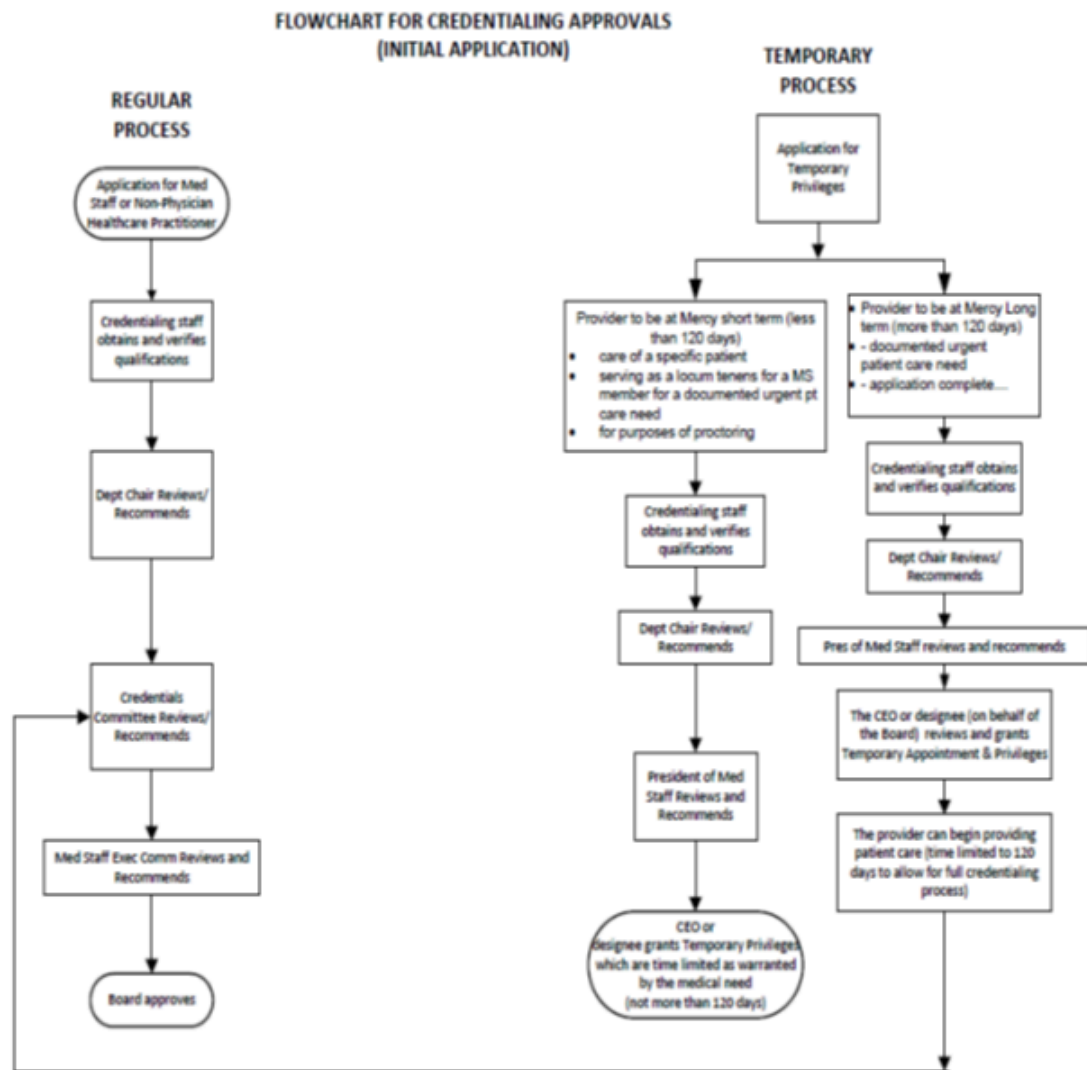
## **ARTICLE IV: TERMINATION OR SUSPENSION OF PRIVILEGES**

Indications for recommending termination or suspension or reduction of clinical privileges include but are not limited to:

- A. Inability to provide patient care in accordance with professional standards

- B. Failure to abide by the Organizational Integrity Program
- C. Failure to abide by the Mercy Standards of Conduct
- D. Failure to maintain education, training or clinical practice requirements
- E. Failure to maintain licensure to practice in Iowa
- F. Failure to complete medical records as required by the By Laws

Refer to the Plan for Fair Hearing these Bylaws for the suspension or termination process.



## PART V: FAIR HEARING Manual

### ARTICLE I: APPLICATION OF REVIEW PROCEDURES

#### Section 1. Scope

This manual provides methods for review, hearing, and appeal of certain types of recommendations made or actions taken with respect to Medical Staff and/or NPHCP Staff Active or Affiliate members and applicants for membership and/or for clinical privileges. An Affected Practitioner is entitled to only one type of hearing; the

selection of the type of hearing is determined by the nature of the recommendation or action involved.

The Board reserves the authority to take any direct action with respect to any Medical Staff or NPHCP appointee charged with clinical incompetence, commission of a felony, inappropriate behavior, inability to work with members of the Medical Staff or Medical Center employees, or violations of the Mercy Medical Staff Bylaws. The Board retains discretion to take any action it deems to be in the best interests of the Medical Center, whether initiated by the Medical Staff or not, and the decision of the Board shall be final.

### **Section 2. When Basic or Special Health Procedures Do Not Apply**

When the formal (basic or special) hearing procedures delineated in this manual do not apply to a recommendation or action, any MS Member, NPHCP Staff Member or initial applicant who believes he/she is aggrieved by any such action or recommendation of the MSEC or Board may seek review of the action or recommendation by submitting a written statement taking exception to such action or recommendation and specifying the reasons therefore. The statement shall be read or furnished to whichever body made the recommendation or took the action, and made a part of the MS or NPHCP Staff Member's or initial applicant's permanent file. The statement may also request an opportunity to appear before the MSEC or Board to informally discuss his/her position on the action, which request may be granted at the discretion of the MSEC or Board. After review, the Board may also, in its sole discretion, direct a basic or special hearing be held (even though one is not required) to review and make recommendations concerning the underlying matter at issue.

## **ARTICLE II – PROCESSES FOR APPLICANTS OR MEMBERS WHO HAVE BEEN EXCLUDED FROM FEDERALLY FUNDED HEALTH CARE PROGRAMS**

### **Section 1.**

New applicants to the MS or NPHCP staff are informed, as soon as their exclusion is known, that they do not qualify for staff membership and that their applications will no longer be processed.

### **Section 2.**

Members of the MS or NPHCP staff who immediately disclose their exclusion to the Medical Center CEO as required by the Bylaws are given the opportunity to request a meeting with the CEO and MSP in order to contest the fact of the exclusion and to present whatever relevant evidence they might have. Following such a meeting, and any additional investigation deemed appropriate, the determination by the CEO and the MSP would be final, without further right of appeal, and the member would be given notice that his/her MS or NPHCP staff membership and privileges were terminated.

### **Section 3.**

Members who fail to report their exclusion as required by the Bylaws will have their membership and privileges terminated, effective immediately, as soon as the exclusion is discovered and is determined to be supported by credible information, without any opportunity for a meeting.

### **Section 4.**

No other hearing rights set forth in this Plan for Fair Hearing apply to these terminations.

### **Section 5.**

No report of the termination is made to the State Board of Medical Examiners or the National Practitioner Data Bank, on the ground that the termination is based on the practitioner's failure to meet a basic qualification of membership.

# ARTICLE III - ADVERSE RECOMMENDATION OR ACTION

## Section 1. Notice of Recommendation or Action

When a recommendation is made or action taken by the MSEC or the Board which, according to this Plan, entitles an Affected Practitioner to a basic hearing or special hearing, prior to a final decision of the Board on that recommendation or action, the affected practitioner promptly receives Special Notice by the CEO. This Special Notice contains:

- A. A statement of the recommendation made and the general reasons for it;
- B. A statement that the Affected Practitioner has the right to request a hearing on the recommendation within 30 days of receipt of the notice;
- C. A statement of the kind of hearing (basic or special) to which the Affected Practitioner is entitled; and
- D. A copy of the Bylaws, unless it has already been provided to the affected practitioner.

## Section 2. Request for Hearing

The Affected Practitioner has 30 days following the date of the receipt of such notice to request a hearing. 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 Hearing

An Affected Practitioner, who fails to request a formal hearing within the time and in the manner specified in Article III Section 2, waives any right to such hearing and to any possible appellate review.

# ARTICLE IV - BASIC HEARING PROCEDURE

## Section 1. Application of Basic Hearing Procedures

The request for a basic hearing is set forth in Article III, Section 2 and applies to the following recommendations or actions:

- A. Automatic suspension of a MS or NPHCP Staff membership or clinical privileges due to loss of licensure; loss of governmentally authorized prescribing authority; or conviction of any felony or any crime arising out of professional practice.
- B. Denial of a request by an active, courtesy or consulting member to obtain clinical privileges which are not ordinarily possessed by professionals of like training, experience, MS or NPHCP Staff category and MS or NPHCP Staff membership duration.
- C. Denial of a requested change of MS or NPHCP Staff category;
- D. Issuance of a letter of reprimand without any reduction or limitation on the exercise of clinical privileges;
- E. Imposition of a consultation requirement of more than 30 days or the duration of hearing and appeal proceedings regarding MS or NPHCP Staff membership or clinical privileges, or the duration of provisional status, whichever is longer;
- F. Non-reappointment to the MS or NPHCP Staff by reason of failure to document financial responsibility/professional liability insurance requirement compliance. (However, a hearing based on this action is limited to the issue of whether financial responsibility compliance has been documented by the MS or NPHCP Staff Member).

## Section 2. Notice of Time and Place for Hearing

Upon receipt of a timely and proper request for a basic hearing, the CEO, after consultation with the MSP or the Board, depending on the body whose recommendation or action prompted the request for hearing, promptly



schedules and arranges for the hearing. At least 25 days prior to the hearing date, the CEO notifies the Affected Practitioner of the date, time and place of the commencement of the hearing by certified mail. The hearing date ordinarily should not be less than 30 days or more than 45 days from the date of receipt of the request for hearing.

### **Section 3. Statement of Reason**

If the reason(s) for the action or recommendation has not already been stated to the Affected Practitioner, he/she may request that such reasons be provided in his/her request for hearing. Such a request is responded by letter from the CEO, mailed or delivered to the Affected Practitioner at least 3 days before the scheduled date of the hearing. The statement of reasons may be amended at any time, provided the Affected Practitioner is given a reasonably sufficient opportunity to prepare for any added reasons.

### **Section 4. Appointment of Hearing Committee**

#### **A. By MS or NPHCP Staff**

1. This committee is a quorum of the MSEC or a subcommittee of no less than three Medical Staff Members, at least one of which persons must be a member of the MSEC, appointed by the MSP to conduct the hearing.
2. The MSP, who shall not be a member of the committee, appoints a member of the committee to serve as its chair.

#### **B. By Board**

1. This committee is composed of not less than three members, at least one of who is a physician, dentist or podiatrist.
2. The Chairperson of the Board, who shall not be a member of the hearing committee, designates a member of the committee to serve as its chair.

**C. Service on Hearing Committee.** A MS or NPHCP Staff or Board member is not disqualified from serving on a hearing committee merely because of prior participation in the investigation of the underlying matter at issue or because of knowledge of facts involved. In any event, all members of a hearing committee are required to consider and decide the case with good faith and objectivity and will have the duty to exclude themselves if a perceived conflict of interest exists.

**D. Notice to Affected Practitioner.** The CEO notifies the Affected Practitioner of the hearing committee's composition.

### **Section 5. Appearance and Representation**

**A. Appearance of Affected Practitioner.** The Affected Practitioner requesting the hearing must be present for the hearing. His/her failure to appear at the date and time set forth in the notice constitutes a waiver of the right to a hearing.

#### **B. Representation**

1. The Affected Practitioner represents him/herself.
2. If the hearing committee is the MSEC or a subcommittee thereof, the MSP may, in his/her discretion, appoint him/her or another MS member to represent the position adverse to the Affected Practitioner.
3. If the hearing committee is a committee appointed by the Board, the Chairperson of the Board may, in his/her discretion, appoint a person to represent the position adverse to the Affected Practitioner.
4. A person assigned to represent the interest adverse to the Affected Practitioner shall be called the "Advocate".
5. Neither the Affected Practitioner nor the Advocate may participate in deliberations of the hearing committee.



## Section 6. Hearing Conduct and Evidence

- A. **Hearing Conduct** The chairperson of the hearing committee is the presiding officer. The presiding officer acts to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer determines the order of procedure during the hearing and makes all rulings on matters of law, procedure and the considerations of evidence. The hearing is conducted in such a manner that both the Affected Practitioner and the Advocate, if any, have an opportunity to make their positions fairly heard and considered. Members of the hearing committee may ask questions of the Affected Practitioner and the Advocate.
- B. **Evidence.** The Affected Practitioner and the Advocate, if any, may submit to the hearing committee for consideration:
1. Written statements, letters and documents, which are relevant to the subject matter of the hearing, including relevant portions of the file maintained by the Medical Center regarding the Affected Practitioner.
  2. Oral statements by the Affected Practitioner, a person representing him/her and the Advocate (if any).
  3. Only when deemed essential to a meaningful hearing, the presiding officer may, in his/her discretion, authorize the appearance, examination and cross-examination of witnesses, consistent with supplemental hearing rules; unless, so authorized, neither the Affected Practitioner nor the Advocate shall have a right to present witnesses, or cross-examine in person.
  4. Evidence admitted in the hearing need not strictly meet the requirements of admissibility of a court of law, and the hearing committee may consider any evidence customarily relied upon by responsible persons in the conduct of serious affairs.

## Section 7. Burden of Proof

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

- A. Arbitrary;
- B. Capricious; and/or
- C. Based on inaccurate or insufficient information through no fault of the Affected Practitioner.

## Section 8. Recording of Hearing

The hearing shall be recorded by minutes prepared by a recording secretary selected by the CEO. Minutes are subject to approval and amendment by the hearing committee. Other means of recording (e.g., electronic tape or court stenographer) is used only at the request or with the consent of the hearing committee.

## Section 9. Recommendation

- A. **Notice.** Within 30 days, after completion of the hearing, the hearing committee meets, deliberates, and issues its report in writing to the CEO. The report is submitted by the CEO to the MSP and/or Board (as appropriate), the Advocate (if any), and to the Affected Practitioner (by Special Notice).
- B. **Action on Recommendation:**
1. If the hearing committee was a subcommittee of the MSEC, its report is submitted to the MSEC for consideration. Thereafter, the MSEC makes its final recommendation, subject to Board action.
  2. If the hearing committee was the MSEC as a whole, the hearing committee report becomes the final recommendation of the MSEC, subject to Board action.
  3. If the hearing committee was one appointed on behalf of the Board, its report becomes its final recommendation, subject to Board action. If requested within 45 days, final Board action may be subject

to reconsideration or appeal.

### **Section 10. Appeal**

If, following a basic hearing pursuant to this Article, the Affected Practitioner believes that the hearing committee's recommendation was arbitrary, capricious, or lacks any evidence in support, which shall be the sole grounds for appeal, he/she may, within 15 days of receipt of notice of the recommendation, submit a written appeal of the recommendation consisting of not more than 10 pages of text (not including exhibits) concisely stating the basis therefore to the CEO. If such an appeal is filed, the hearing committee, a representative thereof, or the Advocate, if any, may submit a written response in opposition within 15 days after the appeal is received. The appeal is considered by the Board, which shall, within 45 days after receipt of the appeal, take one of the following actions:

- A. Refer the matter back to the hearing committee for further review or supplemental findings; if this is done, the hearing committee responds in writing to the Board request within 15 days of request, and the Board takes the actions in B, C, or D below, within 30 days after receipt of the response; or
- B. Uphold the recommendation of the hearing committee and take final action accordingly; or
- C. Reverse the recommendation of the hearing committee, with or without the requirement that further hearings be conducted by the hearing committee; or
- D. Reverse the recommendation of the hearing committee and require a special hearing be held in accordance with the provisions of Article V of the Fair Hearing Manual of the MS Bylaws or Article VII of the NPHCP Bylaws.

The CEO advises in writing the Affected Practitioner, by Special Notice of the outcome of the appeal.

## **ARTICLE V - SPECIAL HEARING PROCEDURES**

### **Section 1. Application of Special Hearing Procedures**

The special hearing procedures apply to the following recommendations or actions:

- A. Non-reappointment to the MS or NPHCP Staff, except when because of: failure to timely submit a re-credentialing form; or to document financial responsibility; or timely request reinstatement following an expiration of leave of absence.
- B. Revocation, involuntary reduction or suspension of clinical privileges of Active or Affiliate category MS or NPHCP member which are ordinarily possessed by MS or NPHCP Staff members of like or similar training and MS or NPHCP Staff duration, for 15 days or more;
- C. Revocation or suspension of MS or **NPHCP** Staff Membership except when because of: failure to timely submit a re-credentialing form; or to document financial responsibility; or to timely request reinstatement following expiration of a leave of absence;
- D. Denial of an initial application for appointment to the MS or NPHCP Staff, except when because of: the application being incomplete; the application containing material inaccuracies; or any reason unrelated to the competence or professional conduct of the initial applicant;
- E. Such other recommendations or actions as the Board may direct at its discretion, after consultation with the MSEC.
- F. When Article IV (10)(D) of the Fair Hearing Manual applies

### **Section 2. Time and Place for Hearing**

- A. Scheduling the Hearing. Upon the receipt of a timely and proper request for a special hearing, the CEO shall promptly schedule and arrange for the hearing. The hearing date shall ordinarily be not less than 30 days or more than 60 days from the date of receipt of the request for hearing.

- B. Shortened Time Limit for Hearing. A hearing for a MS or NPHCP Staff member who is under suspension then in effect may be held in less than 30 days after the request is made, provided such MS or NPHCP Staff member's request for the hearing includes a specific request that the hearing be held in less than 30 days; in the event such a special request for a shorter period is made by a MS or NPHCP Staff member who is under suspension, the hearing shall be held as soon as the arrangement and preparations for it may reasonably be made and requirements for same met, subject to Article V, Section (2)(C ) below.
- C. Lengthened Time Limit for Hearing. If the Affected Practitioner objects to the composition of an ad hoc hearing committee, or a determination is made that an alternate hearing officer shall conduct the hearing, the 60 day maximum limitation shall be deemed waived by the Affected Practitioner. In such event, the hearing shall be held as soon as the arrangement and preparations for it may reasonably be made and the requirements for the same met. The CEO shall advise those involved in the hearing process of changes necessitated by such objections.

### **Section 3. Hearing Notice, Response and Witness Lists**

- A. Hearing Notice. The CEO shall issue a notice of hearing by Certified Mail to the Affected Practitioner and to others involved in the hearing process. The notice of hearing shall specify:
  - 1. **Time and Location** The scheduled date, scheduled time, and location of the hearing
  - 2. **Statement of Reasons.** As applicable, a statement of the alleged acts or omissions of a MS or NPHCP Staff member, a list by number of the specific or representative patient charts in question and/or other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing.
  - 3. **List of Witnesses.** A list of witnesses, if any, that the body which took or proposed adverse action (or its designated representative) believes will be called as witnesses to testify in support of the recommendation or action at the time of the hearing.
- B. **Response and List of Witnesses of Affected Practitioner.** Within 14 days after receipt of the notice of hearing, the Affected Practitioner shall furnish to the CEO his/her written response to the Statement of Reasons and a list of the individuals (and their addresses) that may or will be called as witnesses in support of the Affected Practitioner's position at the time of the hearing.
- C. **Amendments.** The statement of reasons, the response, or the list of witnesses of either party may be amended at any time by the party furnishing them, provided that the opposite party is given a reasonable period in which to prepare to meet the substance of the amendments to the statement of reasons or the substance of testimony of additional witnesses. For the purpose of this provision, a time period of one week shall be presumed to be a "reasonable period". The permissibility of a shorter period of notice shall be subject to the discretion of the presiding officer for the hearing.

### **Section 4. Appointment of Hearing Committee**

#### **A. Hearing Committee, Presiding Officer and Notice**

- 1. The CEO, acting for the Board, after considering the recommendations of the MSP (and that of the Chairperson of the Board, if the hearing is occasioned by a Board determination) shall appoint a hearing committee which shall generally be composed of not less than three members. The committee shall be composed of MS appointees who shall not have actively participated in the consideration of the matter involved at any previous level, or of physicians or laypersons not connected with the Medical Center or a combination of such persons. The committee shall not include any individual who is in direct economic competition with the Affected Practitioner or any individual who is professionally associated with or related to the Affected Practitioner.
- 2. Designation shall also be made of the presiding officer of the hearing committee who may, but need not

be a voting member of the committee, e.g., an attorney may be appointed as presiding officer to participate in committee deliberations and assist in the preparation of the hearing committee report, but not have a vote for or against adoption of the final hearing committee report. The appointments are subject to the further requirements and procedures of this section.

3. Notice of the hearing committee composition shall be given, either as part of the Notice of Hearing or by Certified Mail to the Affected Practitioner.

**B. Service on Hearing Committee.** A MS or NPHCP Staff member or other person appointed to serve on an ad hoc hearing committee shall not be disqualified from serving on a hearing committee merely because of knowledge of the underlying facts or because of participation in an earlier hearing involving the same Affected Practitioner regarding a different matter. However, if after objection timely submitted, the CEO, in his/her good faith discretion, determines that there is reasonable evidence to support the conclusion that a proposed member of the hearing committee is either in direct economic competition with the Affected Practitioner or could not decide the matter with good faith objectivity, the proposed member of the hearing committee shall be removed and, as appropriate, replaced before the hearing.

**C. Questions to Hearing Committee.** Within 7 days after the Affected Practitioner is given notice of those who are proposed to serve on the hearing committee, the such Affected Practitioner shall be entitled to submit reasonable written questions of not more than 10 in number limited to the issues of direct economic competition or bias to all or any one or more of the proposed hearing committee members through the CEO. The CEO shall, in his/her good faith discretion, determine whether questions are reasonable and relevant to the issues of direct economic competition or bias, and shall strike such questions, which are unreasonable or irrelevant. The questions, except those which are deemed by the CEO to be unreasonable or irrelevant, will then be submitted to the proposed hearing committee member(s) to whom directed, who shall then submit his/her response(s) within 30 days to the CEO. The CEO shall in turn forward the answers on a prompt basis to the Affected Practitioner and the MSP or Board Chairperson, depending upon the body which took the action or made the recommendation which is the subject of the hearing.

**D. Objections to Proposed Hearing Committee Members.** Within 7 days after receipt of notice of the proposed hearing committee membership or, if the procedure set forth in Article V, Section 4.C was elected by the Affected Practitioner, 7 days after his/her receipt of the responses to the written questions, the Affected Practitioner shall be entitled to submit his/her written objections, if any, to those proposed members of the hearing committee which he/she believes are in direct economic competition with him/her or are so biased against him/her as to prevent a fair hearing if they serve as a hearing committee member. Such objections, if any, will be reviewed by the CEO who shall determine in his/her good faith, discretion as to whether or not the objections are meritorious.

1. If none of the objections are deemed to be meritorious by the CEO, he/she shall so advise the Affected Practitioner, in writing, and the hearing committee shall be constituted in the manner proposed.
2. If the CEO determines that the objections to any or all of the hearing committee membership have substance, he/she shall confer with the MSP or the Chairperson of the Board, depending upon the body whose recommendation or action is the subject of the hearing, as to possible alternative proposed members of the hearing committee.
  - a. If the MSP or Chairperson of the Board believes that there are other alternative persons who may satisfactorily meet the requirements of membership on the hearing committee, the process set forth in Article V (4)(C and D), regarding written questions and objections, shall be repeated as necessary until an appropriate hearing committee can be constituted.
  - b. If, however, the MSP or Chairperson of the Board believes that there is no person available at the Medical Center or in the community who meets the committee membership requirements for participation on a hearing committee, the requirements of Article V (4) (A) shall not apply.

- E. **Alternate Hearing Officer.** If by reason of objections to proposed membership which are determined to be valid by the CEO, a hearing committee of at least 3 volunteer persons as provided in Article V (4) (A) cannot be constituted, the CEO shall be empowered to appoint a single person to serve as hearing officer (who may, but need not be a MS member) where:
1. In the good faith discretion of the CEO, such person is not in direct economic competition with, and has no known bias towards the Affected Practitioner; and
  2. The CEO has consulted with the Affected Practitioner and the MSP or Board Chairperson (depending upon which body prompted the hearing) regarding the appointment of such person(s) and the CEO has, in his/her good faith discretion, taken into account the legitimate objections, or preferences of the Affected Practitioner and the MSP or Board Chairperson as well as the availability of a qualified person to serve as hearing officer.
  3. As a part of the appointment process, in lieu of consultation provided in (2) above, the CEO may, in his/her sole discretion, provide the Affected Practitioner and the MSP or Board Chairperson with a list, by name, of 2 or more prospective hearing officers from which one person may be appointed by the CEO to serve as hearing officer. If submitted, the Affected Practitioner and the MSP or Board Chairperson, may submit objections and the reasons in writing to the CEO within 7 days of receiving the list. If objections are timely made and meritorious in the judgment of the CEO, this process, may be repeated, until a mutually satisfactory hearing officer can be selected or the procedures of (2) above utilized.
- F. **Notice of Appointment of Hearing Officer.** Notice of the appointment of a hearing officer shall be promptly given to the Affected Practitioner. Such notice shall include the estimated fee and expenses of the hearing officer, if any.
1. If a fee and expenses are required by the hearing officer for his/her services as such, the cost will be equally borne by the Medical Center and the Affected Practitioner and an advance of one-half the estimated costs shall be sent to the hearing officer by the Affected Practitioner within 14 days from notice of the hearing officer's appointment.
  2. If, and only if, the Affected Practitioner who requested the hearing can demonstrate such poverty that he/she is unable to pay his/her portion of the hearing officer's fee, if any, the entire fee for the hearing officer shall be borne by the Medical Center. However, in order to establish this poverty sufficient to relieve the Affected Practitioner of his/her obligation to pay half the fee and expenses for such hearing officer, the Affected Practitioner must provide, upon request, financial information which the CEO deems necessary to make the determination including personal and business income tax returns for the preceding two years, financial statements prepared regarding his/her practice (including any professional corporation or partnership owned in whole or in part by him/her) and a statement of assets under oath.
- G. **Substituted Reference to Hearing Officer.** In the event a hearing officer is appointed instead of a hearing committee, all references in this Article to the "hearing committee" or "presiding officer" shall be deemed to refer instead to the hearing officer, unless the context would clearly otherwise require.
- H. **Waiver of Rights.** In the event the Affected Practitioner fails to, within 7 days after notice, submit written questions or raise objections to proposed members of the hearing committee or to a proposed alternate hearing officer, he/she shall be deemed to have waived his/her right to submit such questions and/or make objections to the composition of the hearing committee or the selection of an alternate hearing officer. Further, a failure of the Affected Practitioner to submit financial information, within 7 days of notice, to the CEO as necessary to establish a claim of poverty with regard to payment of the hearing officer shall constitute a waiver of any right to have the Medical Center pay the full amount of a hearing officer's fee. The failure to timely submit one-half of the estimated fees and expenses of a hearing officer, if one is appointed, shall be deemed to be a waiver of the right to any hearing, unless an exception based on poverty is granted. In addition, the failure of the Affected Practitioner to pay his/her share of the finally determined fees of the hearing officer, after

the hearing, shall result in the withholding of any clinical privileges the Affected Practitioner holds, until such obligation is paid.

### **Section 5. Personal Presence**

The personal presence of the Affected Practitioner shall be required. An Affected Practitioner who fails without good cause to appear and to proceed at such hearing shall be deemed to have waived such rights or review.

### **Section 6. Presiding Officer**

The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present appropriate oral and documentary evidence. The presiding officer shall determine the order of procedure during the hearing and shall make all rulings on the matters of law, procedure, and the considerations of evidence. If a single hearing officer conducts the hearing, he/she shall serve as the presiding officer.

### **Section 7. Representation and Appointment of Advocate**

The Affected Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the MS or NPHCP Staff in good standing or by a member of his/her local professional society. The MSEC or Board, as may be applicable, shall appoint a person to present the facts in support of its adverse recommendation referred to as the "Advocate". The Advocate may present evidence; however, if he/she is a MSEC or Board member, he/she shall not participate in deliberations nor vote on the matter at issue. Representation of either party, by an attorney at law, shall be governed by the provisions of Article VI (1)

### **Section 8. Rights of Parties**

- A. During a hearing, each of the parties shall have the right to:
  - 1. Call and examine witnesses
  - 2. Cross-examine witnesses called by the other party;
  - 3. Introduce exhibits;
  - 4. Question witnesses on matters relevant to the issues; and
  - 5. Rebut any evidence.
- B. If the Affected Practitioner does not testify, he/she may be called and examined as if under cross-examination.

### **Section 9. Procedure and Evidence**

There shall be at least a majority of the members of the hearing committee present to allow the hearing to begin. No proxies shall be allowed. The hearing will not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to, during, at the close of or if specifically requested and authorized by the presiding officer, within 7 days of the hearing, be entitled to submit a memoranda concerning any issue of procedure, fact, or conclusions drawn from fact, and such memoranda shall become part of the hearing record. The presiding officer may, but shall not be required, to order that oral evidence be only taken on oath or affirmation.

### **Section 10. Matters Considered**

In addition to relevant evidence formally presented at the hearing, the hearing committee shall be entitled to consider any pertinent material contained on file in the Medical Center and all other information, which can be considered in connection with applications for appointments or reappointments to the MS or NPHCP Staff and a request for clinical privileges. In this respect, to facilitate the hearing efficiency, subject medical charts, investigative reports, pertinent correspondence, committee minutes, and the statement of reasons, may be furnished by the CEO



in his/her discretion, to the hearing committee provided the Affected Practitioner is advised same have been furnished to the hearing committee and may challenge its relevancy at the hearing. The hearing committee shall be entitled to conduct independent review research and interviews, or retain an independent consultant to do so, but may utilize the products of such in its decision, only if the Affected Practitioner and the Advocate are aware of such, and have an opportunity to rebut any information so gathered.

### **Section 11. Burden of Proof**

The Advocate shall have the initial obligation to present evidence in support of the subject recommendation or action. The Affected Practitioner shall thereafter be responsible for supporting a challenge to the adverse recommendation or action by convincing evidence that:

- A. The grounds therefore are not supported by the evidence; or
- B. The conclusions drawn there-from are arbitrary or capricious.

### **Section 12. Record of Hearing**

A certified court stenographer (reporter) shall record the hearing. The Affected Practitioner shall be entitled to a copy of the record upon payment of the costs for a duplicate copy. If the practitioner desires an alternative means to record the hearing committee minutes, he/she must request approval of alternative means from the Chair of the Hearing Committee. If approved, the alternative method may be used at the practitioner's expense. Full copy of the record will be provided to the Committee.

### **Section 13. Deliberations and Recommendation of the Hearing Committee or Hearing Officer**

- A. **Deliberations.** The hearing committee may recess and continue the hearing to a noted later date. Upon conclusion of the presentation of evidence, the hearing shall be closed. Once closed, the hearing shall not be reconvened without further order from the authority that convened the hearing. Within 30 days thereafter, the hearing committee, outside the presence of any other person, shall conduct deliberations and consider the admitted evidence. The decisions made shall be based upon a majority of hearing committee members present. No proxy votes shall be allowed.
- B. **Contents of Report.** The hearing committee shall prepare a report, which shall contain a concise statement of recommendations and the reasons justifying the recommendations made. This report shall be delivered to the CEO.

### **Section 14. Disposition of Hearing Committee Reports**

Upon its receipt, the CEO shall forward the hearing committee report and recommendation, along with all supporting documentation, to the Board for further action. The CEO shall also send a copy of the report and recommendation by Certified Mail to the Affected Practitioner. A copy of the report of the hearing shall be delivered by the CEO to anybody other than the Board that made the adverse recommendation for informational purposes.

### **Section 15. Notice and Effect of Results**

- A. **Effect of and Action Upon Favorable Hearing Committee Report.** If the hearing committee's report pursuant to Article V, Section 13 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 hearing committee or the MSEC for further consideration or information. Any such referral back shall state the reasons therefore, 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 would result in any of the recommendations or actions listed in Article V (1)(A-D), the Certified Mail shall inform the Affected Practitioner of a right to request an appellate review by the Board as provided in Article V, Section 18 of this Plan, as if the hearing committee's report had been adverse. In such circumstances, the Board's tentative position adverse to the Affected Practitioner shall be represented by a person, selected by the Chairperson of the Board for appellate review. All references in Article V, Section 14 through 16, of this Plan to the "hearing committee" would instead refer to the Board, as the context requires.

**B. Effect of Adverse Hearing Committee Report.** If the report and recommendation of hearing committee pursuant to Article V (13) (B) is adverse to the Affected Practitioner in any of the respects listed in Article IV (1) or Article V (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 V (16) of this Plan.

#### **Section 16. Request for Appellate Review**

An affected Practitioner shall have 10 days following receipt of a notice, to file a written request for an appellate review. Such request shall be delivered to the CEO either in person or by certified mail and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, which was considered in making the adverse action or result.

#### **Section 17. Waiver by Failure to Request Appellate Review**

An Affected Practitioner, who fails to request an appellate review within 10 days and in the manner specified, waives any right to such review. Such waiver shall have the same force and effect as that provided in the Fair Hearing Manual.

#### **Section 18. Notice of Time and Place for Appellate Review**

Upon receipt of a timely request for appellate review, the CEO shall deliver such request to the Board. The Board shall schedule and arrange for an appellate review which shall be not more than 45 days from the date of receipt of the appellate review request; provided, however, that an appellate review for a MS or NPHCP Staff member who is under a suspension then in effect shall be held as soon as the arrangements and preparations for it may reasonably be made. The CEO shall send the Affected Practitioner notice of the time, place and date of the review. The time for the appellate review may be extended, by the Board for good cause.

#### **Section 19. Appellate Review Body**

The Board shall be the appellate review body; one Board member shall be designated as chairperson of the appellate review proceedings.

#### **Section 20. Nature of Appellate Review Proceedings**

The appellate review proceedings of the Board shall be an appellate review based solely upon the record of the hearing before the hearing committee, that committee's report, and all subsequent results and actions thereon. The Board shall also consider the written statements as may be presented and accepted under this Article.

#### **Section 21. Written Statements**

The Affected Practitioner shall submit a written statement detailing those findings of fact, conclusions and procedural matters with which he/she disagrees, and the reason for such disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the Board through the CEO at least 5 days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the MSEC, or if Board action is being appealed, the person selected by the Board to take the position adverse to the Affected Practitioner. If submitted, the CEO shall provide a copy thereof to the Affected Practitioner



at least 2 days prior to the scheduled date of the appellate review.

#### **Section 22. Presiding Officer**

The chairperson of the appellate review proceedings shall be the presiding officer for any appellate hearing and shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

#### **Section 23. Oral Statement**

The Board in its sole discretion may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put by any member of the Board.

#### **Section 24. Consideration of New or Additional Matters**

Subject to Article VI (3) below, new or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in his/her record shall be introduced at the appellate review only under unusual circumstances. The Board in its sole discretion shall determine whether such matters or evidence shall be considered or accepted.

#### **Section 25. Recesses and Adjournment**

The Board may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the proceedings shall be closed. The Board shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared adjourned.

#### **Section 26. Action Taken By Board On Appeal**

The Board may affirm, modify or reverse the adverse result or action taken by the hearing committee or officer pursuant to Article V (15), or, in its discretion, may refer the matter back to the hearing committee or officer for further review and recommendation to be returned to it within 45 days and in accordance with its instructions. Within 15 days after receipt of such recommendation after referral, the Board shall make its final decision.

#### **Section 27. Final Board Action After Appellate Review**

Unless the matter is referred back to a hearing committee or officer pursuant to Article V (26), within 15 days after the conclusion of the appellate review, including referrals back to the hearing committee or officer, the Board shall render its decision in the matter in writing and shall send notice thereof to the Affected Practitioner by Special Notice, to the MSP, and to the MSEC.

#### **Section 28. Health Care Quality Improvement Act of 1986**

Those actions or recommendations, which entitle an Affected Practitioner to a special hearing pursuant to Article IV, are those matters the Medical Center and MS or NPHCP Staff reasonably believe represent "professional review action" and "professional review activity," which may "adversely affect" a "physician" pursuant to the Health Care Quality Improvement Act of 1986. In this respect, it is the intent and purpose of this Plan that the initiation and conduct of professional review actions hereunder comply with all material respects with the provisions of S412 of the Act.

## **ARTICLE VI. GENERAL PROVISIONS APPLICABLE TO BASIC AND SPECIAL HEARINGS**

### **Section 1. Attorneys**

## A. The Parties

1. **Basic Hearings.** If the Affected Practitioner desires to be represented by an attorney at any basic hearing or at any appellate review pursuant to the provisions of Article III of this Plan, the request for such hearing or appellate review must so state. The hearing committee or appellate review body shall, in its sole discretion, determine whether to permit such representation at the hearings. If and only if it allows the Affected Practitioner to be so represented, the MSEC or the Board may also be represented by an attorney at the hearing.
2. **Special Hearings.** If the Affected Practitioner desires to be represented by an attorney at any special hearing or at any appellate review appearance pursuant to the provisions of Article V of this Plan, the request for such hearing or appellate review must so state. The Affected Practitioner shall have an unqualified right to be represented by an attorney at any such special hearing or appellate review appearance. If the Affected Practitioner chooses to be so represented, the MSEC or the Board, may also be represented by an attorney at the hearing. Notwithstanding the foregoing, an attorney may be contacted at appropriate times during the proceedings by any party for advice, provided such contact does not unduly interfere with the conduct of a hearing as determined by the presiding officer.

- B. **The Hearing or Appellate Review Body or Administrator.** A hearing or appellate review body may, in its discretion, consult with legal counsel at any stage of the proceedings for advice on appropriate hearing conduct or the drafting of its report(s). Medical Center counsel may serve as counsel to the Medical Center, the hearing committee and the Advocate in the same proceeding.

### Section 2. Waiver

If at any time after receipt of certified mail of an adverse recommendation, action or result, an Affected Practitioner fails to make a required request or appearance or otherwise fails to comply with this Plan, the Affected Practitioner shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights under the Bylaws then in effect or under this Plan with respect to the matter involved.

### Section 3. Independent Consultants

At any stage of hearing proceedings, a hearing committee or the Board may retain an independent consultant, who may or may not be a member of the MS or NPHCP Staff. The consultant may be provided with medical records, films, slides, reports, or such other materials he/she and the requesting body may deem appropriate for his/her review. The consultant shall present a written or oral report to the requesting body, which shall be made available to the parties. A consultant so elected should not be deemed a witness for any of the parties, but an independent advisor whose opinions represent evidence, which may be considered.

### Section 4. Supplemental Hearing Rules

The presiding officer of any hearing or appellate review body may promulgate, with or without the advice of legal counsel, hearing rules to supplement those contained in these Bylaws. Such rules shall be fundamentally fair to all parties and generally consistent with the provisions of the Bylaws. The supplemental rules may set forth order of presenting evidence and oral statements as well as time limit for presentations. When feasible, the presiding officer may in his/her discretion arrange a pre-meeting with the parties (or their representatives) to decide upon such rules or ask the parties (or their representatives) to meet and propose rules subject to his/her approval. When such rules are promulgated by the presiding officer, they shall be furnished to the parties before the hearing. Written objections by any of the parties shall be considered and, when meritorious, amendments deemed shall be made in the rules to address the objections.

### Section 5. Number of Reviews

Notwithstanding any other provision of the Bylaws of this Plan, no Affected Practitioner shall ever be entitled as a right to more than one hearing and appellate review with respect to an adverse recommendation or action. Further,

the MSEC and the Board need not conduct additional hearings or reviews upon reapplication or request for reconsideration by an Affected Practitioner, absent a clear and convincing indication of new or additional information which has a substantial probability of changing the outcome of the previous hearing or appeal.

#### **Section 6. Release**

By requesting a hearing or appellate review under this Plan, the Affected Practitioner agrees to be bound by the provisions of the Bylaws, this Plan, and the Rules and Regulations, in all matters relating thereto.

#### **Section 7. Adjournments and Time Limit Modification**

Any procedural rule or time limit specified in this Plan may be modified or waived by agreement between the presiding officer of the hearing committee, and the Affected Practitioner, duly authorized designate or any of them. The Board, the presiding officer or a hearing committee may discretionarily grant an extension of any time limits when required for fundamental fairness to any party, to obtain new evidence or for consultation. An Affected Practitioner who requests an extension of any time limit or adjournment which is granted, waives any right to insist on any other time limits specified herein being complied with.

#### **Section 8. Good Faith-Alternative Special Notice**

- A. **Good Faith.** In addition to those duties imposed in the Bylaws, it shall be the duty of each MS or NPHCP Staff member or initial applicant who requests a formal hearing to act with utmost good faith before and during the hearing process. Such good faith shall include, but not be limited to, timely compliance with requirements, cooperation in the receipt of required notices, and the exercise of procedures in this Plan without intent to cause undue delay. In addition to other automatic hearing and appeal right waivers for non-compliance with time limits or appearance requirements, upon a finding by a hearing committee, hearing officer, or the Board that an Affected Practitioner is not acting or has not acted in good faith with regard to the hearing process of this Plan, the hearing committee, hearing officer or Board may limit or deem waived the Affected Practitioner's rights to hearing, appeal, or use of particular procedures in a hearing or appeal.
- B. **Alternative Mailing.** If, in attempting to give Special Notice, postal authorities, despite reasonable efforts, are unable to deliver or obtain signature on a return receipt for registered or certified mail, or a representative of the Medical Center, despite reasonable efforts, is unable to make personal delivery, at the designated place of mail delivery for the Affected Practitioner, such Special Notice may alternatively be given by regular mail that is mailed at least 5 days before any deadline to the last home address and last office address provided by the Affected Practitioner to Administration.
- C. **Time Limits Constructive Receipt.** For the purpose of time limits of this Plan, if the mailing procedure of Article V, Section 8.b is used, the document mailed shall be deemed to have been received at the time the first attempt at registered or certified mail by postal authorities or personal delivery by Medical Center personnel was attempted, as documented by the written statement of either. This presumption of receipt shall be binding on the Affected Practitioner, even if it means rights to hearing, appeal, or objection are waived by failure to comply with time limits. This presumption may be overcome only by a clear and convincing showing to the presiding officer that the failure to make delivery or sign a receipt, was due to error, neglect, or unreasonable delay, of the postal authorities or Medical Center representatives, and not the Affected Practitioner.
- D. **Designated Place of Mail Delivery.** The designated place of mail delivery shall be the office address last provided by the Affected Practitioner to Administration and any person who signs a receipt for mail there shall be deemed as authorized by the Affected Practitioner to do so. In the event of his/her absence, each Affected Practitioner shall either: (a) authorize his/her office staff members to receive and sign receipts for mail on his/her behalf, or alternatively, (b) if his/her office shall be closed for more than two successive business days or he/she does not wish his/her office staff to be authorized to receive and sign a receipt for mail on his/her behalf, he/she must in a writing sent by certified mail to the CEO, designate the name and address of an alternate place of delivery (e.g., a law or accounting firm) and provide a statement that any person who

receives and signs for mail there is authorized to do so on his/her behalf.

- E. **Purpose Good Faith.** The purpose of the foregoing provisions of Article 5, Section 8.a and b are to assure reasonable efforts to give required notices and precede forward with requested hearings, are not thwarted or delayed by refusal to accept delivery, refusal to sign receipts, office closure, absence from the community, or the bad faith on the part of an Affected Practitioner.

### **Section 9. Consolidation**

If two or more hearings and/or appeals with respect to the same MS or NPHCP Staff member are proceeding simultaneously, (e.g., summary suspension and non-reappointment), the Board, at the request of the affected MS or NPHCP Staff member, the CEO, MSP, or the MSEC, may order the two proceedings consolidated into a single hearing or appeal. In this respect, the Board shall have the authority to suspend or modify time limits and take whatever action most reasonably and fairly to all concerned to accommodate the consolidation.

## **ARTICLE VII: INVESTIGATIONS, CORRECTIVE ACTION, AND SUSPENSION**

### **Section 1. Corrective Action**

- A. **Initiation.** Whenever the activities or professional conduct, including any oral or written act, either within or outside of the Medical Center, of any MS or NPHCP Staff member with clinical privileges are, or are reasonably likely to be contrary to patient safety or the delivery of quality patient care, or are reasonably likely to be disruptive to Medical Center operations or the continued effective operation of the Medical Center, corrective action against that MS or NPHCP Staff member may be initiated by any officer of the Medical Staff, by the chair of any department or committee of the Medical Staff, by the Chief Executive Officer, any members of the MSEC, or by the Board.
- B. **Requests and Notification.** All requests for investigation shall be signed and submitted in writing to the President of the Medical Staff and shall include a description of the conduct or statement which constitutes the grounds for the request. Upon receipt of such request, the President of the Medical Staff shall inform the MSEC, which shall then appoint an Ad Hoc Committee to investigate the matter.
- C. **Interview Before Ad Hoc Committee.** Any alleged conduct, for which an investigation has been requested, shall initially be considered by the Ad Hoc Committee. After conducting a preliminary investigation the Ad Hoc Committee may, at their sole discretion, request a practitioner to appear before the Committee. This appearance shall not constitute a hearing and shall be preliminary in nature. None of the procedural rules provided in these Bylaws or the Appended Fair Hearing Plan with respect to hearings or appeals shall apply. The Ad Hoc Committee shall make a record of all such appearances.
- D. **Findings and Recommendations of the Ad Hoc Committee.** At the conclusion of the Committee's investigation, it shall deliver a report to the MSEC, which shall include findings and recommendations. Any action by the MSEC to reduce, suspend, or revoke clinical privileges or to suspend or to revoke MS or NPHCP membership shall confer upon the MS or NPHCP Staff member the procedural rights set forth in the appropriate section of the Fair Hearing Plan.

### **Section 2. Summary Suspension**

Whenever a MS or NPHCP Staff member's activities or professional conduct, including any oral or written act, either within or outside of the Medical Center, are, or are reasonably likely to be, contrary to patient safety or the delivery of quality patient care, disruptive to Medical Center operations or the continued effective operation of the Medical Center, the President of the Medical Staff, the Chief Executive Officer, or the Chairperson of the Board shall have the authority to summarily suspend the MS or NPHCP Staff membership status of all or any portion of clinical privileges of such staff members. Any summary suspension imposed shall be effective immediately upon imposition

and shall, in the event corrective action is recommended, continue pending resolution of the request for corrective action, except as otherwise determined by the Chief Executive Officer. The President of the Medical Staff, the Chief Executive Officer, or the Chairperson of the Board shall promptly notify the practitioner by special notice of the suspension. If the suspension or restriction remains in effect for 15 days or more, the Affected Practitioner is entitled to Special Hearing Procedures outlined in the Fair Hearing Plan, Article No. IV.

### **Section 3. Automatic Suspension**

- A. **Licensure.** A MS or NPHCP Staff member whose license to practice in Iowa is revoked or suspended shall immediately and automatically be suspended from practicing in the Medical Center for as long as the revocation or suspension remains in effect. A MS or AHP Staff member, who has been placed on probation by the Iowa Board of Medicine, may be automatically suspended or his privileges may be retained subject to such conditions as are imposed by the MSEC or the Board.
- B. **DEA Registration.** A MS or NPHCP Staff member whose state or federal (DEA) narcotics registration is revoked or suspended shall immediately and automatically be divested at least of his right to prescribe medications covered by such registration. As soon as possible after such automatic suspension, the MSEC shall convene to review and consider the facts under which the state or federal registration was revoked or suspended. The MSEC may then take such further corrective action as is appropriate to the facts disclosed in its investigation.
- C. **Medical Records.** A MS or NPHCP Staff member who fails to complete medical records as required by these Bylaws and Rules and Regulations of the Medical Staff shall be automatically suspended from exercising all of his clinical privileges in accordance with the procedures set forth in the Rules and Regulations and Policies and Procedures of the Medical Staff.
- D. **Procedure.** In the event of an automatic suspension pursuant to Subsections (a) or (b) of this section, the Affected Practitioner shall be entitled to the Basic Hearing Procedures found in Article III of the Fair Hearing Plan. In the event of an automatic suspension pursuant to Subsection (c) of this section, the practitioner is entitled only to submit a written statement as outlined in Article 1, Section 3 of the Fair Hearing Plan.

### **Section 4. Bylaws Amendment - See Article XIII, Section 2: Medical Staff Composition and Function**

# **MEDICAL STAFF RULES AND REGULATIONS**

## **ARTICLE I: ADMISSIONS**

### **Section 1. Who May Admit Patients**

- A. The provider will be aware of and comply with the Medical Center's Administrative Policy, Patient Flow Management / Surge Plan. Index # 202.
- B. Patients can be admitted to the Medical Center only by Mercy MS members who have been privileged to do so in accordance with Iowa law and criteria for standards of care established by the Medical Staff.
- C. The Medical Center accepts patients for care and treatment commensurate with its clinical services offered and the availability of beds

### **Section 2. Dental Patients**

A dental patient receives the same basic medical assessment as patients admitted for other services. Responsibility is shared by the attending doctor of dental surgery and designated physician.

- A. Attending Doctor of Dental Surgery's Responsibilities include:
  - 1. A detailed dental history justifying admission.

2. A detailed description of the examination of the oral cavity and pre-operative diagnosis.
3. A complete operative report, describing the findings and technique used. In cases of extraction of teeth, the doctor of dental surgery clearly states the number(s) of the teeth removed. All tissue with the exception of that specified in *Laboratory Procedure Manual, Guidelines for Anatomic Pathology*, is sent to Pathology for examination.
4. Progress notes pertinent to the oral condition.
5. Discharge order.
6. Discharge summary

B. Designated Physician's Responsibilities include:

1. Medical history and physical pertinent to the patient's general health to determine the patient's condition prior to and suitability for anesthesia and surgery.
2. Supervision of the patient's general health status while hospitalized.

### Section 3. Podiatric Patients

A podiatric patient receives the same basic medical assessment as patients admitted for other services. The attending doctor of podiatric medicine and designated physician shares responsibility.

A. Attending Doctor of Podiatric Medicine's Responsibilities include:

1. A detailed history justifying admission.
2. A detailed description of the examination of the foot and pre-operative diagnosis.
3. A complete operative report, describing the findings and technique used. All tissue with the exception of that specified in *Laboratory Procedure Manual, Guidelines for Anatomic Pathology*, is sent to Pathology for examination.
4. Pertinent clinical progress notes.
5. Discharge order.
6. Discharge summary

B. Designated Physician's Responsibilities include:

1. Medical history and physical pertinent to the patient's general health to determine the patient's condition prior to and suitability for anesthesia and surgery.
2. Supervision of the patient's general health status while hospitalized.

### Section 4. Admitting Responsibilities

A. The provider will be aware of and comply with the Medical Center's Administrative Policy, Patient Flow Management / Surge Plan Index # 202.

B. All Medical Staff and **NPHCP** staff members must follow the admitting policies of the Medical Center, including specific admission criteria.

1. Except in an emergency, no patient is admitted to the Medical Center until a provisional diagnosis or valid reason for admission has been stated in the patient's medical record.
2. Each patient is the responsibility of an Attending MS member whether inpatient or outpatient. In the case of a group practice, the MS member who admits the patient may or may not be the Attending MS member. The Attending MS member must be identified at time of admission in the medical record. The Attending MS member is responsible for:
  - a. Quality medical care and treatment.



- b. Clinical accuracy of the medical record.
  - c. Providing the Medical Center with information concerning patient as may be necessary to protect the patient, other patients, or personnel from infection, disease or other harm, and to protect the patient from self-harm.
  - d. Completion of the discharge summary and final diagnosis documented in the medical record.
  - e. Prompt completion and accuracy of the medical record.
  - f. Necessary special instructions.
  - g. Transmittal of reports of condition of the patient to the referring practitioners and to relatives of the patient will be in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
- C. Diagnostic tests, procedures, surgery, therapy, treatment and care performed on or provided for patients while admitted are provided through Medical Center facilities or if Medical Center facilities are not available, through other facilities for which prior arrangement has been made with the Medical Center.

**Section 5. Alternate Coverage/ Internal Transfer of Care to Another Medical Staff Member**

- A. Each MS member provides professional care for his/her patients by being available or having available an alternate MS or **NPHCP** staff member who has clinical privileges sufficient to care for the patient and with whom prior arrangements have been made. Failure to meet the requirements concerning availability will be reported to the MSEC and may result in loss of clinical privileges. Alternate coverage other than routine call coverage arrangements are indicated in the patient's medical record.
- B. Whenever the admitting MS member transfers responsibility of the patient to another MS member, other than routine call coverage, the transfer is indicated in the patient's medical record. The MS member to whom the patient has been transferred, acknowledges the transfer within the patient's medical record. This MS member then is responsible for the care of the patient until discharge or formal transfer of care to another MS member.

**Section 6. Potentially Suicidal Patients**

Precautions are taken in the care of potentially suicidal patients to include but are not limited to:

- A. Any patient who has committed an overt act and/or apparent attempted suicide and/or homicide is admitted to the Behavioral Health area of the Medical Center, unless an acute condition requires placement in another medical unit. If there are no accommodations available in the Behavioral Health area, the patient is referred to another institution where suitable facilities are available. When transfer is not possible, the patient is admitted to a general area of the Medical Center with appropriate nursing and/or security measures provided.
- B. EMTALA guidelines are followed in all patient transfers. Prior to transfer to another facility, necessary care is rendered in order to protect the physical well being of the patient prior to, during and after transfer. Prior to transfer, temporary measures may be taken in order to maintain the safety of the patient and hospital personnel.
- C. Any patient known or suspected to be suicidal must be offered consultation or care by a Psychiatrist.

**Section 7. Emergency Admissions**

- A. The provider will be aware of and comply with the Medical Center's Administrative Policy, [Emergency Medical Treatment and Labor Act \(EMTALA\)](#) Index # 270.
- B. 24-Hour Coverage:
  - 1. 24-hour emergency service physician coverage is provided in the Medical Center's Emergency Center.
  - 2. In an emergency, if the provisional diagnosis or valid reason for admission isn't possible at the time of admission, such statement is recorded as soon after admission as possible.



3. If a staff physician is on-call to provide emergency services or to consult with an emergency room physician in the area of his or her expertise, that physician is considered to be available at the hospital. A determination as to whether the on-call physician must physically assess the patient in the emergency department is the decision of the treating emergency physician. If this specialty physician is requested to come to the hospital to physically assess the patient, he or she will do so. This physician may send a **NPHCP** (Orthopedic tech or **NPHCP**) as his or her representative. If the treating physician disagrees with the on-call physician's decision to send a representative and requests the appearance of the on-call physician, the on-call physician must comply.

C. Call List

1. The Emergency Department Providers are responsible for ensuring that treatment is provided and/or that appropriate consultation is obtained from the on-call providers.
2. The hospital will maintain an on-call list of providers, including specialists and sub-specialists who are routinely available to examine and treat patients with emergency medical conditions.

D. EMTALA guidelines are followed.

E. The provider will be aware of and comply with the Medical Center's Administrative Policy, [Physician "On Call" Coverage](#), Index # 350. On-call providers will respond to page within 15 minutes. On-call providers will be present in the Emergency Department within 45 minutes after receiving communication indicating that their attendance is required. Policies, including procedures to be followed when each particular specialty is not available or when on-call providers cannot respond, are maintained in the Emergency Department. The Emergency Department policies include treatment responsibilities, procedures for non-response of on-call providers, and other duties.

F. Coverage for MS Member not in Immediate Vicinity

1. Any MS member who doesn't reside in the immediate vicinity names a member of the MS who does reside in the immediate area who may be called to attend his/her patients in an emergency until he/she arrives.
2. In case of failure to name such an associate, the President of the Medical Staff, Department Chair or the Medical Center's CEO has the authority to call in any member of the Active MS.

G. Emergency Services Medical Record Requirements:

1. An appropriate medical record is kept for every patient receiving emergency service.
2. The medical record contains information concerning the time of the patient's arrival, means of arrival, by who transported, and information otherwise required by medical records.
3. The physician who is responsible for its clinical accuracy signs each patient's emergency medical record.

H. Emergency Preparedness

1. In the case of a disaster, the [Code Gray: Emergency Preparedness Policy](#) is followed.
2. Instructions for Medical Staff Privileges during a disaster can be located in the [Administrative Policies #805](#) on the Intranet.

## Section 8. Admitting Priorities

Patients are admitted according to the following order of priorities:

- A. Emergency – includes those patients whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permanent harm and any delay in admitting the patient for treatment would add to that harm or danger. Evidence of willful or continued misuse of this classification is brought to the attention of the MSEC for appropriate action.

- B. Urgent – includes non-emergency patients whose admission is considered imperative by the attending MS member. Urgent admissions are given priority when beds become available over all other categories except emergency. Evidence of willful or continued misuse of this classification is brought to the attention of the MSEC for appropriate action.
- C. Routine – includes elective admissions involving any services. If unable to handle all such admissions, admissions are made on a first scheduled basis.

### **Section 9. Admitting Locations/Transfer Priorities (within the Medical Center)**

- A. No patient is transferred without such transfer being approved by the responsible MS member.
- B. When possible, patients are admitted to the appropriate nursing unit customarily designated as:
  - 1. Providing care in a specific field for a specific service (i.e. obstetrics, orthopedics, pediatrics, etc).
  - 2. When deviations are made from the customary assigned areas, an attempt to correct these assignments will be made at the earliest possible time, keeping within transfer priorities.
- C. Any questions as to validity of admission to or discharge from the Critical Care Unit are referred to the Medical Director of the CCU or his/her designee.
- D. Transfer Priorities: (within the Medical Center)
  - 1. From a general care area to the Critical Care Unit.
  - 2. From Emergency Department to an appropriate patient care area.
  - 3. From Birth Center to general care area, when medically indicated.
  - 4. From Critical Care Unit to general care area.
  - 5. From Temporary placement and a non-clinical area to an appropriate clinical service area, sufficient to meet the patient's medical needs.
  - 6. From semi-private room to private or from private to semi-private upon the request of the practitioner or patient, with mutual agreement of both.

### **Section 10. Continued Hospitalization**

The attending MS member is required to document the need for continued hospitalization after specific periods of stay as identified by governmental regulations, third party payers or per protocol of Medical Center Medical Records/Utilization Review. Documentation includes:

- A. A progress note entry as to the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient).
- B. The estimated period of time the patient will need to remain hospitalized.
- C. Plans for post-hospital care.

### **Section 11. Readmission**

- A. When a patient is readmitted within 7 days for the same or a related problem, an interval history and physical exam, or admission note reflecting any subsequent changes may be used in the medical record provided the original information is readily available and the interval history reflects the fact of the prior admission within 7 days.
- B. In case of readmission of the patient, all previous records are available for use by the attending medical staff member, whether the patient is attended by the same provider or by another.

### **Section 12. Transfer of Patients (External)**

- A. A patient may be transferred when the Medical Center exhausts its capabilities in attempting to resolve an emergency medical condition by inability to provide the services required or by request of the patient or the patient's representative.
- B. The Medical Center and/or the attending MS member:
  - 1. Assists the patient and family in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient. If the patient is to be transferred to another health care facility, the responsible MS member or designee enters all the appropriate information on the patient's medical record prior to transfer. EMTALA guidelines are followed in all patient transfers.
  - 2. Does not transfer a patient unless medical treatment within the capacity of the Medical Center is provided to minimize the risk to that individual's health and, in the case of a woman in labor, the health of the unborn child during the transfer.
  - 3. Ensures that a patient is not transferred to another medical care facility until the receiving facility has consented to accept the patient, has space and qualified personnel available for the treatment.
- C. Ensures the transfer is affected through qualified personnel and transfer equipment.
- D. Ensures that medical records related to the emergency medical condition available at the time of transfer are sent to the receiving facility.

### **Section 13. Secluded/Restrained Patients**

Care of patients in restraints or seclusion will be followed as outlined in Administrative Policy [RESTRAINT Index No. 187](#).

### **Section 14. Drugs and Medications**

- A. All drugs and medications administered to patients are those listed in the latest edition of:
  - 1. United States Pharmacopoeia, National Formulary
  - 2. Medical Center's Formulary
  - 3. American Hospital Formulary Service OR
  - 4. AMA Drug Evaluations.
- B. Drugs for bona fide clinical investigation may be exceptions. Requests to use experimental drugs are forwarded to the Institutional Review Board for approval or rejection.

## **ARTICLE II: DEATHS**

### **Section 1. Deaths within the Medical Center**

- A. The deceased is pronounced dead by the attending MS member or his/her designee within a reasonable time. Exceptions are made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death.
- B. The body is released from the morgue according to the Administrative Policy, [Autopsy/Morgue/Patient Death #223](#).

### **Section 2. Autopsies**

It is the duty of all MS members to attempt to secure autopsies in all cases required by the Code of Iowa. MS members determine the necessity of autopsies recommended by the Code of Iowa as listed in Administrative policy, [Autopsy/Morgue/Patient Death #223](#).

Autopsy requirements:

- A. An autopsy is performed only with written consent, signed in accordance with state law, except for Medical Examiner's cases.
- B. Autopsies shall be performed by a pathologist trained or with experience in forensic pathology, licensed to practice medicine and surgery or osteopathic medicine and surgery in the state of Iowa and board-certified by the American Board of Pathology, or under the direct supervision of a physician with these qualifications.
- C. The attending physician is notified when an autopsy is being performed.
- D. Provisional anatomic diagnoses are recorded in the medical record within 3 days of the death. The complete autopsy report (including a gross, microscopic, and final diagnostic report) is made part of the clinical record within 60 days of the autopsy unless exceptions for special studies (for example: chromosome analysis) are established in writing by the clinical staff.
- E. If the autopsy diagnosis disagrees with the final clinical diagnosis, the report is forwarded to the Department Chair, who will determine if the case warrants going to FPPE. The credentialing committee then reviews the findings of the FPPE.

## **ARTICLE III: MEDICAL RECORDS**

### **Section 1. General Rules**

- A. A medical record is maintained for each patient who is evaluated or treated as an inpatient, outpatient, ambulatory care (clinic) patient, emergency patient, Medical Center Home Care patient, or Hospice patient.
  - 1. Only authorized individuals make entries in medical records. The attending MS member is responsible for the preparation of an accurate, complete, legible and timely medical record for each patient under his/her care. This responsibility cannot be delegated.
  - 2. The contents of the medical records are pertinent and current. A single attending MS member is identified in the medical record as being responsible for the patient at any given time.
- B. The following requirements are enforced by the Health Information Management Department: (Refer to Medical Record – Required Elements)
  - 1. History and Physicals are performed in accordance with this Article.
  - 2. Consultations are documented within 24 hours of the consultation and are performed in accordance with this Article.
  - 3. Progress notes are performed in accordance with this Article.
  - 4. All surgical procedures are fully described by the operating surgeon who records information immediately after the procedure, and are performed in accordance with this Article.
  - 5. Medication Reconciliation
    - a. Admission Medication reconciliation will be completed and documented within 24 hours of admission, and is the responsibility of the attending physician.
    - b. Transfer Medication reconciliation will be completed and documented when a patient transfers from one level of care to another level of care, and is the responsibility of the physician continuing the care of the patient.
    - c. Discharge Medication reconciliation will be completed prior to the patient being discharged from the facility, and is the responsibility of the discharging physician.
  - 6. When an autopsy is performed, provisional anatomic diagnosis is recorded in the medical record within 3 days and the complete autopsy report is included in the medical record within 60 days of the death.

### **Section 2. Abbreviations, Signs, Symbols**

- A. Only those abbreviations, signs, and symbols authorized by Trinity Health are used in the Medical Record. No abbreviations, signs or symbols are used in recording the patient's final diagnosis or any unusual complications. There are no acceptable abbreviations for medicine names: complete spellings for all drug names are used.

**Section 3. Authentication/Signature Stamps**

- A. All clinical documentation (orders, progress notes, caregiver notes, anesthesia record, consultation and operative reports, transfer and discharge summaries) in the medical record are dated, timed, and authenticated by the author of the entry.
- B. A single signature on the face sheet of the record does not suffice to authenticate the entire record.
- C. Indication of authentication includes written or electronic signatures. Signature stamps or copies of signatures are not allowed in the medical

**Section 4. Co-signatures**

The following table indicates when Co-signatures of an MD or DO are required:

	H & P	ORDERS	ORDERS: MEDS	PROGRESS NOTES	ANESTHESIA RECORD	CONSULT DICTATION	OPERATIVE/PROCEDURE REPORT	DISCHARGE/TRANSFER SUMMARY
<b>DDS</b>	Out of Scope	In Scope	In Scope	In Scope	In Scope w Co-Signature	In Scope	In Scope	In Scope
<b>DPM</b>	Out of Scope	In Scope	In Scope	In Scope	In Scope w Co-Signature	In Scope	In Scope	In Scope
<b>PA</b>	In Scope	In Scope*	In Scope*	In Scope*	Out of Scope	In Scope w Co-Signature	In Scope w Co-Signature	In Scope w Co-Signature
<b>CCNS</b>	In Scope	In Scope*	In Scope*	In Scope*	Out of Scope	In Scope w Co-Signature	Out of Scope	In Scope w Co-Signature
<b>CNM</b>	In Scope	In Scope*	In Scope*	In Scope*	Out of Scope	In Scope w Co-Signature	In Scope	In Scope w Co-Signature
<b>CNP</b>	In Scope	In Scope*	In Scope*	In Scope*	Out of Scope	In Scope w Co-Signature	Out of Scope	In Scope w Co-Signature
<b>CRNA</b>	Out of Scope	In Scope	In Scope	In Scope	In Scope w Co-Signature	Out of Scope	Out of Scope	Out of Scope
<b>Phys Therapist</b>	Out of Scope	Out of Scope	Out of Scope	In Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope
<b>Occup Therapist</b>	Out of	Out of Scope	Out of Scope	In Scope	Out of	Out of	Out of	Out of

	H & P	ORDERS	ORDERS: MEDS	PROGRESS NOTES	ANESTHESIA RECORD	CONSULT DICTATION	OPERATIVE/PROCEDURE REPORT	DISCHARGE/TRANSFER SUMMARY
	Scope				Scope	Scope	Scope	Scope
<b>Speech Therapist</b>	Out of Scope	Out of Scope	Out of Scope	In Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope
<b>RN</b>	Out of Scope	Out of Scope	Out of Scope	In Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope
<b>Residents / Fellows</b>	In Scope w Co-Signature	In Scope	In Scope	In Scope	In Scope w Co-Signature	In Scope w Co-Signature	In Scope w Co-Signature	In Scope w Co-Signature
<b>Medical Student</b>	In Scope w Co-Signature	In Scope w Co-Signature	In Scope w Co-Signature	In Scope w Co-Signature	Out of Scope	In Scope w Co-Signature	In Scope w Co-Signature	In Scope w Co-Signature
<b>CRNA Student</b>	Out of Scope	In Scope w Co-Signature	In Scope w Co-Signature	In Scope w Co-Signature	In Scope w Co-Signature	Out of Scope	In Scope w Co-Signature	Out of Scope

\* = Co-signature In Scope required in designated Rural Health Clinics

The statement "Dictated by \_\_\_\_\_, ARNP, PA or other for Dr \_\_\_\_\_" is used when the dictation requires Co-signature is indicated.

## Section 5. Medical Orders

### A. Who May Write Orders

All orders for treatment, diagnostic studies and procedures are written by those who have the authority as permitted by their license, clinical privileges and/or their scope of practice. **Under defined guidelines, patients may self-order specific wellness tests.**

### B. General Requirements for Orders

1. Written orders must be clear, legible, and complete. Orders that are illegible or improperly written are not carried out until they are clarified by the ordering provider and are understood by the nurse. Repeated illegibility of orders will be reported to the MSEC and may result in suspension of clinical privileges.
2. Use of the terms "renew", "repeat", and "continue" as stand-alone orders are not acceptable.
3. Writing blanket orders (e.g. resume pre-op medications, resume home medications) is not acceptable.
4. When a patient is transferred from one provider of care to another or to another level of care, all orders for medication or treatment are reviewed and reconciled.
5. MS will provide appropriate communication when patient care is transferred from one MS provider to the next MS provider.

### C. Verbal Orders

1. A verbal or phone order for medication or treatment is accepted only under circumstances when it is impractical for such orders to be entered electronically or written by the ordering MS or **NPHCP** member.
2. Verbal or phone orders are given only to authorized individuals. [Receiving Verbal Orders](#) (Administrative

Policy #366) Verbal or phone orders are to be recorded, verbally repeated back to the ordering provider to verify accuracy (Verbal Read Back) by the receiving staff, and entered electronically. In situations where recording the verbal or phone order is not feasible, authorized individual will verbally repeat back the complete order to the provider before carrying out the order.

3. Verbal or phone orders include the name of the person who gave the order, date, time and order communication type.
4. The signature of the person receiving the verbal or phone order is required if the verbal or phone order is written instead of immediately recorded into the electronic record.
5. A verbal or phone order that is written on paper should be entered into the electronic record with an order communication type of "transcribed verbal". This order will be sent to the ordering provider's Inbox for signature.
6. Verbal or phone orders are signed by the prescribing provider as soon as possible, which means the earlier of the following:
  - a. The next time the prescribing provider provides care to the patient, assesses the patient, or documents information in the patient's medical record
  - b. Within 25 days of when the order was given
  - c. **In-patient Admit orders must be signed prior to discharge.**
7. Counter signatures may be delegated to another provider in the absence of the prescribing provider.
8. Verbal or phone orders for Restraint of Behavioral Health patients are signed within one hour. Verbal or phone orders for restraint of all other patients are signed within 24 hours.
9. Acceptance of a verbal or phone order is limited to the following with noted restrictions:
  - a. An MS or **NPHCP** staff member with clinical privileges at the Medical Center.
  - b. A professional RN or LPN.
  - c. A pharmacist may receive a verbal order pertaining to drugs/medications.
  - d. A respiratory therapist may receive a verbal order pertaining to respiratory therapy treatment.
  - e. A Cardiovascular Technician (CVT) in the cardiac catheterization lab may receive a verbal order for labs, ABGs, x-ray, O2 sat, Echo, and Cardiac Cath.
  - f. A physical therapist, occupational therapist, or a speech pathologist may receive verbal orders for rehabilitation needs of a patient.
  - g. A licensed dietitian may receive a verbal order for the patient's dietary needs.
  - h. Medical Technologists, Medical Lab Technicians, and clinic Lab Assistant's orders pertaining to laboratory.
  - i. Medical assistants in the clinic setting may receive orders.
10. Acceptance of verbal orders by other departments/professionals is determined by the MSEC.
11. Repeated violation in the use of verbal orders will be reported to the MSEC and may result in suspension of clinical privileges.

#### D. Orders for Diagnostic or Specific Procedures

1. All requests for diagnostic tests or other special examinations and services shall include the reason for the exam. Departments have the authority to refuse to carry out requested studies if such information has not been provided, and should seek clarification when information is not complete.
2. Orders for serial electrocardiograms must specify both the desired frequency and the duration of the



series except for patients in the critical care unit.

3. All orders for therapy are entered into the patient's record, dated and timed and signed or counter-signed by the ordering MS or **NPHCP** staff member.
4. The attending MS or **NPHCP** staff member is responsible for ordering a therapeutic diet.
5. Written orders presented to the Patient Registration Department for Out Patient tests and procedures include the reason for the test or diagnosis, and must be signed and dated.

## **Section 6. Requirements of the Medical Record**

### **A. Policy related to the Medical Record:**

1. Reports of procedures, tests, and test results and other information obtained from outside sources and clearly identify the outside source, may be included as part of the patient's record.
2. All major entries that are dictated and received for entry into the medical record shall reflect the date of dictation and date of transcription.
3. Advance Directives are noted and addressed in the medical record.
4. The medical record for children and adolescents also includes the following:
  - a. An evaluation of the patient's developmental age.
  - b. Consideration of educational needs and daily activities as appropriate.
  - c. The parent's report or other documentation of the patient's immunization status.
  - d. The expectations of the family members and/or guardians for involvement in the assessment, treatment, and continuous care of the patient.
5. All medical record forms are standardized. No revision, deletion, or discontinuance of a Medical Record form is made without the approval of the Forms Committee. All new forms proposed for use in the medical record are submitted to the Forms Committee for review. The Medical Forms Committee has authority to approve or reject forms recommended for inclusion in the medical record. Approved changes are not made until the mechanics of standardization have been met.
6. In case of readmission of the patient, all previous records are available for use by the attending MS member through the EHR. This applies whether the patient is attended by the same provider, or by another.

### **B. Components of the Medical Record**

*SEE TABLE: MEDICAL RECORD – REQUIRED ELEMENTS*

History and Physical - See Medical Staff Bylaws Article XII, Requirements for History and Physical

#### **1. Consultations *SEE TABLE: MEDICAL RECORD – REQUIRED ELEMENTS***

##### **a. Who May Give Consultations?**

Any MS member with clinical privileges at the Medical Center or other professional can be asked for consultation or for professional opinion within his/her area of expertise.

##### **b. Responsibility for Requesting a Consultation:**

- The attending MS member, ARNP or PA is responsible for requesting and calling in a qualified consultant, when indicated.
- The attending MS member provides written authorization in the medical record to permit another MS member to attend or examine his/her patient, except in an emergency.
- If a nurse employed by the Medical Center has any reason to doubt or question the care

provided to any patient, or believes that appropriate consultation is needed and has not been obtained, that nurse notifies the Nursing Supervisor who in turn may refer the matter to the Chief Nursing Officer or the VP of Patient Services.

c. Consultations are required and are documented in the Medical Record for the following:

- All non-emergency cases whenever requested by the patient or the patient's personal decision-maker if the patient is incompetent.
- All cases in which the attending MS member concludes that:
  1. The diagnosis is obscure after ordinary diagnostic procedures.
  2. There is doubt as to choice of therapeutic measures to be used.
  3. Unusually complicated situations are present that require specific skills of another practitioner.
  4. The patient exhibits severe symptoms of mental illness or psychosis.
  5. The patient is not a good medical or surgical risk.

d. Psychiatric Consultations

- Any patient known or suspected to be suicidal must be offered consultation by a psychiatrist. If psychiatric care is recommended, evidence that such care has at least been offered or appropriate referral made is documented in the patient's medical record.
- Additional requirements for consultation may be established by the MSEC, as required.

e. Contents of a Consultation Report (when applicable)

- Examination of the patient,
- Consultant's opinion and recommendations.
- Date and time of the consultation.
- Consultant's signature.
- Statements such as "I concur" do not constitute an acceptable consultation report.
- The consultation report is made a part of the patient's medical record.
- If the consultation is for an operative or invasive procedure, and the need for consultation is not an emergency, the consultant's report is recorded in the patient's medical record prior to the procedure.

## 2. Progress Notes

- a. Progress Notes provide a pertinent, chronological report of the patient's course of care at the Medical Center. MS and **NPHCP** staff members can write Progress Notes as permitted by their clinical privileges.
- b. Progress Notes document the date of observation and contain sufficient information to ensure continuity of care at the Medical Center or other health care facility to which the patient might later be transferred.
- c. When possible, each of the patient's clinical problems are clearly identified in the Progress Notes and correlated with specific orders as well as results of tests and treatments.
- d. Progress Notes are completed at least daily, except for SNU, in which progress notes are completed at least every 14 days.
- e. Progress Notes documentation includes at least the following items:

- Comments describing the current status of the patient, including the patient's response to the treatment regimen.
- Any complications, new symptoms, or additional diagnosis for which the patient is evaluated or treated.
- Plans for additional work-ups, consultations, or definitive treatments.
- The final Progress Note which at a minimum states the discharge order and the principle diagnosis.
- For expired patients, the final Progress Note states, at a minimum, the diagnosis, date and time of death.

### 3. Informed Consents

#### a. Admission:

- The patient or patient's decision-maker signs the admission consent form at the time of admission.
- The admission consent form becomes part of the medical record

#### b. Invasive, Surgical, Non-routine or High Risk Medical Procedure:

- It is the responsibility of the attending MS member to obtain written consent or assure that the appropriate MS or **NPHCP** staff member obtains written consent from the patient or the patient's decision-maker.
- The MS member, who performs any invasive, surgical, non-routine or high-risk medical procedure that the Medical Center has determined requires written consent, obtains written consent prior to the procedure.
- Except in emergencies, failure to include a completed consent form in the patient's medical record prior to the procedure automatically cancels the surgery or procedure.
- Whenever a patient's condition prevents the obtaining of consent, every effort is made and documented to obtain the consent of the patient's decision-maker prior to the surgery or procedure. The detail is fully explained in the patient's medical record, when because of emergency needs, consent cannot be immediately obtained and the need involves a minor or otherwise incompetent patient.
- Should a second surgery or procedure be required during the same admission, a second consent is obtained. If two or more specific procedures are performed at the same time, and such information is known in advance, both procedures may be described and consented to on the same form.
- All informed consents are obtained in accordance with the Medical Center's policies and procedures and Iowa law.
- A patient or the patient's decision-maker retains the right to refuse medical treatment, even in an emergency. If a patient continues to refuse such treatment after an explanation of the potential risks that could result from lack of treatment, a refusal of care and appropriate release of responsibility form is executed and, if possible, signed by the patient. The form becomes part of the medical record.
- Consent Components include:
  1. The name of the specific procedure, or other type of medical treatment for which consent is being given; including the anatomical side, when applicable;
  2. Name of the responsible practitioner who is performing the procedure or administering the

medical treatment;

3. The risks, benefits, and consequences associated with the procedure or treatment as deemed by the physician.
4. The alternatives to this treatment or procedure, if applicable;
5. Indication that the patient and/or the patient's decision-maker have had the opportunity to ask and have questions answered.

4. Pre-Op or Pre-Invasive Procedure Record (when applicable):

Except in emergencies and in those circumstances required under Iowa law (i.e. pregnancy or best interests of a minor), the following data is recorded in the patient's medical record prior to surgery or other invasive procedure, or the operation or invasive procedure may be automatically cancelled.

- a. A pre-operative diagnosis.
- b. Verification of patient identity.
- c. Medical history and supplemental information regarding drug sensitivities and other pertinent facts.
- d. Provisional diagnosis
- e. Lab test results, if applicable.
- f. Radiology report, and other ancillary reports, if applicable.
- g. Consultation reports, if applicable.
- h. Consent form signed by the patient or the patient's legal decision maker.
  - In an emergency situation, the attending surgeon writes a note on the patient's condition stating that delay caused by reporting these elements would constitute a danger to the health or safety of the patient.
  - If the H&P has been dictated but not entered in the chart, an admission note and statement to that affect is entered in the chart for the attending physician

5. Operative or Other High-Risk Procedure Report (when applicable)

- a. An operative or other high-risk procedure report or written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. It includes:
  - The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
  - The name of the procedure performed
  - A description of the procedure
  - Findings of the procedure
  - Any estimated blood loss
  - Any specimen(s) removed
  - The postoperative diagnosis

When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes:

- The name(s) of the primary surgeon(s) and his or her assistant(s)
- Procedure performed and a description of each procedure finding

- Estimated blood loss
  - Specimens removed
  - Postoperative diagnosis
- b. The MS member who performed the procedure authenticates the completed operative report as soon as possible following the procedure.
- c. Any practitioner who attends the patient also enters an operative progress note in the medical record immediately after the procedure in order to provide pertinent information, as the patient is cared for in subsequent settings.
- d. Post-operative documentation records the patient discharge from the post-anesthesia care area by the responsible MS or AHP member according to discharge criteria, and records the name of the MS member responsible for discharge.
6. Anesthesia Record (when applicable)  
*SEE TABLE: MEDICAL RECORD – REQUIRED ELEMENTS*
- a. The anesthesia provider discusses anesthesia options and risks with the patient and family before anesthesia administration. An assessment of the patient's condition is performed before surgery, except in emergency cases where a modified assessment is acceptable.
- b. The patient is re-evaluated immediately before anesthesia induction according to anesthesia policy. The pre-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services.
- c. For the duration of the anesthetic, a record is maintained which reflects the care and monitoring of the patient's physiological status.
- d. General anesthesia for surgical procedures is not administered in the Emergency Center unless the surgical and anesthetic procedures are considered life saving.
- e. The patient's post-operative status is assessed on admission to the recovery area. Patients are discharged from the post-anesthesia recovery area using discharge criteria, which have been approved by the Medical Director of Anesthesiology.
- f. A Pre and post anesthesia evaluation for all patients undergoing surgery or other procedures that require anesthesia must be documented in the medical record. This documentation includes, but is not limited to, information relative to the choice of anesthesia for the procedure and any related unusual risk possibilities. The pre anesthesia evaluation must be performed by an individual qualified to administer anesthesia, and documented in the medical record within 48 hours prior to surgery or a procedure requiring anesthesia services. The post anesthesia evaluation must be performed by an individual qualified to administer anesthesia, and documented in the medical record no later than 48 hours after surgery or a procedure requiring anesthesia services.
- g. Anesthesiologists' assist with development of policies and procedures that address the care provided to patients who undergo procedures that could result in loss of protective reflexes (i.e. endoscopy lab, cardiac catheterization laboratory, emergency center, Birth Center, radiology department, and electroconvulsive treatment rooms).
7. Pathology Report (when applicable)
- a. All specimens, tissue and non-tissue (with the exception of that specified in Laboratory Procedure Manual, **Guidelines for Anatomic Pathology**) that are removed or passed during a surgical or other invasive procedure are sent to Pathology for examination.
- b. The pathologist determines the extent of the examination necessary for diagnosis.

- c. Pertinent clinical information including its source, pre-op and post-op surgical diagnosis accompanies the specimen.
  - d. The Pathologist documents the receipt of all specimens and signs the pathology report that becomes part of the patient's medical record. The pathology report containing a pathology diagnosis for each such specimen is filed in the medical record within 3 days unless additional special histological procedures are required.
8. Transfer Summary (when applicable)
- a. Whenever a patient is transferred within the Medical Center from one level of care to another and the caregivers change, a Transfer Summary may be substituted for the Discharge Summary. A Transfer Summary includes:
    - 1. Patient condition at time of transfer.
    - 2. The reason for the transfer.
    - 3. Current medication information.
9. Transfer Note
- a. Whenever a patient is transferred within the Medical Center from one level of care to another and the caregivers remain the same, a Transfer Note can be written in the Progress Notes: A Transfer Note includes:
    - 1. Patient condition at time of transfer.
    - 2. The reason for the transfer
    - 3. Current medication information.
10. Discharge Summary *SEE TABLE: MEDICAL RECORD – REQUIRED ELEMENTS*
- a. Patients are discharged only upon an order of the attending MS member, or his/her designee. Should a patient leave the Medical Center against the advice of the attending physician, or without proper discharge order, a notation is made in the patient's Medical Record and the patient is requested to sign an AMA (Against Medical Advice) form.
  - b. The attending MS member completes and authenticates the Discharge Summary.
  - c. A Discharge Summary summarizes previous care. At a minimum, the Summary includes:
    - 1. The reason for hospitalization.
    - 2. Specific findings.
    - 3. Procedures performed and treatment rendered.
    - 4. Condition at discharge.
    - 5. Instructions to patient and family.
    - 6. Medications, diet, activity and follow-up visit
    - 7. If pre-printed instructions are given to the patient, the Medical Record indicates so.
    - 8. Principle and other diagnoses.
  - d. Summary for Patients Hospitalized less than 48 hours
    - 1. For newborns, uncomplicated deliveries, and for those patients hospitalized for less than 48 hours with only minor problems, a Progress Note may be substituted for the Discharge Summary. The Progress Note is labeled Final Summary and includes:
      - Condition at discharge.

- Instructions to patient and family.
  - Medications, diet, activity and follow-up visit
  - If pre-printed instructions are given to the patient, the Medical Record indicates so.
  - Principle diagnoses.
- e. Short Stay Form (template)
1. A Short Stay Form may be used for those hospitalized for less than 48 hours or for same day surgery patients.
  2. **The attending MS member completes and authenticates the Short Stay form.**

11. Medication Reconciliation

- a. Admission Medication reconciliation will be completed and documented within 24 hours of admission, and is the responsibility of the attending provider.
- b. Transfer Medication reconciliation will be completed and documented when a patient transfers from one level of care to another level of care, and is the responsibility of the provider continuing the care of the patient.
- c. Discharge Medication reconciliation will be completed prior to the patient being discharged from the facility, and is the responsibility of the discharging provider.

12. Patients Receiving Continuing Ambulatory Care

- a. Medical records of patients receiving continuing ambulatory care contains a summary list including:
  1. Known significant medical diagnosis and conditions.
  2. Known significant operative and invasive procedures.
  3. Known adverse and allergic drug reactions, and
  4. Medications known to be prescribed or used by the patient.
- b. This summary list is maintained in each Medical Center outpatient clinic within the Medical Center in which the patient is receiving continuing care.



**MEDICAL RECORD – REQUIRED ELEMENTS**

	H & P Hospital	H & P Clinic	Consultation	Operative Report	Discharge Summary	Pre-Anesthesia	Post-Anesthesia
<b>Provider Names</b>							
Name of Dictating Provider (including the name of the MS members for whom you are dictating, if applicable)	x	x	x	x	x		
Name of Consulting Physician			x				
Name of Surgeon				x			
Name of Anesthesia Provider						x	x
Name of Assistant (or none)				x			
Names of providers of direct patient care nursing services, or the names of the people who supervised that care if provided by a non RN				x			x
<b>Patient Information</b>							
Patient Name	x	x	x	x	x		
Patient Medical Record #	x		x	x	x		
<b>Dates</b>							
Date of Admission	x				x		
Date of Consult			x				
Date of Surgery				x	x		
Date of Discharge					x		
<b>Clinical Information</b>							
Preoperative Diagnosis				x			
Postoperative Diagnosis				x	x		
Principle Diagnosis		x			x		
Secondary Diagnosis		x			x		
Title of Surgical Procedure				x			
Indication for Surgical Procedure					x	x	
Description of Operative Site						x	
Blood Pressure/Pulse	x	x					
Anesthesia				x			
Vital Signs and Level of Consciousness (Post-Op)							x
Findings		x		x	x		
Procedure (description)				x	x		
Specimens Removed				x	x		
Medications (including IV fluids), blood and blood components				x	x		x
Any unusual events or post-op complications, including blood transfusion reactions, and the management of those events				x	x		x
The patient's discharge from the post-anesthesia care - either by an LIP or by use of relevant discharge criteria				x			
Reason for Consultation			x				
Chief Complaint	x	x				x	
History of Present Illness	x	x				x	
History relating to problem initiating the consultation		x	x				
Past Medical / Surgical History	x	x				x	
Allergies	x	x				x	
Medications	x	x			x		
Social History	x	x					

NOTE: Elements of the H&P will be considered as part of the H&P if they are included in any of the following documents: H&P, the surgical H&P update specific to the surgery, or the Preoperative Consultation.

**Section 7. Delinquent Medical Records**

- A. The medical record for each patient is complete at the time of the patient's discharge, including the final diagnosis, unless reports of final laboratory work are pending. This should then be noted in the final Progress Note. Patient medical records not completed at discharge are completed as soon as possible, not to exceed 25 days, at which time they are delinquent.
- B. Records need to be completed by day-25 post discharge. Physicians will be reviewed for suspension of privileges for any records that remain incomplete for 25 days or longer post discharge.
- C. The practitioner is notified in writing, by Certified Mail – Return Receipt Requested, or by the Medical Center Courier – Return Receipt Requested (if within the Mercy Campus) of the relinquished privileges. The relinquishment of privileges continues until the medical record(s) of all discharged patients are complete. At that time, the practitioner's privileges are automatically reinstated.
- D. No practitioner whose privileges have been relinquished may have patients admitted under another practitioner's name. Any such admission will be brought to the attention of the MSEC.

- E. This policy may be waived by the MSEC during a period a practitioner is incapacitated by illness or during a period of absence due to an unusual event. Practitioners anticipating an absence of more than three days are to complete all medical records before the absence.

#### **Section 8. Patient Access to and Release of Medical Records**

- A. All medical records are the physical property of the Medical Center and are not taken from the jurisdiction of the Medical Center unless in accordance with a court order, subpoena, or statute. When such a removal is mandated, every reasonable attempt is made to notify the attending medical staff member. Unauthorized removal of a medical record from the Medical Center by an MS member constitutes grounds for professional review action.
- B. No patient record is removed from the Health Information Management Department except for purposes of medical care and treatment of a patient, medical care evaluation studies, teaching conferences, chart completion, and/or as needed by the CEO or designee.
- C. Written consent of the patient is required for release of medical information to those not otherwise authorized to receive information.
- D. Any record taken from the Health Information Management for the purpose of patient readmission is returned with the current record upon discharge of the patient.
- E. All access to and release of Medical Records follow HIPAA guidelines.

#### **Section 9. Medical Information to and from other Hospitals/Health Care Facilities**

- A. Upon request and with written authorization of the patient, the Health Information Management department will transmit information to other hospitals or health care facilities concerning the patient's previous admissions, record name, date of birth, and dates of previous hospitalizations.
- B. Similarly, the Health Information Management department, upon written authorization of the patient, may request information from other hospitals or health care facilities concerning the patient. Reports of procedures, tests and tests results and other information obtained from outside sources which clearly identified the outside source, may be filed and become an addendum to the patient's record.

#### **Section 10. Filing of the Medical Record**

- A. A Medical Record is not permanently filed until completed by the attending MS member or ordered to be filed by the UR/MR Committee. The reason for filing a Medical Record as incomplete is noted and signed in the Medical Record by the Chair of the UR/MR Committee. A listing of filed incomplete records is submitted quarterly to Risk Management.
- B. One MS member cannot complete a Medical Record for another MS member.

## **ARTICLE IV: CONTINUING EDUCATION**

### **Section 1.**

- A. All Members participate in continuing education to support the need for quality improvement, periodic re-licensing, re-credentialing, and re-privileging in order to maintain clinical skills and competence in accordance with privileges granted.
- B. Evidenced-based medical education activities are designed to promote a change in competence, performance or patient outcomes, and there is a method in place to analyze the data, determine the effectiveness, and provide feedback. Educational activities are designed to match the current or potential scope of the MS member.
- C. Hospital sponsored educational activities for MS members are based upon priorities recommended by the MS

in regard to identified professional learning gaps of the MS members. These activities support the professional practice of the organization, and promote a culture of life-long learning and professional development.

- D. Educational activities that award Continuing Medical Education (CME) are designed to match the expected results of the CME program's mission statement. Requests for CME Activities are reviewed and approved by the Graduate Medical Education Committee (GMEC), and the Accreditation Council for Continuing Medical Education (ACCME) Criteria is followed.

## **ARTICLE V: RESIDENTS/FELLOWS**

### **Section 1.**

- A. Graduates of a school of allopathic or osteopathic medicine, actively participating in an accredited residency (hereinafter called resident/fellow) may obtain training at the Medical Center. The resident/fellow abides by applicable bylaws, rules and regulations and policies and procedures of the Medical Staff, of the Departments and Services of the Medical Center and the resident's residency/fellowship program. Termination of affiliation with the residency/fellowship program for any reason, or failure of the residency/fellowship program itself to be accredited will result in termination of all privileges.
- B. The resident completes an approved application for MS membership and request for privileges, and submits it to Medical Staff Services.
- C. Full-time resident/fellow physicians are required to have a valid Iowa resident physician license or an Iowa permanent physician license.
- D. Visiting resident/fellow physicians, who come to Iowa to practice as part of their resident/fellow training program, must have a resident or permanent license in good standing in the home state of the resident/fellow training program. An Iowa temporary license is required of a physician in training if the physician does not hold a resident or permanent physician license in good standing in the home state of the resident/fellow training program (IA Code 653-9.2(2)).
- E. The resident/fellow will be under the general supervision of an Active, Affiliate or Provisional MS member with appropriate privileges at the Medical Center.
- F. All patients are admitted under the name and direct responsibility of an Attending Physician (Active, Affiliate or Provisional MS member). The Attending Physician is the one who oversees all medical care of the hospitalized patient and is responsible for the clinical accuracy and completeness of the medical record.
- G. A resident/fellow cannot be an attending physician.
- H. The resident/fellow may evaluate patients, order and/or perform diagnostic tests, write orders and provide medical care as directed by the attending or other Active, Affiliate or Provisional Medical Staff member as is common in accredited residency/fellowship programs. Written descriptions of the role, responsibilities, and patient care activities of the resident/fellow are developed by the faculty in the resident's residency program in consultation with the MS members, under whom the resident serves, and/or the Departments and Services of the MS. These descriptions are provided to the MS. A privileged MS member will perform those procedures for which the resident/fellow is not privileged.
- I. The resident/fellow may complete medical records. The ultimate responsibility for the medical record lies with the attending practitioner who is responsible for the authentication and accuracy of the medical record, verification of the final diagnosis, all relevant coding/billing information and other information as required by regulatory agencies as reflected in the patient's medical record.
- J. The Senior Vice President of Physician Integration and the Residency/Fellowship Director/responsible site physician will serve as the liaison between the residency/fellowship program, the MS, and the Medical Center. The residency/fellowship program and MS regularly communicate about the safety and quality of patient care provided by, and the related educational and supervisory needs of the resident. The Residency/Fellowship

program and the governing body periodically communicate about the educational needs and performance of residents

- K. No resident actively participating in a residency will be eligible to become an Active or Affiliate MS member while a resident/fellow. Second-year and Third-year residents in the Medical Center's program may be privileged to care for patients in the Urgent Care Center and the Emergency Center when a staff ER physician is present.

## **ARTICLE VI: MEDICAL STUDENTS (Medical, Non-physician health care practitioner)**

- A. A medical student is defined as a person enrolled in a Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA) medical school who is supervised by a designated preceptor or teaching physician.
- B. The Medical Center has formal written education affiliation agreements with any medical school that desires to send medical students or non-physician health care practitioner students to the Medical Center for a learning experience.
- C. Students cannot work autonomously; all activities are under the direct supervision of a designated preceptor or teaching physician, documented in writing.
- D. Specific duties on a given rotation are outlined in writing prior to the learning experience. It is the responsibility of the preceptor or teaching physician to assure that the student works within the scope of the rotation outline and that every activity is supervised.
- E. The preceptor or teaching physician can only teach those procedures for which he/she is privileged.
- F. Medical Student may document services in the medical record. However, the preceptor or teaching physician must verify in the medical record all student documentation or findings including history, physical exam and/or decision-making.
- G. The preceptor or teaching physician must personally perform (or re-perform) the physical exam and medical decision-making activities of the evaluation and management service being billed. Medical student documentation is submitted to the preceptor or teaching physician for review, needed corrections, and co-signature.
- H. Non-physician health care practitioner student notes will be reviewed, corrected and cosigned by the supervising physician. The documentation of non-physician health care practitioner notes shall not be used for billing purposes or to satisfy any documentation requirement within the health record. Providers shall not use any part of the medical student note to support or use within their own documentation.
- I. Medical or non-physician health care practitioner students may not independently place orders. Any orders placed by the medical or non-physician health care practitioner student must be co-signed by the designated preceptor or teaching physician prior to implementation.

## **ARTICLE VII: OBSERVER**

"Observer" means a person who is not enrolled in an LCME or AOA medical school or osteopathic medical school, who observes care to patients in Iowa for a defined period of time and for a noncredit experience, and who is supervised and accompanied by an Iowa-licensed physician.

- A. The following activities require licensure to practice in Iowa, therefore an observer shall not:
  - 1. Provide or direct hands-on patient care, regardless of the observer's level of training or supervision.
  - 2. Chart in the medical record

3. ; Touch a patient as part of an examination
  4. Conduct an interview
  5. Order, prescribe, or administer medications
  6. Make decisions that affect patient care
  7. Direct others in providing patient care
  8. Conduct procedures, including surgery
- B. The supervising physician may authorize an observer to perform the following:
1. Read a chart
  2. Observe a patient interview or examination
  3. Witness procedures, including surgery.
  4. An observer may touch a patient to verify a physical finding in the immediate presence of a physician but shall not conduct a more inclusive physical examination.
  5. Participate in discussions regarding the care of individual patients, including offering suggestions about diagnosis or treatment, provided the observer does not direct the care
  6. Elicit information from a patient provided the unlicensed physician observer does not actually perform a physical examination or otherwise touch the patient.

## ARTICLE VIII: CODE OF CONDUCT

It is the policy of the Medical Center Medical Staff that all Practitioners will treat others with respect, courtesy and dignity, and will conduct themselves in a professional and cooperative manner. The Medical Staff Code of Conduct policy is intended to set forth a procedure for resolution of complaints of disruptive conduct and / or sexual harassment brought by Hospital employees, Practitioners, patients or others about a Practitioner. The MS refers to and abides by this policy; to provide a fair and unbiased procedure, when appropriate, to address conduct of Practitioners. [Code of Conduct Policy](#).

## ARTICLE IX: PRACTITIONER HEALTH COMMITTEE

This committee addresses matters of individual practitioner health by collegial intervention – separate from MS disciplinary functions.

### Section 1. Purpose

To provide overall guidance and direction on how to proceed when a MS or or NPHCP Staff member is potentially impaired. The purpose of the process is to help with the rehabilitation, rather than discipline, to aid a practitioner in retaining and regaining optimal professional functioning that is consistent with protection of patients.

### Section 2. Policy

The Provider Health – Impaired Provider policy is maintained in Medical Staff Services and contains the following elements:

- A. Education of the MS and NPHCP Staff about illness and impairment recognition Issues, specific to practitioners.
- B. Means to report to MS leadership instances in which a practitioner is providing unsafe care to patients.
- C. Means for referral: self referral and referral by other Mercy staff.
- D. Evaluation of the credibility of a complaint, allegation, or concern.

- E. Internal and external resources for diagnosis and treatment and referral of the affected practitioner to an appropriate professional.
- F. Parameters for confidentiality.
- G. Steps for monitoring the affected practitioner and the safety of patients during and after rehabilitation.

### **Section 3. Practitioner Health Committee Structure**

An ad hoc committee of the MS is identified by the MSP per the Provider Health-Impaired Provider Policy.

## **ARTICLE X: APPROVAL OF CONTRACTS**

### **Section 1. Approval of Contracts**

- A. The MSEC consults with administration on the quality aspects of contracts for patient care services with entities outside of the Medical Center.
- B. Requirements for all individuals/agencies outside of the Medical Center that provide patient care services include:
  - 1. Provision of timely patient care, consistent with the needs of the patient
  - 2. Compliance with all laws, regulations, and standards of all applicable governmental authorities, regulatory, and accreditation bodies.
  - 3. Agreement to provide services in an ethical and lawful manner, in accordance with the terms of the Medical Center's Compliance Policy
  - 4. Provision of documentation of competency and of ongoing quality assessment and improvement results.
- C. Contracts for organ recovery teams include a statement that the Organ Procurement Organization will send only "qualified, trained individuals."

## **ARTICLE XI: AMENDMENT TO THE RULES AND REGULATIONS**

### **Section 1. Bylaws Rules and Regulations Amendment**

- A. If the voting members of either the organized Medical Staff or MSEC propose to adopt or change a rule or regulation the proposed change discussed at any regular or special meeting of the MSEC. MSEC has the authority to amend or adopt any Medical Staff Rule or Regulation. Newly approved Rules and Regulations, shall replace any previous Rules and Regulations, and shall become effective when approved by the MSEC. Notification of all changes is electronically communicated to all Active, Affiliate, Provisional, Fellow, and Resident members of the Medical Staff and all members of the Allied Health Professionals Staff. The approved document will be posted on the Medical Center's intranet.
- B. The Medical Staff Policies and Procedures are revised and amended as frequently as necessary to reflect the Medical Center's current practice OR at least every three years.
- C. The Rules and Regulations and Policies and Procedures will not conflict with the policies and bylaws of the Board.
- D. Any administrative policies and procedures referenced in the Medical Staff Policies and Procedures need to be approved by the MSEC.

### **Section 2. Access to Medical Staff Rules and Regulations**

All sections of the Medical Staff Bylaws are available on the Medical Center's Intranet. An electronic copy is offered to each new medical staff member at time of initial appointment.

## Attachments

---

No Attachments

## Approval Signatures

---

Step Description	Approver	Date
Medical Staff Executive Committee	Gina Boehmer	03/2021
	Suzan Brunes	03/2021

## Applicability

---

MercyOne North Iowa Medical Center