

**MercyOne Waterloo Medical Center**  
**Medical Staff Bylaws**

**December 1, 2022**

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**BYLAWS OF  
THE MEDICAL STAFF OF MERCYONE  
WATERLOO MEDICAL CENTER**

**PREAMBLE**

In an effort to ensure that the philosophy, purpose, and objectives of the hospital are achieved insofar as they relate to patient services, medical education, and research, the members of the MEDICAL STAFF OF MERCYONE WATERLOO MEDICAL CENTER, Waterloo, Iowa, hereby organize themselves, in conformity with the Bylaws hereinafter stated, to carry out the responsibilities and functions delegated by the Board of Directors of MercyOne Waterloo Medical Center. These Bylaws set forth the organization, membership, privileges, officers, committees, meetings, hearings, procedures, and practices of the Medical Staff and a due process procedure for practitioners who are subject to certain adverse actions regarding their staff membership and clinical privileges.

The Medical Staff has the authority, and so upholds the Board of Directors' responsibility, to implement an effective Quality Improvement Program, to maintain acceptable ethical and professional standards, and to guide all its activities in accordance with the Ethical and Religious Directives for Catholic Health Care Services.

**ARTICLE I  
DEFINITIONS**

1. **ADMINISTRATION.** The term Administration shall be interpreted to refer to the Administrator and other persons appointed to assist him/her in the overall management of the Hospital.
2. **APPLICANT.** A licensed Physician, dentist, or podiatrist applying for Privileges on the MercyOne Waterloo Medical Center Medical Staff who has not yet received formal approval by the Board of Directors.
3. **BOARD OF DIRECTORS.** The term Board of Directors shall be interpreted to refer to the Board of Directors of MercyOne Waterloo Medical Center, Inc.
4. **CAREGIVER LAW** –Refers to any state or federal felony or misdemeanor pursuant to which the individual is banned from access to patients pursuant to applicable law including under the Iowa Department of Public Safety, Department of Human Services, and Department of Inspection and Appeals program found at Iowa Code 135B.34, 135C.33, and its related regulations.
5. **MERCYONE CENTRALIZED CREDENTIALS VERIFICATION ORGANIZATION (“MCCVO”).** The term MCCVO shall refer to the health professional credentialing services organization.
6. **DAYS.** The term Days shall mean calendar days.
7. **EXECUTIVE COMMITTEE.** Unless otherwise indicated, the term Executive Committee refers to the Executive Committee of the Medical Staff of MercyOne Waterloo Medical Center.
8. **EX-OFFICIO.** The term Ex-Officio shall be interpreted to mean a non-voting member of a committee who holds the committee appointment due to the fact that he or she holds another position or office.
9. **HOSPITAL.** The term Hospital shall be interpreted to refer to MercyOne Waterloo Medical Center.
10. **LICENSED INDEPENDENT PRACTITIONER.** Any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual’s license and consistent with individually granted Clinical Privileges.
11. **MEDICAL STAFF.** The term Medical Staff means the Hospital’s organized component of Physicians, dentists, and podiatrists appointed by the Board of Directors and granted specific Clinical Privileges for the purpose of providing appropriate medical, surgical, oral maxillofacial/dental, and podiatric care for the patients of the Hospital.
12. **MEDICAL STAFF OFFICE.** The term Medical Staff Office shall refer to the Medical Staff Office of MercyOne Northeast Iowa, located at MercyOne Waterloo Medical Center. The Medical Staff Office may delegate its duties as set forth in these Bylaws to the CCCVO.
13. **MEDICAL STAFF YEAR.** The Medical Staff year shall commence July 1 and end June 30.
14. **MEMBER.** A licensed Physician, dentist, or podiatrist approved by the Board of Directors for membership on the Medical Staff of MercyOne Waterloo Medical Center.

15. **PHYSICIAN.** The term Physician shall be interpreted to refer to a licensed Practitioner holding the degree of Doctor of Medicine or Doctor of Osteopathic Medicine.
16. **PRACTITIONER.** The term Practitioner, unless otherwise specifically limited, shall mean any appropriately licensed Physician, dentist, or podiatrist applying for or exercising Clinical Privileges in the Hospital.
17. **ADMINISTRATOR** The term Administrator shall be interpreted to refer to the Chief Operating Office or Chief Medical Officer.
18. **PRESIDENT OF THE MEDICAL STAFF.** The term President of the Medical Staff shall refer to the Member of the Medical Staff elected by the Medical Staff and appointed by the Board of Directors to administer the affairs of the Medical Staff. The President of the Medical Staff may also be referred to as the Chief of Staff, and the two titles may be used interchangeably.
19. **PRIVILEGES.** The term Privileges or Clinical Privileges shall mean the permission granted to a Medical Staff Member or other Licensed Independent Practitioner or allied health professional to render specific diagnostic, therapeutic, medical, oral maxillofacial/dental, podiatric, or surgical services, which may or may not include permission to admit patients.
20. **RESIDENT.** The term Resident shall mean a Physician, podiatrist, or dentist participating in an instructional arrangement with the Hospital for an approved training program.
21. **SCOPE OF PRACTICE.** The term Scope of Practice shall mean the permission granted to an allied health professional to render specific diagnostic, therapeutic, medical, oral maxillofacial/dental, podiatric, or surgical services.
22. **VICE PRESIDENT OF MEDICAL AFFAIRS.** The term Vice President of Medical Affairs shall refer to the Vice President of Medical Affairs of MercyOne Northeast Iowa.
23. **MERCYONE HOSPITAL** – Refers to any MERCYONE NORTHEAST IOWA owned, affiliated and/or managed hospital.

**ARTICLE II**  
**NAME OF ORGANIZATION**

The name of this organization shall be the “Medical Staff of MercyOne Waterloo Medical Center, Inc.”



**ARTICLE III  
PURPOSES AND RESPONSIBILITIES**

**3.1 Purposes.**

The purposes of the Medical Staff are:

- A. To be the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by individual Practitioners and the obligations of Medical Staff membership may be fulfilled.
- B. To serve as the primary means for providing assurance as to the appropriateness of the professional performance and ethical conduct of its Members.
- C. To provide a means through which the Medical Staff may participate in the Hospital's policy making, planning, and continuous quality improvement processes.

**3.2 Responsibilities.**

The responsibilities of the Medical Staff are:

- A. To facilitate a high level of professional performance of all Members of the Medical Staff authorized to practice in the Hospital through appropriate delineation of Clinical Privileges and through an ongoing review and evaluation of each Member's performance in the Hospital.
- B. To help prioritize Hospital-sponsored continuing education.
- C. To participate in utilization review to facilitate allocation of inpatient medical and health services based upon evaluation of individual medical needs.
- D. To recommend to the Board of Directors action with respect to appointments, reappointments, Clinical Privileges, Medical Staff category, and corrective action.
- E. To account to the Board of Directors for the quality and efficiency of patient care rendered to patients at the Hospital through regular reports and recommendations.
- F. To initiate and pursue corrective action with respect to Members when warranted.
- G. To assure that Medical Staff matters are pursued in accordance with applicable law and accreditation standards, including the prohibition of the practice of the division of fees between Medical Staff Members.
- H. To develop, administer, and seek compliance with these Bylaws, the Rules and Regulations of the Medical Staff, and other Hospital and Medical Staff Policies related to patient care.
- I. To strive to conduct all affairs involving Medical Staff Members, patients, and employees in a manner and an atmosphere free of discrimination because of age, sex, creed, national origin, race, financial status, disability or any illegal discriminatory basis.

- J. To exercise the authority granted through these Bylaws to adequately fulfill these and other responsibilities delegated by the Board of Directors.

**3.3 Medical Staff's Authority to Act.**

The Medical Staff is delegated the authority to undertake the above-described purposes and responsibilities by the Board of Directors consistent with applicable laws, regulations, and accreditation standards.

**3.4 Board of Directors' Authority to Act.**

Consistent with applicable laws, regulations, and accreditation standards, the Board of Directors may appoint committees and delegate to such committees the responsibilities of the Board of Directors. Notwithstanding any delegation, all actions and recommendations of such committees are subject to the final approval of the Board of Directors.

**ARTICLE IV  
MEDICAL STAFF MEMBERSHIP**

**4.1 Nature of Membership.**

- A. Membership on the Medical Staff of MercyOne Waterloo Medical Center is a privilege extended to professionally competent Physicians, dentists, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and such other policies as are adopted from time to time by the Board of Directors.
- B. No Practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges in the Hospital merely by virtue of the fact that he or she is duly licensed to practice medicine, dentistry, or podiatry in the State of Iowa or by virtue of membership in any professional organization or past or present privileges at another hospital.

**4.2 Basic Qualifications for Staff Membership.**

To be eligible to be and remain on the Medical Staff, a Practitioner shall have the burden of demonstrating to the Board of Directors and the Medical Staff that (s)he is of good moral character; that (s)he possesses sound professional ethics; that the requested Privileges are consistent with any Medical Staff plan approved by the Board of Directors; that (s)he possesses the background, experience, training, and demonstrated competence which assures, in the judgment of the Board of Directors, that any patient treated by him/her in the Hospital will be given quality medical care; and that (s)he, at a minimum meets the following requirements(the “Basic Qualifications”):

- A. Is a graduate of an accredited medical, osteopathic, podiatric, or dental school and is a qualified practitioner of medicine, osteopathy, podiatry, or dentistry;
- B. Possesses an unrestricted license to practice medicine and surgery, podiatry, or dentistry in the State of Iowa, including full compliance with all continuing education requirements of licensure;
- C. Successfully completed a residency program approved by the Accreditation Council of Graduate Medical Education or the American Osteopathic Association, or a PSR-12 podiatric residency with documentation demonstrating performance of forefoot surgical procedures and a one year podiatric preceptor program with hospital inpatient experience with documentation demonstrating an exceptional level of performance of procedures on the basic podiatric surgical privileges list from the American Podiatry Association;
- D. Maintains certification by a board approved by the American Board of Medical Specialties, the American Osteopathic Association, American Board of Oral & Maxillofacial Surgery, American Dental Association or the American Board of Foot and Ankle Surgery, as applicable to the practitioner’s specialty and requested privileges.

If not certified, having completed the formal training requirements leading to certification and be eligible for certification by the American Board of Medical Specialties, the American Osteopathic Association, American Board of Oral &

Maxillofacial Surgery, or the American Board of Foot and Ankle Surgery, as applicable. Each practitioner must receive certification within the time set forth by the applicable Specialty Board. A failure to achieve such certification within the specified time period shall result in automatic non-renewal of privileges, unless the Executive Committee makes a recommendation for an extension for the purpose of obtaining a certification and such extension is approved by the Board of Directors;

Board certification requirement may be waived by sixty percent (60%) of the voting members of the Executive Committee upon the specific recommendation of the Practitioner's department chair, in order to respond to unmet community needs or to allow uniquely qualified Practitioners to participate in the care of Hospital patients;

Physicians, podiatrists and oral surgeons who were appointed to the Medical Staff prior to July 1, 1988 and who are not board certified shall not be required to become board certified as a condition of continued Medical Staff membership and clinical privileges, provided they otherwise meet the established competency requirements and other relevant criteria as established by the Medical Staff and Board of Directors;

- E. Is qualified legally, professionally, and ethically for the position to which the Applicant may be appointed;
- F. Is free from physical or mental conditions which would impair his/her ability to exercise Clinical Privileges requested or to care for patients;
- G. Possesses the ability to work effectively with Members of the Medical Staff, Administration, other Practitioners, and employees of the Hospital;
- H. Possesses current valid professional liability insurance coverage in such form and in amounts satisfactory to the Board of Directors;
- I. Is eligible to participate in the Medicare/Medicaid programs; and
- J. Shall have a record that is free from any state or federal felony conviction or any "Caregiver Law" conviction, except as is otherwise permitted pursuant to the Pre-Application process set forth in these Bylaws. This requirement may not otherwise be waived.

While professional competence is the primary qualification for Medical Staff appointment, the needs of the Hospital for additional Practitioners in a given area of practice or specialty, the ability of the Hospital to support the Practitioner with personnel, supplies and equipment, as well as the growth and development of the Medical Staff may be considered in granting or denying appointment or reappointment.

Medical Staff applications and applications for clinical privileges shall not be denied on the basis of race, color, religion, sex or national origin or on any illegal discriminatory basis.

#### **4.3 Basic Requirements/Conditions of Staff Membership.**

The following requirements shall apply to every Medical Staff Applicant and Medical Staff Member and shall be conditions for consideration of applications for appointment and reappointment and for continued Medical Staff appointments.

Each Applicant and Member of the Medical Staff shall:

- A. Provide patients with continuous care at the level of quality and efficiency generally professionally recognized and refrain from delegating responsibility for diagnosis or care of hospitalized patients to a Practitioner who is not qualified to undertake the responsibility;
- B. Agree to be bound by the Medical Staff Bylaws and all other lawful standards, policies, procedures, rules, and regulations of the Medical Staff and Hospital and all applicable Iowa and federal laws and regulations;
- C. Discharge such Medical Staff, department, section, committee, and Hospital functions for which the Member is responsible by appointment, election, or otherwise;
- D. Attend electronic medical record training at initial appointment and maintain competency throughout Medical Staff membership by attending ongoing training opportunities and assigned competencies.
- E. Prepare and complete in a timely manner, as defined elsewhere by the Executive Committee, the medical and other required records for all patients admitted or in any other way provided care by the Member in the Hospital;
- F. Abide by ethical principles of the medical profession, the Ethical and Religious Directives for Catholic Health Care Facilities as promulgated by the United States Catholic Conference, and the Code of Ethics of the American Medical, Dental, Osteopathic, or Podiatry Association, as applicable. Should there be a conflict between any provision of the applicable Code of Ethics and the Ethical and Religious Directives, the latter shall prevail;
- G. Provide, with or without request, new or updated information that is pertinent to any question on the application form as it occurs. Except as required by Section 4.3(I) below, failure to provide such information within one (1) week may constitute grounds for automatic withdrawal of an Applicant's application or automatic termination of a Member's Clinical Privileges and Medical Staff membership. Applicants whose applications are deemed withdrawn pursuant to this provision and Members whose Clinical Privileges and membership are terminated pursuant to this provision are not entitled to fair hearing and appeal rights;
- H. Refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- I. Provide emergency call coverage as established by each department pursuant to the Medical Staff Bylaws and department rules approved by the Executive Committee and Board of Directors;
- J. Notify the Administrator, Chief of Staff/President of the Medical Staff, Vice President of Medical Affairs or the Medical Staff Office, within forty-eight (48) hours of, and provide such additional information as may be requested, regarding each of the following:
  1. Voluntary or involuntary revocation, limitation, or suspension of his/her professional license, Drug Enforcement Administration (DEA) registration,

or Iowa Controlled Substances Act (CSA) certificate (if applicable); any reprimand or other disciplinary action taken by any state or federal government agency relating to his/her professional license; or the imposition of terms of probation or limitation by any state;

2. Voluntary or involuntary cancellation or change of professional liability insurance coverage;
3. Receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation or the filing of charges relating to health care matters by a Medicare peer review organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Iowa;
4. Receipt of notice of the filing of any suit against the Practitioner alleging professional liability in connection with the treatment of any patient in or at the Hospital;
5. Being charged with any violation of any state or federal felony or any Caregiver Law or if the Practitioner becomes aware that he or she is the subject of any active investigation, involving his or her violation of any federal or state felony or violation of any Caregiver Law;
6. Being convicted of any state or federal felony or any Caregiver Law; or
7. Termination, suspension or restriction of staff membership or privileges, whether temporary or permanent, at any hospital or other health care facility, including without limitation any MercyOne Hospital.

Failure to timely make notification of any of the items (1) through (7) above of this Section shall constitute an automatic withdrawal of an Applicant's pending application. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic withdrawal shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and Applicants whose applications are deemed to be automatically withdrawn pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

For current Members of the Medical Staff, failure to timely make the notifications of the items specified in (1) through (4) of this Section shall result in automatic suspension hereunder. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic suspension shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and Members whose Medical Staff membership and Clinical Privileges are deemed to be automatically suspended pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

For current members of the Medical Staff, failure to timely make the notifications with respect to items (5), (6) or (7) above of this Section shall result in automatic termination hereunder. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic termination shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and Members whose Medical Staff membership and

Clinical Privileges are deemed to be automatically terminated pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

- K. Submit and maintain on file at all times current evidence of continued licensure, DEA registration or CSA certificate (if applicable), and professional liability insurance coverage in an amount determined by the Board of Directors;
- L. At the request of the Board of Directors, agree to undergo a health examination by a physician acceptable to the Board of Directors or to submit other reasonable evidence of current health status that may be requested by the Medical Staff Executive Committee or the Board of Directors. The presence of a physical or mental condition which would impair the Practitioner's ability to exercise the Clinical Privileges requested or to care for patients will not constitute a bar to the granting of Medical Staff membership or Clinical Privileges if, with reasonable accommodation, the Practitioner can safely perform the Clinical Privileges requested and safely care for patients. Practitioners must also provide evidence of any laboratory results of immunizations as required by the State of Iowa;
- M. Agree that any misrepresentation, misstatement in, or omission from the pre-application or application, whether intentional or not, shall result in automatic termination of the application process. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery shall result in automatic termination from the Medical Staff and of Clinical Privileges;
- N. Agree to sufficiently use the Hospital and its equipment so as to accommodate evaluation of current competence by appropriate committees and individuals;
- O. Maintain eligibility to participate in the Medicare/Medicaid programs; and
- P. Comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and corresponding regulations.
- Q. Complete and document a medical history and physical exam for each patient no more than 30 days before or 24 hours after admission or registration at the Hospital, but prior to surgery or a procedure requiring anesthesia services (and if the history and physical are performed with 30 days before admission or registration, each Practitioner must complete an updated exam of the patient, including changes in the patient's condition, within 24 hours after admission or registration), all as further described in the Medical Staff Rules and Regulations.
- Q. Submit the applicable Application or Re-Application Fee. Failure to submit the required Application or Re-Application Fee will constitute grounds for automatic withdrawal of the Applicant's/Re-Applicant's application, and the application will not be further processed. Applicants/Re-Applicants whose applications are deemed withdrawn pursuant to this provision are not entitled to fair hearing and appeal rights.

#### **4.4 Burden of Providing Information.**

- A. The Applicant shall have the burden of producing adequate information for a proper evaluation of competence, character, ethics, and other qualifications and for resolving

any doubts about such qualifications. Should information provided in the initial application for appointment change during the course of an appointment period, the Member has the burden of providing information about such change to the Hospital.

- B. Until the Applicant has provided all information requested by the Hospital, and provided the applicable Application Fee, the application for appointment or reappointment will be deemed incomplete and will not be further processed.
- C. Failing to adequately complete the application form, failing to submit the required Application Fee, withholding requested information, providing false or misleading information, or failing to provide new or updated information shall be a basis for denial or revocation of Medical Staff membership.

#### **4.5 Receipt and Processing of Information.**

The following statements are express conditions applicable to all Medical Staff Applicants, all Members of the Medical Staff, and all others having or seeking Privileges at the Hospital. By applying for appointment, reappointment, or Clinical Privileges, the Applicant expressly accepts these conditions during the processing and consideration of the application, whether or not appointment or Privileges are granted.

A. Immunity.

To the fullest extent permitted by law, the Applicant or Member releases from any and all liability and extends immunity to the Hospital, its authorized representatives, and third parties as defined in subsection (E) below, with respect to any acts, communications, or disclosures involving the applicant or appointee concerning the following:

1. Application for appointment or Clinical Privileges;
2. Monitoring of any Practitioner or allied health professional under any monitoring protocol established by the Medical Staff;
3. Evaluations concerning reappointment or changes in Clinical Privileges;
4. Proceedings for suspension or reduction of Privileges or for revocation of Medical Staff appointment or any other disciplinary action;
5. Hearings and appellate reviews;
6. Medical care evaluations;
7. Utilization reviews;
8. Other activities relating to the quality of patient care or professional conduct;
9. Matters concerning the Applicant's or Member's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior; or



10. Any other matter that might directly or indirectly relate to the Applicant's or Member's competence, to patient care, or to the orderly operation of the Hospital.

B. Authorization to Obtain Information.

The Applicant or Member specifically authorizes the Hospital and its authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, competence, character, mental and emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the individual's satisfaction of criteria for initial or continuing appointment to the Medical Staff.

This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of said third parties that may be relevant to such issues. The individual also specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request.

C. Authorization to Release Information.

The Applicant or Member specifically authorizes the Hospital and its authorized representatives to release to MercyOne Hospitals and other hospitals, health care facilities, and their agents information solicited for the purpose of evaluating the Applicant's or Member's professional qualifications pursuant to a request for appointment, reappointment, and/or Clinical Privileges. In addition, the Applicant or Member authorizes the Hospital and its authorized representatives to release information solicited to the MCCVO. The MCCVO will enter such information into its database, and the information may be used to provide credentials verification to other health care organizations.

D. Time Periods for Processing.

Applicants for appointment and reappointment acknowledge that while good faith efforts will be made to consider applications in a reasonably timely manner and within specified time periods, the specified time periods shall not be deemed to create any rights on the part of the Practitioner to have his/her application processed within those periods or to be automatically appointed or reappointed.

E. Definitions.

1. As used in this section, the term "Hospital and its authorized representatives" means the Hospital and any of the following individuals who have any responsibility for obtaining or evaluating the Applicant's or Member's credentials or for acting upon that individual's application or conduct at the Hospital: the members of its Board of Directors and their appointed representatives, the Administrator or his/her designees, other Hospital employees, consultants to the Hospital, the Hospital's attorneys, and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the individual's credentials or for acting upon that individual's application or conduct at the Hospital.

2. As used in this section, the term “third parties” means all parties from whom or which information has been requested by the Hospital or its authorized representatives including appointees to the Hospital’s Medical Staff; appointees to the medical staffs of other hospitals; physicians, nurses, health practitioners, or other individuals; and organizations, associations, partnerships, corporations, or government agencies, whether or not hospitals or health care facilities.

**ARTICLE V  
MEDICAL STAFF ORGANIZATION**

**5.1 Categories/Statuses of the Medical Staff.**

Appointments to the Medical Staff shall be to one of the following categories:

- |    |                   |    |                           |
|----|-------------------|----|---------------------------|
| A. | Provisional Staff | D. | Consulting/Outreach Staff |
| B. | Active Staff      | E. | Honorary Staff            |
| C. | Courtesy Staff    | F. | Registry Staff            |

No appointment shall exceed two (2) years.

A. Provisional Staff.

1. All new Applicants to the Medical Staff , except those who are requesting Membership only or those who have graduated within the past twelve months from a residency program sponsored by the Hospital and who are requesting privileges consistent with those taught in their residency program, shall complete a period of Focused Professional Practice Evaluation for an initial period of up to six (6) months. Performance and clinical competence shall be reviewed and documented during this period. At the end of this first Provisional period, the Executive Committee may, upon the written recommendation of the chairperson of the department to which the Practitioner has been assigned or his or her designee, and based on activity, monitoring of performance, and clinical competence, recommend that the Board of Directors grant the Practitioner Active, , Courtesy, or Consulting/Outreach Staff status, or again grant the Practitioner Provisional Staff status for a period of up to six (6) additional months. In the event that Provisional Staff status is continued, performance and clinical competence shall be reviewed and documented during this period. At the end of this second six-month period of Provisional Staff status, the Executive Committee may, upon the written recommendation of the chairperson of the department to which the Practitioner has been assigned, or his or her designee, and based on activity, monitoring of performance, and clinical competence, recommend that the Board of Directors grant the Applicant Active, , Courtesy, or Consulting/Outreach Staff status or again grant the Practitioner Provisional Staff status for a period of up to six (6) additional months. In the event that Provisional Staff status is continued, performance and clinical competence shall be reviewed and documented during this period. At the end of this third six-month period of Provisional Staff status, the Executive Committee may, upon written recommendation of the chairperson of the department to which the practitioner has been assigned, or his or her designee, and based on activity, monitoring of performance, and clinical competence, recommend that the Board of Directors grant the Applicant Active, Courtesy, or Consulting/Outreach Staff status. If a Provisional Medical Staff Member remains unacceptable for appointment to Active, Courtesy, or Consulting/Outreach Staff status after eighteen (18) months, the Practitioner will not be reappointed to the Medical Staff and will be given proper notice thereof, and will be given notice of his or her right to a hearing, if applicable, in accordance with Article VII of these bylaws. The President of the Medical Staff or designee and the chairperson of the

department or designee to which the Practitioner has been assigned may establish procedures for the supervision and review of a Member of the Provisional Staff as appropriate.

2. Members of the Provisional Staff shall have the following prerogatives:
  - a. May admit, see in consultation, or contribute to the care of an unlimited number of patients, consistent with the privileges granted.
  - b. May serve on Medical Staff committees as appointed, except for the Credentials Committee and the Executive Committee.
  - c. May vote at meetings of committees of which they are members.
3. Members of the Provisional Staff are subject to the following restrictions:
  - a. May not serve as chairperson of committees and may not vote at Medical Staff or department meetings.
  - b. May not hold Medical Staff or department office.
4. To maintain Provisional Staff membership, Members of the Provisional Staff shall meet the same requirements as those set forth above and in Sections 5.1(B)(3)(a) through 5.1(B)(3)(j) and shall be involved in the treatment of a sufficient number of patients to accommodate evaluation of current competence by appropriate committees and individuals.

B. Active Staff.

1. The Active Staff shall consist of Physicians, dentists, and podiatrists who are professionally qualified and are willing and able to devote their time to the interest of the Hospital and who have been selected to transact all business of the Medical Staff. By accepting assignment to the Active Staff, each Member agrees to assume all functions and responsibilities of appointment to the Active Staff, which include promoting quality of medical care in the Hospital, offering sound counsel to the Administrators and the Board of Directors, and participating in the internal government of the Medical Staff according to these Bylaws.
2. Members of the Active Medical Staff shall have the following prerogatives:
  - a. May admit, see in consultation, or contribute to the care of an unlimited number of patients.
  - b. May vote at all meetings of the Medical Staff, departments, and committees of which they are members.
  - c. May hold Medical Staff or department office.
  - d. May serve on any Medical Staff committee as appointed.

3. To maintain Active Medical Staff membership, Members of the Active Medical Staff shall:
  - a. Accept committee assignments, if appointed, for two (2) years and attend at least 50% of committee meetings;
  - b. Participate in educational activities as requested by his/her department chairperson, including supervising and proctoring initial appointees and allied health professionals;
  - c. Be reasonably available for continuous patient care;
  - d. Have demonstrated a willingness to follow the Policies and Rules and Regulations of the Medical Staff and MercyOne Waterloo Medical Center, including those addressing patient care, peer review, utilization review, and quality improvement;
  - e. Support the Medical Center in accordance with the Medical Staff Bylaws and Hospital and Medical Staff Policies;
  - f. Acknowledge that (s)he has received information from the Hospital regarding the mission, vision, and values of MercyOne Medical Center and agree to conduct him/herself in a manner that is consistent with said mission, vision, and values in the performance of all of his or her obligations as a Member of the Medical Staff;
  - g. Participate in covering the emergency room or make provisions for such coverage and participate in call coverage consistent with Clinical Privileges;
  - h. Attend at least 50% of the meetings of his or her assigned department and section; and
  - i. Shall complete the Focused Professional Practice Evaluation (FPPE) requirements pertaining to the initial privileges granted in their area of practice; and
  - j. Admit, see in consultation, or perform procedures (excluding the provision of lab services) of at least twenty-five (25) patients per year.

C. Courtesy Staff.

The Courtesy Medical Staff shall consist of Practitioners of demonstrated competence, qualified for staff appointment, who are not eligible for appointment to the Active Staff because they intend to be and during each appointment year are involved in the admission, consultation, or performance of procedures (excluding the provision of lab services) of up to twenty-four (24) patients per year at the Hospital.

Members of the Courtesy Staff shall have the following prerogatives:

- a. May admit, see in consultation, or perform procedures (excluding the provision of lab services) of up to twenty-four (24) patients per calendar year. (Note: This admission restriction excludes pediatricians' newborn admissions and patient care provided by emergency Physicians working in the Emergency Department.) If this number is exceeded at any time during the calendar year, the Member must apply for Active Staff membership.
- b. May serve on Medical Staff Committees as appointed, except for the Executive Committee.
- c. Are eligible to vote at meetings of committees of which they are members.
- d. Are encouraged to participate in educational programs and to attend Medical Staff meetings.

Members of the Courtesy Staff are subject to the following restrictions:

- e. Shall not vote at Medical Staff or department meetings.
- f. Shall not hold Medical Staff or department office.

To maintain Courtesy Medical Staff membership, in addition to requirements specified in Paragraph C(1) above, Members must meet the requirements set forth in Sections 5.1(B)(3)(a) through 5.1(B)(3)(i).

D. Consulting/Outreach Staff.

The Consulting/Outreach Staff shall consist of those Members whose primary hospital interest is not MercyOne Waterloo Medical Center, or who have a limited hospital-based practice, but who:

- a. May wish to perform preadmission history and physical exams, order non-invasive outpatient diagnostic tests and services, review medical records, and consult with a patient's attending physician, and/or
- b. May wish to provide a ready resource of special skill, diagnostic test interpretation, or medical consultation.

Members of the Consulting/Outreach Staff shall have the following prerogatives:

- c. To care for patients, consistent with approved privileges, and provide consultation to other Members upon request.
- d. May serve on committees as appointed, with the exception of the Credentials Committee and the Executive Committee.
- e. Are eligible to vote at committee meetings of which they are members.
- f. Are encouraged to participate in educational programs and to attend Medical Staff and department meetings.

Members of the Consulting/Outreach Staff are subject to the following restrictions:

- g. May not hold Medical Staff or department office.
- h. May not vote at Medical Staff or department meetings.
- i. May not admit or discharge patients, serve as the attending of record, perform procedures or treatment, or initiate written or verbal inpatient orders.

To maintain Consulting/Outreach Staff membership, in addition to requirements specified in 5.1(D)(1), Members must meet the requirements set forth in Sections 5.1(B)(3)(a) through 5.1(B)(3)(f) and (i).

If the granting of membership in the Consulting/Outreach Staff status was specifically based on the Applicant/Member providing a special service to the Hospital or Medical Staff, then the membership and Clinical Privileges will terminate automatically upon termination of the special services or upon failure to renew arrangements for the provision of such special services with the Medical Staff or Hospital. If the Consulting/Outreach Staff Member is providing special services pursuant to a contract between the Hospital and a professional corporation that employs the Consulting/Outreach Staff member, loss of employment with the contracting professional corporation shall automatically terminate the Member's membership and Clinical Privileges. The termination of Medical Staff membership and Clinical Privileges under this Section will not give rise to hearing and appeal rights under the Medical Staff Bylaw's Hearing and Appeal Procedures except where the termination of Medical Staff membership and Clinical Privileges is based on quality of care concerns.

E. Honorary Staff.

The Honorary Staff category shall consist of those former Members of the Medical Staff who are retired but who wish to maintain an affiliation with the Medical Staff.

Honorary Staff appointment must be requested by the Medical Staff Member to the President of the Medical Staff. Honorary members do not hold clinical privileges, may not admit patients, vote, or hold office. They may serve as members of committees, if so appointed. They shall not be required to attend meetings other than meetings of committees of which they are members. They must otherwise abide by these Bylaws

F. Registry Staff.

The Registry Staff category shall consist of Members of the Medical Staff who are appointed for the purpose of replacing a Member of the Medical Staff during an absence which exceeds one hundred twenty (120) consecutive days or providing a service at the Hospital on a long-term periodic basis which will last for more than 120 consecutive days.

Members of Registry Staff are subject to the following restrictions:

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- a. May not hold Medical Staff or department office.
- b. May not vote at Medical Staff or department meetings.
- c. May not serve on Medical Staff committees.

Registry Staff Members shall not be required to attend meetings. They must otherwise abide by these Bylaws.



**ARTICLE VI  
APPOINTMENT, REAPPOINTMENT AND CLINICAL PRIVILEGES**

**6.1 Initial Appointment.**

A. Pre-Application Process.

1. An individual seeking appointment to the Medical Staff shall first complete a request for an application for appointment.
2. Individuals who meet Basic Qualifications for appointment and who have completed the Pre-Application Process described herein shall then be sent an application for appointment. Individuals who fail to meet Basic Qualifications will be notified that they are not eligible to apply for Medical Staff membership at any of the MercyOne Northeast Iowa hospitals, and they will not be sent applications.
3. Notwithstanding any other term or condition of these Bylaws, a prospective Applicant shall not be eligible to receive an application for appointment or membership to the Medical Staff, nor shall an application be accepted from a prospective Applicant, if, based on information from a pre-application questionnaire or any other source, it is determined that any of the following exist:
  - i. The prospective Applicant does not meet the Basic Qualifications set forth in these Bylaws.
  - ii. The prospective Applicant's medical staff membership and/or all privileges at any MercyOne Hospital have been terminated or suspended, whether on a temporary or permanent basis, (other than by voluntary resignation by the Practitioner unrelated to any investigation) or the prospective Applicant is aware that he or she is the subject of a pending investigation involving the potential termination or suspension of his/ her medical staff membership and/or all privileges at any MercyOne Hospital.
  - iii. The prospective Applicant currently has charges pending, or is aware that he or she is the subject of any active investigation, involving the prospective Applicant's violation of any federal or state felony or violation of any Caregiver Law.
  - iv. The prospective Applicant has been convicted of a violation of state or federal law as follows:
    - (a) Caregiver Law Convictions. If the prospective Applicant was convicted of a Caregiver Law, then the prospective Applicant is not eligible to receive an application, at any time, except as set forth in Subsection (b) below.
    - (b) Caregiver Law Convictions Where Rehabilitation Waiver Granted. If the prospective Applicant was convicted of a Caregiver Law, and such conviction was entered more than two

(2) years from the date of the prospective Applicant's request for an application, then the prospective Applicant is still not eligible to receive an application for membership to the Medical Staff, unless he or she is able to affirmatively demonstrate, to the satisfaction of the Pre-Application Background Review Committee ("PBR Committee") (defined below), in its sole discretion, that he or she has been deemed rehabilitated in accordance with applicable law and therefore not banned by state law from patient access, and the following requirements are also satisfied:

- 1) The prospective Applicant does not pose a threat to the health or safety of any individuals;
- 2) The conviction and the prospective Applicant's conduct is not inconsistent with the Mission, Vision or Values of MercyOne Northeast Iowa; and
- 3) The conviction and the prospective Applicant's conduct does not have the potential to cause any material injury to the reputation of the Medical Staff or the Hospital.

(c) *Other Felony Convictions Entered More than 2 Years from Date of Request.* If the prospective Applicant was convicted of a state or federal felony other than a Caregiver Law conviction and such conviction was entered more than two (2) years from the date of the prospective Applicant's request for an application, then the prospective Applicant is still not eligible to receive an application for membership to the Medical Staff unless he or she is able to affirmatively demonstrate, to the satisfaction of the PBR Committee, in its sole discretion, that the following requirements are met:

- 1) The conviction and the prospective Applicant's activities are not related to medical staff membership or privileges or patient care;
- 2) The prospective Applicant does not pose a threat to the health or safety of any individuals;
- 3) The conviction and the prospective Applicant's conduct is not inconsistent with the Mission, Vision or Values of MercyOne Northeast Iowa; and
- 4) The conviction and the prospective Applicant's conduct does not have the potential to cause any material injury to the reputation of the Medical Staff or the Hospital.

B. Submission of Application. For telemedicine privileges application and credentialing process, follow 6.2(J). For all other privileges applications, follow the process below.

1. The MercyOne Northeast Iowa Hospitals Medical Staff application form shall contain a request for Medical Staff category, for department assignment, and for specific Clinical Privileges desired by the Applicant and shall require detailed information concerning the Applicant's qualifications, including:
  - a. The names and addresses of at least two physicians, dentists, or other practitioners, as appropriate, at least one of whom must be a peer, who have had recent experience in observing and working with the Applicant and who can provide adequate information pertaining to the Applicant's present professional competence, character, and ability to work with others;
  - b. A full summary of the Applicant's education and institutional positions held;
  - c. A list of the facilities at which Applicant has practiced, been employed, been associated, or been privileged, and whether the association has been discontinued;
  - d. Information as to whether the Applicant's medical staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, denied, revoked, suspended, reduced, or not renewed by any other hospital or health care facility;
  - e. Information as to whether the Applicant has ever withdrawn his/her application for appointment, reappointment, and/or clinical privileges or resigned from a medical staff before final decision by a hospital's or health care facility's governing board of directors;
  - f. Dates and numbers of state licenses (the Iowa medical license will be primary source verified at appointment, reappointment, and upon renewal of license);
  - g. Information as to whether the Applicant's license to practice any profession in any state, DEA license, or CSA certificate is or has ever been suspended, modified, terminated, restricted, or is currently being challenged;
  - h. Information as to the Applicant's current professional liability insurance coverage, and the Applicant's professional liability insurance coverage for the past ten years, including the name of the insurance company and the amount and classification of such coverage, and whether said insurance covers the Clinical Privileges the Applicant seeks to exercise at the Hospital and information as to whether the Applicant has ever been refused professional liability insurance;
  - i. Information as to any past or pending involvement in any quality inquiry, sanction action, or formal investigation by a Medicare peer review organization, the Department of Health and Human Services, or any law

enforcement agency or health regulatory agency of the United States or the State of Iowa;

- j. Information concerning the Applicant's malpractice litigation and claims history;
- k. Information concerning professional misconduct proceedings involving the Applicant in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations, the substance of the findings, the ultimate disposition of any such proceedings or actions that have been closed, and any other additional information deemed appropriate;
- l. A consent to the release of information from the Applicant's present and past professional liability insurance carriers;
- m. A statement and verification that the Applicant has no health problems that could affect his or her ability to provide quality and efficient care, evidence of current Medical Staff and Hospital required immunizations, vaccinations, and titers, and completion of a health assessment, as required by the Hospital;
- n. Information as to whether the Applicant has ever been convicted of a state or federal felony or Caregiver Law;
- o. Information on the Applicant's citizenship and/or visa status;
- p. The Applicant's signature; and
- q. Such other information as the Board of Directors may require.

The Applicant shall complete and send his/her application, along with the required Application Fee, to the Medical Staff Office. The Applicant will produce either a current picture hospital identification card or a valid picture identification issued by a state or federal agency, so that the Hospital may verify the Applicant is the same as that identified in the credentialing documents.

- 2. The Medical Staff Office shall query the National Practitioner Data Bank (NPDB) and conduct a criminal background check. The results shall be reviewed with the application.
- 3. After determining that all questions on the application have been answered, determining that all required supporting documents and the required Application Fee have been supplied, and after verifying information provided with the primary sources, to the extent that such verification is feasible, the Administrator or his/her designee shall transmit the complete application and supporting materials to the appropriate department chair. It is the responsibility of the Applicant to provide a complete application. Applications that continue to be incomplete ninety (90) days after the Applicant has been notified of additional required information shall be deemed to be withdrawn. It is anticipated that the time frame from when a

complete application is received in the Medical Staff Office until the Board of Directors acts upon the application may span ninety (90) days (three (3) months). This timeframe may vary depending on the clarity and completeness of the information supplied on the application, the timeliness and content of the responses received, and any additional information received that may require follow up.

C. Department Review.

1. The chair of the department to which assignment is sought shall review and evaluate the Applicant's education, training, experience, character, professional competence, ethical standing, and ability to work with others. Such evaluation may include an interview with the Applicant by the respective department chair, section chair if the department chair so designates, or other designee. If Privileges requested span more than one department, the chair of the department to which the Applicant has requested assignment shall consult with the chairs of all involved departments before making a recommendation.
2. If the department chair wishes to support an Applicant who would require a waiver of the board certification requirement as specified in Section 4.2(D) preceding, the department chair must request a vote of the Executive Committee pursuant to Section 4.2(D) of that article prior to submitting a recommendation to the Credentials Committee.
3. The department and/or section chair or designee shall provide the Credentials Committee with a written recommendation concerning the Applicant's qualifications for appointment and proposed delineation of the Applicant's Clinical Privileges.

D. Credentials Committee Review.

1. The Credentials Committee shall evaluate the Applicant's character, competence, qualifications, and experience and shall determine whether the Applicant has satisfied necessary qualifications for appointment and requested Clinical Privileges. The Credentials Committee will also assess the Applicant's competence in six (6) core areas: (i) patient care; (ii) medical/clinical knowledge; (iii) patient-based learning and improvement; (iv) interpersonal and communication skills; (v) professionalism; and (vi) system-based practice.
2. The Credentials Committee may require a personal interview with the Applicant at its discretion; it may require a physical and/or mental examination of the Applicant; and it may use the expertise of a department member or an outside consultant.
3. When it appears that the recommendation of the Credentials Committee will be negative or not in accord with the staff status or Privileges requested by the Applicant, the Credentials Committee shall invite the affected Practitioner to meet with the Credentials Committee prior to finalizing such

recommendation. This informal meeting shall not be a hearing subject to the Fair Hearing and Appeal Procedures.

4. The Credentials Committee shall submit a written report to the Executive Committee setting forth its recommendations regarding the Applicant's appointment to the Medical Staff and Clinical Privileges (including any recommendations for privilege conditions or restrictions) in light of required Medical Staff qualifications, the ability of the Hospital to provide adequate facilities and support services for the Applicant and his/her patients, and the Hospital's needs and requirements.
    - a. Each recommendation for initial appointment to the Medical Staff (except to the Courtesy or Consulting/Outreach Staff) shall be for assignment to the Provisional staff for six (6) months.
    - b. When the Credentials Committee's recommendation is to defer, the basis for this recommendation shall be stated and the recommendation shall specify when the application will be recommended for acceptance or rejection.
  5. The Credentials Committee's report shall be forwarded to the Executive Committee upon completion.
  6. The recommendations of the Credentials Committee are advisory to the Executive Committee and do not of themselves constitute professional review action.
- E. Executive Committee Review.
1. The Executive Committee shall, after receipt of the report of the Credentials Committee, carefully consider the Applicant's character, competence, qualifications, and experience in order to determine whether the Applicant satisfies necessary qualifications for appointment and requested Privileges.
  2. Following its consideration, the Executive Committee shall determine, by majority vote, whether to recommend to the Board of Directors that the Applicant be appointed to the Medical Staff, that the application be deferred for further consideration, or that the application for appointment and Clinical Privileges be denied. All recommendations to appoint must also specifically recommend Clinical Privileges to be granted, which may be qualified by probationary or other conditions or restrictions.
  3. The Executive Committee's recommendations must be in writing.
  4. A recommendation by the Executive Committee to defer for further consideration or investigation must be followed up within ninety (90) days by a recommendation for appointment to the Medical Staff with specified Privileges or for rejection of the application. Within ten (10) days of the Executive Committee's decision to defer an application, the Applicant must be notified of the reason(s) for the deferral and of any request for additional information. If the Applicant does not respond within thirty (30) days of

written notification of the deferral, his or her application shall be considered voluntarily withdrawn.

5. If the Executive Committee decides to make a recommendation contrary to the recommendation(s) of the Credentials Committee, the Executive Committee shall either:
  - a. Remand the matter to the Credentials Committee for its further investigation and response to specific questions raised by the Executive Committee; or
  - b. Set forth in its report clear reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation(s) and forward its report along with the Credentials Committee's recommendation(s) to the Board of Directors, subject to the requirements of paragraph F, below.
6. When the recommendation of the Executive Committee is negative or not in accord with the status or privileges requested by the Applicant, prior to any referral of the recommendation to the Board of Directors for action it shall be forwarded to the President of the Medical Staff, who will notify the Practitioner involved and give him/her an opportunity either to waive any procedural rights which are contained in these Bylaws by accepting the recommendation or to exercise such review rights as are set forth in these Bylaws.
7. If the Executive Committee fails to make a recommendation on an application within ninety (90) days of receipt of the report of the Credentials Committee, the Board of Directors may review and act upon the application without an Executive Committee recommendation, in the same manner as required by the Executive Committee.

F. Board of Directors Action.

1. The Board of Directors shall either:
  - a. Accept or reject the recommendation in whole or in part; or
  - b. Refer it back to the Executive Committee indicating reasons that further consideration is necessary and setting a time limit for receipt of subsequent recommendation.
2. The Administrator shall transmit the final decision of the Board of Directors to the Applicant within sixty (60) days of the decision, including notice of Medical Staff category, Clinical Privileges granted, and any special conditions associated with initial appointment. If the Applicant is accepted, the Administrator shall notify the appropriate department(s) of the Applicant's acceptance by the Board of Directors. If an application is rejected, the Administrator shall inform the Applicant of the reason for rejection and of his or her hearing rights pursuant to these Bylaws.

## 6.2 Clinical Privileges.

### A. General Provisions.

1. Each individual who has been appointed to the Medical Staff shall be entitled to exercise only those Privileges granted by the Board of Directors.
2. Requests for Clinical Privileges will be considered only when all information specified in the Hospital's description of threshold requirements is provided. If all requested information is not provided, the Applicant will be notified and the request for Privileges will be considered incomplete and will not be processed. If there are no approved threshold requirements for requested Clinical Privileges, the request will be tabled for a period not to exceed ninety (90) days, during which time the Credentials Committee, with assistance from departments as necessary, shall create requirements under which the request may then be processed. All threshold Privilege requirements will consist of baseline criteria specifying the minimum amount of required education, training, experience, and evidence of competency and shall be approved by the Executive Committee prior to implementation. For Practitioners applying for telemedicine privileges only, the process outlined in Subsection 6.2(J) shall be followed.
3. Decisions to grant Clinical Privileges shall be based upon:
  - a. The Applicant's education, training, experience, competence and judgment, references, utilization patterns, and health status;
  - b. Availability of qualified Medical Staff Members to provide medical coverage for the Applicant in case of the Applicant's unavailability;
  - c. Adequate levels of professional liability insurance coverage with respect to Clinical Privileges requested;
  - d. The Hospital's currently available—or available within the time requested—space, equipment, staffing, financial resources and personnel;
  - e. Any previous or pending challenges to licensure or registration, voluntary or involuntary relinquishment of licensure or registration, or information concerning termination of medical staff appointment or limitation, reduction, or loss of clinical privileges at another health care institution; and
  - f. Other relevant information.
4. The Applicant has the burden of establishing his/her satisfaction of requirements for Clinical Privileges (s)he requests.

### B. Clinical Privileges for Dentists and Podiatrists.



1. The scope and extent of surgical procedures that a dentist or podiatrist may perform in the Hospital shall be delineated and recommended in the same manner as other Clinical Privileges.
2. Surgical procedures performed by dentists or podiatrists shall be under the overall supervision of the Chair of the Department of Surgery or his/her designee. A medical history and physical examination of the patient shall be made and recorded by a Physician who holds an appointment to the Medical Staff before dental or podiatric surgery shall be scheduled for performance, and a designated Physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

C. Residents.

Residents in approved training programs are not Members of the Medical Staff. Unless specifically appointed to the Medical Staff pursuant to the appointment process set forth above, they shall have no Medical Staff rights or responsibilities. Any Privileges granted must be, and remain, within the scope of their training. Residents act under the direction of their Residency Faculty and/or the appropriate attending Medical Staff Members. A Resident's scope of privileges cannot be greater than that of the attending Physician. Please refer to the MercyOne Northeast Iowa Resident Job Description for more information.

D. Temporary Clinical Privileges.

1. In accordance with this Section 6.2(D), the Administrator or designee may, upon the concurrence of the appropriate department/section chair or designee and the President of the Medical Staff or designee, grant temporary Privileges to an Applicant for up to 120 consecutive days, only in the following circumstances:
  - a. When a new Applicant with a complete application that raises no concerns is awaiting review and approval of the Executive Committee and the Board of Directors; or
  - b. To fulfill an important patient care, treatment, or service need. There are three types of temporary privileges that meet this requirement: (1) locum tenens; (2) care of a specific patient; and (3) special need for time-limited services. In any event, temporary privileges will be granted rarely and only when necessary, and the reason for requesting temporary privileges will be set forth with specificity by the person requesting them.
    - i. An applicant for temporary privileges in any of these circumstances shall submit the following information:
      - a. A completed request for temporary Privileges form, which must include sufficient information to query the NPDB, such as Social Security number, date of birth, and home address;
      - b. A delineation of the Clinical Privileges being requested;

- c. Dates and numbers of state licenses (the Iowa medical license will be primary source verified);
  - d. Information which will allow the Medical Staff Office to verify the Applicant's DEA license and CSA certificate, as well as information as to whether the Applicant's DEA license or CSA certificate is or has ever been suspended, modified, terminated, restricted, or is currently being challenged;
  - e. A copy of his/her current Professional Liability Insurance Face-sheet;
  - f. A copy of a TB Skin Test Result from within the past year. If the Applicant is a positive reactor, then a TB questionnaire must be completed and a chest x-ray result from within the past five (5) years must be submitted;
  - g. If requested by the Medical Staff Office, a copy of proof of any additional immunizations;
  - h. If possible, written or verbal confirmation that the Applicant is in good standing at another health care facility, preferably a hospital; and
  - i. The individual's signed acknowledgement to be bound by the Hospital Bylaws, the Medical Staff Bylaws, and Medical Staff and Hospital Policies, Rules, and Regulations in all matters, especially those relating to the temporary Clinical Privileges and medical records completion.
- ii. The Hospital shall verify the Practitioner's current licensure and competence, search the OIG Exclusion Database, query the NPDB, and complete a criminal, child abuse, and/or dependent adult abuse background check. If the information reasonably supports a favorable determination regarding the Practitioner's qualifications, ethical standing, competence, ability, and judgment to exercise the requested Privileges, the Administrator or designee, with the recommendations of the Medical Staff President or designee and the appropriate department/section chair or designee, may grant the Practitioner temporary privileges for up to 120 consecutive days, after which the Practitioner must apply for Medical Staff membership and Clinical Privileges in order to continue to exercise Privileges at the Hospital.
  - iii. Locum tenens applicants for temporary privileges: A Member of the Medical Staff or designee may submit a written request to the Medical Staff Office for locum tenens coverage by a qualified Practitioner. Whenever possible, notice of planned locum tenens

should be submitted to the Hospital at least sixty (60) days in advance by the Medical Staff Member or designee. Temporary Privileges for a locum tenens Practitioner shall be automatically relinquished upon completion of services as a locum tenens Practitioner. Locum tenens Practitioners shall be granted privileges in a department in accordance with their qualifications.

- iv. Temporary Privileges for the care of a specific patient:  
Temporary privileges for the care of a specific patient shall be automatically relinquished upon completion of the Practitioner's care for the patient.
  - v. Temporary Privileges for provision of special services:  
Temporary privileges granted to a Practitioner when the Hospital has a special, time-limited need for the provision of the Practitioner's services shall be automatically relinquished when the need for the services no longer exists.
2. Practitioners who are performing services in the Hospital pursuant to temporary Privileges granted in accord with this Section 6.2(D) shall be under the overall supervision of the President of the Medical Staff and the chair of the department/section in which the Practitioner has Clinical Privileges or his or her designee. The President of the Medical Staff, appropriate department/section chair, Administrator or designee shall be entitled to suspend or revoke such temporary Privileges when the conduct of the Practitioner so indicates. Suspension or revocation of such temporary Privileges shall not be subject to the fair hearing procedures or appellate review procedures set forth in these Bylaws. In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to a Medical Staff Member by the chair of the department responsible for supervision or designee. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner. In addition, temporary Privileges shall be automatically terminated at such time as the Credentials Committee makes an unfavorable recommendation with respect to an Applicant's appointment to the Medical Staff, and, at the Credentials Committee's discretion, temporary Clinical Privileges shall be modified to conform to the Credentials Committee's recommendation that the Applicant be granted different permanent Privileges from the temporary Privileges.

E. Emergency and Disaster Privileges

1. Emergency Privileges.

a. Definition.

For the purpose of this section, an emergency is defined as:

- i. Any condition in which the life of the patient is in immediate danger and any delay in administering treatment would increase the danger; or

- ii. Any condition which, without immediate attention, serious permanent harm or aggravation of injury or disease could result to the patient.
  - b. Emergency Privileges for Medical Staff Members.
    - i. In case of an emergency, and regardless of department, Medical Staff status or Clinical Privileges, any Medical Staff Member shall be expected to do all in his/her power to provide care within the scope of his or her license and assist any patient(s) in immediate danger including the calling of such consultation as may be available.
    - ii. When an emergency situation no longer exists, the Medical Staff Member must request the Privileges necessary to continue to treat the patient. In the event such Privileges are denied, or the Staff Member does not desire such Privileges, the patient shall be assigned to an appropriate Medical Staff Member.
- 2. Emergency Disaster Privileges for Non-Members/Volunteer Practitioners.
  - a. For the purposes of this section, a “disaster” exists when the Hospital implements its emergency management plan and the Hospital is unable to handle the immediate patient needs.
  - b. During a disaster and in the best interest of immediate patient care the Administrator or designee may, at his or her discretion, grant emergency disaster Privileges on a case-by-case basis to non-members and volunteer Practitioners upon presentation of a valid government- issued photo identification from a state or federal agency, and at least one of the following:
    - i. A current hospital picture ID card/badge (a photocopy will be made when possible);
    - ii. A current license to practice and a valid picture ID (a photocopy will be made when possible, or primary source verification of license);
    - iii. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) (a photocopy will be made when possible);
    - iv. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances by a federal, state, or municipal entity (a photocopy will be made when possible); or
    - v. Presentation by current Hospital or Medical Staff Members(s) with personal knowledge regarding the volunteer Practitioner’s identity and professional ability.

- c. The responsible lead or supervising Physician or department chair will have the overall responsibility for assignment of duties to any volunteer Practitioner(s) who is granted emergency disaster Privileges and for keeping the Administrator or designee apprised of the patient care provided by the volunteer Practitioner(s).
  - d. As soon as the immediate situation is under control, additional information will be gathered from and about the volunteer Practitioner(s). The Medical Staff Office shall complete the verification process, which shall be identical to the process for granting temporary Privileges for a special, time-limited need. Primary source verification of licensure shall be completed within seventy-two (72) hours from the time the volunteer presents at the Hospital. In extraordinary circumstances when primary source verification cannot be completed within seventy-two (72) hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, primary source verification is not required.
  - e. When possible, all persons granted emergency Privileges during a disaster will be identified by a "Voluntary Practitioner: Emergency Privileges Granted" ID badge.
  - f. When the Administrator or designee deems a disaster or emergency situation to no longer exist or to be under control:
    - i. The emergency disaster Privileges shall expire, and the Practitioner(s) who was granted emergency disaster privileges may apply for Medical Staff membership and Clinical Privileges necessary to continue to treat the patient; or
    - ii. In the event such Privileges are denied or the volunteer Practitioner does not desire such Privileges, the patient shall be assigned to an appropriate Medical Staff Member.
3. In regards to the granting of Emergency Disaster Privileges the "designee" of the Administrator or Medical Staff President may include:
- a. the Hospital's Administrator-On-Call,
  - b. the Vice President of Medical Affairs,
  - c. any Hospital Administrator or Vice President,
  - d. the Medical Staff Vice President/President-Elect or Immediate Past President, or

e. the Emergency Department Physician on duty at the time of the disaster.

F. Procedures for Requesting Increase in or Modification of Clinical Privileges.

Any Member of the Medical Staff may apply for a change in Clinical Privileges at any time throughout the year by written request on a form to be submitted to the Medical Staff Office. The request shall state in detail specific changes desired and the Member's relevant recent training and experience which justify any requested increased Privileges. The NPDB will be queried and recent training and experience will be primary source verified. The Medical Staff Office will transmit this application to the Department Chair, and thereafter it will be processed in the same manner as an application for initial Clinical Privileges. In cases where the recommendation of the Executive Committee is to reject the request, the Applicant may have, as applicable, hearing rights as specified in Article VII of these Medical Staff Bylaws. Prior to the consideration of granting of any Privilege not currently delineated on a MercyOne Northeast Iowa request for privileges form, it shall be determined, through a collaborative process of the Hospital and Medical Staff leadership, whether the resources necessary to support the requested new Privilege are currently available, and, if not available, the specified time that they will be available. Also see Sections 4.2 and 6.2(A) of these Bylaws.

G. Procedure for Leave of Absence.

1. Leave of absence for periods of longer than three (3) weeks may be granted to Members of the Medical Staff who do not hold Provisional Staff status after written application to the President of the Medical Staff and due approval by the President of the Medical Staff, the Executive Committee, and the Board of Directors due to reasons of illness, attendance at postgraduate courses, military service, and other valid reasons. Members of the Medical Staff who are also Hospital employees should also refer to the Hospital's Human Resources policies regarding leave of absence for any reason. The period of leave of absence may not exceed the Medical Staff Member's present term of appointment to the Medical Staff. Three (3) months prior to the conclusion of any period of leave of absence lasting longer than six (6) months, a complete reapplication form must be submitted and will be processed in accordance with this Article. All Medical Staff Privileges shall be voluntarily relinquished during the period of a leave of absence.
2. At the conclusion of any leave of absence that lasts for less than six (6) months and does not exceed the Medical Staff Member's current term of appointment to the Medical Staff, the individual may be reinstated upon filing a written statement with the Executive Committee and Board of Directors summarizing professional activities undertaken during the leave and such other information as may be requested by the Hospital or Medical Staff at that time. The Iowa medical license will be primary source verified, and the NPDB will be queried. The information provided will be subject to verification prior to Executive Committee review.
3. In the case of a leave of absence for medical reasons, the Practitioner must also submit information regarding any temporary work restrictions, a report from his/her treating physician indicating that the Practitioner is physically and/or mentally capable of resuming a hospital practice and performing the

clinical privileges that are requested to be reinstated, and/or any additional information requested by the Hospital.

4. In acting upon the request for reinstatement, the Board of Directors may approve reinstatement either to the same or a different Medical Staff category and may limit or modify Clinical Privileges to be extended based upon recommendations from the Executive Committee. As provided by the fair hearing and appeal procedures contained herein, an action by the Board of Directors that reduces or limits the exercise of clinical privileges may entitle the Practitioner to fair hearing and appeal rights.

H. Focused Professional Practice Evaluation.

1. A period of focused professional practice evaluation shall be implemented for: (i) all initially requested Privileges; and (ii) in response to concerns regarding the provision of safe, high-quality patient care. Triggering events for such evaluation may consist of single incidents or evidence of a clinical practice trend.
2. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of the Practitioner's current clinical competence, practice behavior and ability to perform the requested Privileges.
3. Information for focused professional practice evaluation includes, as appropriate, chart review, monitoring clinical practice positions, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient.
4. The performance monitoring process will also include a method for establishing a monitoring plan specific to the requested Privilege, a method for determining the duration of performance monitoring, and circumstances under which monitoring by an external source is required.

I. Ongoing Professional Practice Evaluation.

1. A process of ongoing professional practice evaluation exists to continuously review Medical Staff Member's care and to identify professional practice trends that impact on quality of care and patient safety.
2. The criteria used in the ongoing professional practice evaluation may include such factors as: (i) the review of operative and other clinical procedures performed and their outcomes; (ii) patterns of blood and pharmaceutical usage; (iii) requests for tests and procedures; (iv) length of stay patterns; (v) morbidity and mortality data; (vi) Practitioner's use of consultants; and (vii) other relevant factors as determined by the Medical Staff.
3. The information used to review the ongoing professional practice evaluation factors shall include, as appropriate, periodic chart reviews, direct observation, monitoring of diagnostic and treatment techniques, and discussions with other individuals involved in the care of each patient,

including consulting Physicians, assistants at surgery, and nursing and administrative personnel.

4. Relevant information obtained from the ongoing professional practice evaluation shall be integrated into Medical Staff performance improvement activities. Such information shall help determine whether existing Privileges should be maintained, revised or revoked.

J. Telemedicine Privileges.

1. Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board shall have final approval of the clinical services to be provided through telemedicine after considering the recommendations of the appropriate department and the Executive Committee.

This subsection applies only to those Licensed Independent Practitioners who will have total or shared responsibility for the care of a patient through the use of a telemedicine link. "Total or shared responsibility" is evidenced by the Practitioner having the authority to write medical orders and direct a patient's care, treatment, or services.

Originating Site: The hospital where the patient is located at the time the service is provided

Distant Site: The hospital where the Practitioner providing the professional service is located.

In processing a request for telemedicine Privileges, the Originating Site will use the credentialing and privileging decisions from the Distant Site to make a final privileging decision if: (1) the Distant Site credentialing process meets Medicare standards (2) the Practitioner is privileged at the Distant Site for those services to be provided at the Originating Site; (3) the Distant Site provides a current list of the Practitioner's privileges; and (4) the Practitioner holds a license issued or recognized in the state where patients at the Originating Site will receive services (i.e., Iowa); and (5) the Originating Site conducts internal reviews of the Practitioner's telemedicine services and sends the Distant Site hospital such performance information for use in its periodic appraisals of the Practitioner. At a minimum, the internal review information the Originating Site sends to the Distant Site must include all adverse events that occur at the Originating Site and all complaints the Originating Site has received about the Practitioner. (In the event the Distant Site is not a Medicare-participating hospital, the Originating Site will credential and privilege the Practitioner consistent with the process as outlined in the Medical Staff Bylaws.)

All requests for telemedicine services will be evaluated by the Medical Staff at the Originating Site to make sure that they can be safely provided in an ongoing basis. This evaluation will include discussion of which clinical services are appropriately delivered by Licensed Independent Practitioners through a telemedicine link and are consistent with commonly accepted quality standards.



The Medical Staff at the Distant Site will be involved in evaluating the performance of those services as part of privileging and as part of the reappraisal conducted at the time of reappointment or renewal or revision of Clinical Privileges.

2. Practitioners who provide telemedicine services through a third party contracted provider are credentialed and privileged as confirmed in a contract entered into by the Hospital and the contracted provider.

### **6.3 Reappointment.**

#### **A. Application.**

1. Each current Member who is eligible to be reappointed to the Medical Staff shall be responsible for completing a reappointment application and submitting the required Re-Application Fee. The reappointment application must be submitted to the Administrator or his/her designee at least three (3) months prior to the expiration of the Member's current appointment period. Failure to submit an application or pay the required Re-Application Fee at that time will result in automatic expiration of the Member's appointment and Clinical Privileges at the end of his/her term, and the Member will not be entitled to hearing and appeal rights.
2. If granted, reappointment will be for a period of not more than 2 years. If an application for reappointment is filed and the Board of Directors has not acted on it prior to the expiration of the Member's current term of appointment, that appointment shall continue in effect until such time as the Board of Directors acts on the reappointment application.

#### **B. Factors to Be Considered.**

Recommendations concerning the reappointment of a Medical Staff Member, a change in Medical Staff category, and/or increase or decrease of Clinical Privileges shall be based on, but need not be limited to, the following:

1. Relevant recent training and satisfactory completion of continuing medical education requirements with CME credits that pertain, at least in part, to the Practitioner's specialty;
2. Peer review via direct observation of patient care provided or review of the records of patients treated in the Hospital or in other health care facilities, including but not limited to MercyOne Hospitals;
3. The Member's voluntary or involuntary limitation, reduction, suspension, or loss of clinical privileges at another hospital or health care entity;
4. Cooperation with other Members of the Medical Staff, Hospital Administration, and Hospital personnel;
5. The Member's professional ethics, competence, and clinical judgment in treatment of patients;

6. Physical, mental, and emotional capacity to treat patients;
7. Compliance with Hospital Bylaws and policies, Medical Staff Bylaws and policies, and department policies;
8. Any recent challenges to licensure;
9. Completion of medical records in accordance with Iowa statutes and Medical Staff policies;
10. Extent to which the Member meets the Basic Qualifications set forth in these Bylaws; and
11. Other reasonable indications of continuing qualifications and relevant findings from the Hospital's quality improvement/assessment activities.

C. Procedure.

1. Department Procedure.
  - a. Each month, the Administrator or his/her designee shall transmit to the chair of each department or his/her designee copies of reappointment applications and other relevant information for Members of the department who are due for reappointment to the Medical Staff and the requests of those Medical Staff Members who have applied for a change in Clinical Privileges or a change in Medical Staff category. The Medical Staff Office shall primary source verify the Iowa medical license, request a NPDB report, search the OIG Exclusions Database and conduct a criminal background check; this information shall also be transmitted to the chair of each department or his/her designee.
  - b. The chair of each department or his/her designee shall then submit the following information to the Credentials Committee:
    - i. The department Member(s) recommended for reappointment in the same Medical Staff category with the same Clinical Privileges they then hold.
    - ii. Individual recommendations and reasons therefor, for any changes recommended in Medical Staff category or in Clinical Privileges, for non-promotion of an eligible Medical Staff Member, or for non-reappointment both of those who applied for changes and those who did not.
    - iii. As part of the periodic reappraisal relative to reappointment, the chair of the each department shall report to the Credentials Committee any suspected physical or mental disease or illnesses of a Member which would in any manner restrict the Member's ability to care for patients. (S)he shall also recommend an appropriate examination or evaluation necessary for renewed membership on the Medical Staff.

- iv. If Member(s) recommended were initially appointed with a waiver of Basic Qualifications, pursuant to Section 4.2(D), the chair needs to reaffirm his/her recommendation for continuation of the waiver.

2. Credentials Committee Procedure.

- a. The Credentials Committee shall review all information available regarding the competence and activity of the Medical Staff Members due for reappointment and shall make recommendations to the Executive Committee concerning the reappointment, non-reappointment, and/or Medical Staff category of each Medical Staff Member based upon a consideration of the factors set forth in Section 6.3(B). The results of quality assessment and improvement activities and the monitoring performed during a term of provisional appointment, if applicable, shall be considered in the appraisal of the Applicant's professional performance, judgment, and technical and/or clinical skills.
- b. As part of the process of making its recommendation, the Credentials Committee may require that an individual seeking reappointment procure a physical and/or mental examination by one or more physician(s) satisfactory to the Credentials Committee. The results of such examination shall be available for the Credentials Committee's consideration. Failure of an individual seeking reappointment to procure such an examination within a reasonable time after being requested to do so by the Credentials Committee shall constitute a voluntary relinquishment of Medical Staff membership and all Clinical Privileges until such time as the Credentials Committee has received and evaluated the examination results.
- c. The Credentials Committee has the right to require the Member to meet with the Credentials Committee to discuss any aspect of the individual's reappointment application, qualifications, or Clinical Privileges requested.
- d. The Credentials Committee shall forward written findings and recommendations to the Executive Committee in time for the Executive Committee to consider the reappointments at one of its regularly scheduled meetings before expiration of the Applicant's appointment period. Where non-reappointment, non-promotion, or a change in Clinical Privileges is recommended, the reason for such shall be stated.

3. Executive Committee Procedure.

- a. The Executive Committee shall prepare and forward a written report to the Board of Directors through the Administrator with recommendations concerning the reappointment/non-reappointment, staff category, and/or Clinical Privileges of each Medical Staff Member due for reappointment. If there is dissent from any recommendation, such should be noted and the reasons given.

- b. When non-reappointment, non-promotion, a change in Medical Staff status, or a reduction of clinical privileges is recommended, the reasons for such recommendation shall be stated and documented, and the report shall not be transmitted to the Board of Directors until the affected Member has exercised or waived his or her right to a hearing as provided in these Bylaws.
  - c. If the Executive Committee has determined to make a recommendation contrary to the Credentials Committee's recommendations, the Executive Committee shall either:
    - i. Remand the matter to the Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Executive Committee prior to its final recommendation; or
    - ii. Set forth in its report clear reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendations, and forward its report, together with the Credentials Committee's recommendations, to the Board of Directors through the Administrator subject to 3(b), above.
4. Board of Directors Procedure.
- a. The Board of Directors shall, at its next regular meeting after receipt of the recommendations of the Executive Committee relative to the reappointment of each staff member, either:
    - i. Accept or reject the recommendation concerning a Medical Staff Member, or
    - ii. Refer the recommendation back to the Executive Committee indicating reasons for referral and setting a time limit for a subsequent recommendation to be received by the Board of Directors.
  - b. The Administrator shall transmit the final decision of the Board of Directors to the Applicant, including notice of Medical Staff category, Clinical Privileges granted, and any special conditions associated with appointment. If an application is rejected, the President of the Hospital shall inform the Applicant of his or her hearing rights pursuant to the Fair Hearing and Appeal Procedures in these Bylaws.

#### **6.4 Limits on Reapplication.**

A. Final Adverse Decision.

An Applicant who has received a final adverse decision, as defined below, regarding appointment, reappointment, and/or Clinical Privileges shall not be eligible to reapply for

the membership status or Privileges that were the subject of the adverse decision for a period of two (2) years from the date of final adverse decision.

A Medical Staff Member who has been convicted of a state or federal felony or Caregiver Law violation shall not be eligible to reapply for membership or Clinical Privileges except as provided in Section 6.1(A)(3)(iv) herein.

B. Initial Application.

Any reapplication under this section shall be processed as an initial application, but the Applicant shall submit such additional information as the Medical Staff or Board of Directors may require to demonstrate that concerns relating to the basis for the earlier adverse decision no longer exist.

C. Scope of Hearing.

If the recommendation of the Medical Staff or the action proposed by the Board of Directors upon reapplication under Section 6.3(C)(4) continues to be adverse, the scope of the hearing to which the Applicant is entitled shall be limited to consideration of the sufficiency of the additional information submitted to demonstrate that the concerns relating to the basis for the earlier adverse decision no longer exist.

D. Adverse Decision.

For the purposes of this Article VI, an adverse decision is defined as:

1. A decision based on events that did or could give rise to a request for corrective action; or
2. Voluntary relinquishment of Medical Staff membership and/or Clinical Privileges for failure to respond to a request for additional information associated with an initial application for appointment or an application for reappointment.

E. Date Considered Final.

An adverse decision shall be considered final on the date the application was withdrawn or on the date that a decision is announced following the completion of all discussions and hearings, whichever comes later.

F. Actions Not Considered Adverse Decisions.

In addition to the other items specifically identified in these Bylaws, the following are not considered adverse decisions and will not give rise to the required wait times set forth in this Article VI: automatic expiration of appointment and Clinical Privileges for failure to submit a timely reappointment application or pay the required Application or Reapplication Fee; voluntary relinquishment of elective or emergency admitting Privileges or voluntary relinquishment of membership and Clinical Privileges for failure to complete medical records; and expiration of DEA registration or CSA certificate.

## 6.5 Corrective Action.

### A. Grounds for Action.

Whenever, on the basis of information and belief, any officer of the Medical Staff, chair of any department, chair of any standing committee of the Medical Staff, Vice President of Medical Affairs, Administrator, or chair of the Board of Directors, has cause to question the clinical competence of a Member; the care or treatment of a patient or management of a case by a Member; suspected violation of the Bylaws, policies, rules, or regulations of the Hospital or Medical Staff; or behavior or professional conduct of any Member that: (a) is considered lower than the standards or aims of the Medical Staff, or (b) is considered disruptive to the operations of the Hospital, an investigation may be requested. All requests for investigation shall be in writing, shall be made to the President of the Medical Staff (who shall receive the request on behalf of the Executive Committee), and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request. The Medical Staff President shall promptly notify the Administrator of the request and keep him/her informed of action taken in connection therewith.

### B. Investigative Procedure.

1. The Executive Committee shall meet as soon after receiving the investigation request as practicable and determine: 1) that the request contains information sufficient to warrant a recommendation for corrective action, as defined in the Fair Hearing and Appeal Procedures contained in these Bylaws; 2) to immediately commence an investigation of the matter; or 3) that no further action is warranted under the circumstances.
2. The Executive Committee's investigation shall be performed either by the Executive Committee, a subcommittee of the Executive Committee, or an Investigating Committee appointed by the Executive Committee. The individuals performing the investigation shall not include partners, associates, or relatives of the affected individual or Practitioners in direct economic competition with the individual.
3. The group performing the investigation shall have available the full resources of the Medical Staff and the Hospital to aid in its work, as well as authority to use outside consultants, as needed. The investigating group also may require a physical or mental examination of the Member by a physician(s) satisfactory to the group and shall require that the results be made available for the group's consideration.
4. The individual with respect to whom an investigation has been requested will have the opportunity to meet with the investigating group before it makes its report. At this meeting, the individual will be informed of the general nature of the evidence supporting the investigation and shall be invited to discuss, explain, or refute it. This interview will not constitute a hearing, and none of the procedural rules provided for in the Fair Hearing and Appeal Procedures, contained herein, or Hospital or Medical Staff policies shall apply. A summary of the interview will be made by the investigating group and included with its report to the Executive Committee.

5. At any time during the investigation, the Practitioner may be subject to Precautionary Suspension under Section 6.6. It shall not indicate the validity of the charges and shall remain in force, without appeal, during the course of the investigation. If such a suspension is placed into effect, the investigation must be completed within fourteen (14) days of the suspension, or reasons for the delay will be transmitted to the Board of Directors prior to the expiration of the fourteen (14) days so that it may consider whether the suspension should be lifted. In the event of suspension of Privileges, the appropriate department chair or, if unavailable, the President of the Medical Staff, shall immediately assign to another Medical Staff Member with appropriate Clinical Privileges responsibility for the care of patients of the suspended Member until the suspension has been lifted or such patients are discharged from the Hospital, giving consideration whenever possible to the wishes of the patient.

C. Procedure Thereafter.

1. Within sixty (60) days after the Executive Committee's receipt of the request for investigation, the investigating group shall make a report of its investigation to the Executive Committee. The report may recommend the following:
  - a. No action;
  - b. Issuance of a written warning;
  - c. Issuance of a letter of reprimand;
  - d. Imposition of terms of probation;
  - e. Imposition of a requirement for consultation or monitoring;
  - f. Reduction of Clinical Privileges;
  - g. Suspension of Clinical Privileges for a term;
  - h. Revocation of Medical Staff appointment; or
  - i. Such other recommendations as the Executive Committee deems appropriate.
2. The Executive Committee shall take action within ten (10) days of receipt of the investigation report. Any recommendation for reduction, suspension, or revocation of Clinical Privileges or for suspension or revocation of Medical Staff membership shall entitle the affected individual to procedural rights provided for in the Fair Hearing and Appeal Procedures of these Bylaws. A requirement for consultation, monitoring, or similar action shall not be an adverse professional review action generating a right of hearing unless such action also limits or reduces the Practitioner's Clinical Privileges.

3. If the action of the Executive Committee does not entitle the individual to a hearing, the action shall take effect immediately, and a report of the action taken and the reasons therefore shall be made to the Board of Directors, and the action shall stand unless modified by the Board of Directors.
4. Any recommendation by the Executive Committee that would entitle the Practitioner to procedural rights provided for in the Fair Hearing and Appeal Procedures contained herein shall be forwarded to the Administrator who shall promptly notify the affected individual by certified mail, return receipt requested. The Administrator shall then hold the recommendation until after the individual has exercised or waived the right to a hearing. At that time, the Administrator shall forward the recommendation of the Executive Committee, along with all supporting information, to the Board of Directors.
5. In the event that the Executive Committee's recommendation is favorable to the Practitioner but the Board of Directors determines to consider modification of such action of the Executive Committee, and such modification would entitle the individual to a hearing in accordance with the Fair Hearing and Appeal Procedures, the Board of Directors shall so notify the affected individual, through the Administrator, and shall take no final actions thereon until the individual has exercised or waived the procedural rights provided.

## **6.6 Precautionary Suspension of Clinical Privileges.**

### **A. Grounds for Precautionary Suspension.**

The President of the Medical Staff, the chair of any department in which the affected Medical Staff Member has privileges, the Vice President of Medical Affairs, the Administrator, the chair of the Credentials Committee, or the chair of the Board of Directors shall each have the authority, based on imminent danger to the health of any individual, to suspend all or any portion of the Clinical Privileges of a Medical Staff Member or other individual for a period of time of up to, and including, fourteen (14) days, and such suspension shall become effective immediately upon imposition and shall be reported immediately to the Administrator, the President of the Medical Staff, and the chair of the Credentials Committee. Such precautionary suspension shall be deemed an interim precautionary step in the professional review activity to be taken with respect to the individual but is not a complete professional review action in and of itself.

### **B. Procedure.**

1. The Executive Committee shall review the matter resulting in the precautionary suspension and, within fourteen (14) days of its imposition, take such further action as is required in the manner specified in Article VI. If the Executive Committee's recommendation is for revocation of membership or Privileges, the suspension shall not expire at the end of fourteen (14) days.



2. If the suspension of Clinical Privileges extends beyond fourteen (14) days, the affected individual shall be entitled to request that the Executive Committee promptly facilitate a hearing on the matter within a reasonable time period in accordance with the procedures set forth in the Fair Hearing and Appeal Procedures contained in these Bylaws.
3. If suspension of Clinical Privileges extends beyond fourteen (14) days, and the affected individual has requested a hearing on the matter and also requests a removal of the suspension pending the hearing and appellate review (if any), the Executive Committee of the Board of Directors shall be promptly convened. The written positions of the affected member and the Medical Staff Executive Committee on the singular issue of maintenance of the suspension pending hearing and appellate review, as well as the recommendations of the Administrator, President of the Medical Staff, and the chair of the Member's department, shall be considered by the Executive Committee of the Board of Directors. The Executive Committee of the Board of Directors shall be authorized to maintain, modify, or lift the suspension pending hearing and appellate review and shall reduce its determination to a written finding.
4. Immediately upon the imposition of a suspension, the President of the Medical Staff or responsible department chair shall provide for alternative medical coverage for the patients of the suspended Member who are still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative Member. The suspended Member shall confer with the alternative Member to the extent necessary for patient care.

## 6.7 Automatic Termination

Automatic Termination. The following shall result in automatic termination of a Medical Staff Member's membership and clinical privileges:

1. Conviction of the Practitioner of any state or federal felony or conviction of any Caregiver Law. There will be no review, fair hearing, or appeal of the termination based on such conviction.
2. The Practitioner's medical staff membership at any other MercyOne Hospital have been terminated (other than voluntary resignation by the Practitioner unrelated to any investigation). There will be no review, fair hearing, or appeal of the termination based on the foregoing.
3. Failure to timely make the notifications required by Section 4.3 (J) (5), (6) and (7) above of these Bylaws. There will be no review, fair hearing, or appeal of the termination based on the foregoing
4. Upon the happening of any of the situations identified in Section 4.3.L. above of these Bylaws. There will be no review, fair hearing, or appeal of the termination based on the foregoing

5. In the event that a Practitioner has been decertified, debarred or excluded from participation in the Medicare or Medicaid program. There will be no review, fair hearing, or appeal of the termination based on the foregoing

Immediately upon the imposition of an automatic termination, the Practitioner shall provide for alternative medical coverage for the patient(s) who are still in the Hospital at the time of such termination. The wishes of the patient(s) shall be considered in the selection of such alternate Practitioner(s). The terminated Practitioner shall confer with the alternate Practitioner to the extent necessary to safeguard the patient(s). If the Practitioner is unable or unwilling to coordinate alternative medical coverage for the patient(s) in the Hospital, the Chief of Staff, Vice President of Medical Affairs or responsible Department Chief shall have the authority to provide for alternative medical coverage for patients of the terminated Practitioner.

Notwithstanding any other term or condition of these Bylaws, automatic termination for the reasons set forth in this Section shall not be deemed an adverse action nor shall it be deemed a professional review action and thus does not give rise to any right of hearing or appellate review.

**6.8 Automatic Suspension.** The following shall result in automatic suspension of a Medical Staff member's membership and clinical privileges:

- A. Action by the State Board of Medicine revoking or suspending a Practitioner's license, or imposing probation or limitation of practice, shall automatically suspend all of the Practitioner's Hospital privileges. Such shall occur whether the action of the Board of Medicine is unilateral or agreed to by the Practitioner. In such an event, the Executive Committee shall promptly review the matter and submit a recommendation to the Board of Directors regarding the Practitioner's Medical Staff status and clinical privileges. The Executive Committee shall, if concurred in by the Administrator be authorized to lift or modify any such automatic suspension pending final determination by the Board of Directors. In the event that such limitation imposes only a requirement to obtain additional continuing medical education and no other restrictions or practice limitations, the Chief of Staff may, if concurred by the Administrator, lift such automatic suspension pending review by the Executive Committee.
- B. An automatic suspension shall be imposed, after a warning of delinquency, upon a Practitioner for failure to complete medical records in accordance with the time limits set forth in the current Medical Staff Rules and Regulations, except as otherwise set forth in the Rules and Regulations. Such suspension shall take the form of withdrawal of the Practitioner's admitting privileges and shall be effective until requirements for medical record completion, as stated in the Rules and Regulations are met. Such suspension of privileges shall not affect the status or privileges of the Practitioner as regards patients who are at the time of the automatic suspension in the Hospital under the care of the Practitioner
- C. An automatic suspension shall be imposed, after a warning of delinquency, upon a Practitioner for failure to pay Medical Staff assessments within sixty (60) days of billing, except as otherwise set forth in the Rules and Regulations. Such

suspension shall take the form of withdrawal of the Practitioner's admitting privileges and shall be effective until the delinquent assessments are paid. Such suspension of privileges shall not affect the status or privileges of the Practitioner as regards patients who are at the time of the automatic suspension in the Hospital under the care of the Practitioner.

- D. A Practitioner whose DEA number or State CSA certificate expires, is revoked or restricted or voluntarily surrendered shall automatically be divested of the right to prescribe medications controlled by such number.
- E. An automatic suspension of all privileges shall be imposed by the Administrator after discussion with the Chief of Staff, for misconduct that does not directly involve clinical issues but is in violation of Hospital policy. Such misconduct can consist of, but is not limited to: sexual harassment or abuse of others; drug, alcohol or other addiction; criminal, fraudulent or other improper conduct.
- F. An automatic suspension shall be imposed upon a Practitioner's failure without good cause to supply information or documentation requested by any of the following: the Administrator his or her designee, the Credentials Committee, the Executive Committee or the Board. Such suspension shall be imposed only if: (1) the request was in writing, (2) the request was related to evaluation of the Practitioner's current qualifications for membership or clinical privileges, (3) the Practitioner failed to either comply with such request or to satisfactorily explain his or her inability to comply, and (4) the Practitioner was notified in writing that failure to supply the request information within 15 days from receipt of such notice would result in automatic suspension. Any automatic suspension imposed pursuant to this paragraph may be a suspension of any portion or all of the Practitioner's privileges and shall remain in effect until the Practitioner supplies the information or documentation sought or satisfactorily explains his or her failure to supply it.
- G. An automatic suspension shall be imposed upon a Practitioner's failure to maintain professional liability insurance coverage in accordance with limits established by the Medical Staff;

Immediately upon the imposition of an automatic suspension, the Practitioner shall provide for alternative medical coverage for the patient(s) who are still in the Hospital at the time of such suspension. The wishes of the patient(s) shall be considered in the selection of such alternate Practitioner(s). The suspended Practitioner shall confer with the alternate Practitioner to the extent necessary to safeguard the patient(s). If the Practitioner is unable or unwilling to coordinate alternative medical coverage for the patient(s) in the Hospital, the Chief of Staff, Vice President of Medical Affairs or responsible Department Chief shall have the authority to provide for alternative medical coverage for patients of the suspended Practitioner.

Notwithstanding any other term or condition of these Bylaws, automatic suspension for the reasons set forth in this Section shall not be deemed an adverse action nor shall it be deemed a professional review action and thus does not give rise to any right of hearing or appellate review.

**6.9 Other Actions.** The actions set forth in this Section 6.9 are not professional review actions and do not give rise to hearing or appeal rights. Individuals subject to any of the following actions will be immediately notified of the action by certified mail, return receipt requested.

- A. Failure to Submit the Required Application or Re-Application Fee. If an Applicant fails to submit the required Application Fee when due, the Applicant's application will be deemed voluntarily withdrawn. If a Medical Staff Member fails to submit the required Re-Application Fee when due, the Member's Medical Staff membership and Clinical Privileges may be deemed voluntarily relinquished.
- B. Failure to Provide New or Updated Application Information. If an Applicant or Medical Staff Member fails to provide new or updated information that is pertinent to any question on the application within one (1) week of learning the information, an applicant's application may be deemed voluntarily withdrawn or a member's Medical Staff membership and Clinical Privileges may be deemed voluntarily relinquished. Notwithstanding the above statement, if an Applicant or Member fails to make any notification required under Section 4.3(J) within forty-eight (48) hours, his/her application shall be automatically withdrawn or his/her Medical Staff membership and Clinical Privileges shall be automatically suspended or terminated subject to the terms of Section 4.3(J).

Immediately upon the imposition of the voluntarily withdrawal, the Practitioner shall provide for alternative medical coverage for the patient(s) who are still in the Hospital at the time of such suspension. The wishes of the patient(s) shall be considered in the selection of such alternate Practitioner(s). The suspended Practitioner shall confer with the alternate Practitioner to the extent necessary to safeguard the patient(s). If the Practitioner is unable or unwilling to coordinate alternative medical coverage for the patient(s) in the Hospital, the Chief of Staff, Vice President of Medical Affairs or responsible Department Chief shall have the authority to provide for alternative medical coverage for patients of the suspended Practitioner.

Notwithstanding any other term or condition of these Bylaws, voluntary withdrawal for the reasons set forth in this Section shall not be deemed an adverse action nor shall it be deemed a professional review action and thus does not give rise to any right of hearing or appellate review.

**6.10 Confidentiality, Reporting, and Peer Review Protection.**

- A. Confidentiality.

Actions taken and recommendations made pursuant to these Bylaws shall be treated as confidential in accordance with applicable law and such policies regarding confidentiality as may be adopted by the Board of Directors.

- B. Reports.

Reports of action taken pursuant to these Bylaws shall be made by the Hospital President to such government agencies as may be required by law.

- C. Peer Review Protection.

All minutes, reports, recommendations, communications and actions made or taken pursuant to these Bylaws are deemed to be covered by the provisions of Iowa Code

Section 147.135 or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees or groups charged with making reports, findings, recommendations, or investigations pursuant to these Bylaws shall be considered to be acting on behalf of the Hospital and its Board of Directors when engaged in such professional review activities and thus shall be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986.

**6.11 Voluntary Resignation.**

Medical Staff Members who wish to voluntarily resign their membership and Privileges shall submit a letter to the Medical Staff President or his/her designee. Such letter shall designate the time frame in which the Member requests that the voluntary resignation be deemed effective. Voluntary resignations may be deemed effective a minimum of thirty (30) days from receipt of the letter by the Medical Staff President or designee.

**ARTICLE VII**  
**HEARING AND APPEAL PROCEDURES FOR MEMBERS OF THE MEDICAL STAFF**

**7.1 Initiation of Hearing.**

A. Grounds for Hearing.

1. Except as otherwise provided in these Bylaws, the following recommendations or actions shall, if deemed a professional review action pursuant to Section 2, below, entitle the Practitioner affected thereby to a hearing:
  - a. Denial of Medical Staff appointment, reappointment, or requested Privileges.
  - b. Precautionary suspension of Medical Staff membership or Clinical Privileges which has been in place for more than fourteen (14) days.
  - c. Revocation of Medical Staff membership.
  - d. Denial of requested advancement in Medical Staff category when such denial affects the exercise of Clinical Privileges.
  - e. Reduction in Medical Staff category when such reduction affects the exercise of Clinical Privileges.
  - f. Limitation of admitting prerogatives.
  - g. Revocation of Clinical Privileges.
  - h. Terms of probation that limit Clinical Privileges.
  - i. Requirement of consultation that limits Clinical Privileges.
  - j. Any Professional Review Action that would be reportable to the National Practitioner Databank, upon final action.
2. Except as otherwise provided in these Bylaws, a recommendation or action listed in Section A(1), above, shall be deemed a professional review action only when the recommendation or action is taken by the Board of Directors or by the Medical Staff, acting through the Executive Committee, and is based on the Practitioner's professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a patient, and which adversely affects or may adversely affect the Practitioner's Clinical Privileges. In formulating such action or recommendation, the acting body should conclude that there is a reasonable belief that the action is in furtherance of quality health care, that reasonable efforts are and have been taken to obtain the pertinent facts, and that a reasonable belief exists that the action is warranted by the facts.

B. No Hearing Rights.

No Practitioner shall be entitled to a hearing as a result of any action recommended or taken that does not meet the above definition of “professional review action.”

## **7.2 The Hearing.**

### **A. Notice of Professional Review Action.**

A Practitioner against whom professional review action has been taken pursuant to this Article VII shall, within ten (10) days, be given special notice of such action by the Administrator. “Special notice,” as used herein, shall mean written notification either sent by certified or registered mail, return receipt requested, or hand delivered to the addressee. The date of receipt shall be deemed to be either the date indicated on the mail receipt or five working days after mailing, whichever is earlier. The special notice to the Practitioner shall state:

1. That a professional review action has been taken or is proposed to be taken against the Practitioner;
2. The reasons for the professional review action;
3. That the Practitioner has a right of hearing pursuant to the Fair Hearing and Appeal Procedures contained herein and has up to thirty (30) days from the date of receipt of the notice to request a hearing; and
4. A summary of the hearing procedures and rights of the Practitioner, which summary can be accomplished by furnishing the practitioner a copy of the Fair Hearing and Appeal Procedures contained in these Bylaws with the notice.

### **B. Request for Hearing.**

A Practitioner shall have thirty (30) days following the receipt of a notice pursuant to Section 7.2 (A) above to file a written request for a hearing. If the practitioner desires to be represented at the hearing, such request must so indicate, as described in Section 7.4(F). Such request shall be delivered to the Administrator either in person or by certified mail. By requesting a hearing, the Practitioner agrees to be bound by the provisions of the Medical Staff Bylaws and Policies and Procedures in all matters relating thereto.

### **C. Waiver by Failure to Request a Hearing.**

In the event that a Practitioner fails to request a hearing within the time and manner specified in Section 7.2(B) above, the Practitioner shall be deemed to have waived the right to such hearing and to any appellate review to which the Practitioner might otherwise have been entitled and to have accepted the action involved, and such action shall thereupon become effective upon final Board of Directors action.

## **7.3 Hearing Prerequisites.**

### **A. Notice of Hearing and Statement of Reasons.**

1. Upon receipt of a timely request for hearing, the Administrator shall deliver such request to the President of the Medical Staff or the Chair of the Board of Directors, depending upon whose recommendation or action prompted the request for hearing, who shall promptly provide notice to the Practitioner of the place, time, and date of the hearing, which date shall not be less than 30 days after the date of the notice (unless otherwise agreed to by the Practitioner and the Administrator), as well as a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Staff or Board of Directors, depending upon whose recommendation or action prompted the request for hearing. The notice provided under this subsection shall also be accompanied by a concise statement of the basis for the recommended action, a list by number of the specific or representative patient records in question and/or the other reasons or subject matter forming the basis for the professional review action which is the subject of the hearing. The statement and the list of patient records and other supporting information may be amended or added to at any time so long as the additional material is relevant to the subject matter of the hearing.
2. For a Practitioner who is under suspension that has been continued in effect for more than fourteen (14) days, at the Practitioner's specific request, an expedited hearing shall be held as soon as arrangements for it may reasonably be made.

B. Witness List.

The individual requesting the hearing shall provide to the Hearing Committee and the Executive Committee or Board of Directors (as appropriate) a written list of the names and addresses of individuals expected to offer testimony or evidence on the affected individual's behalf within five (5) days after receiving notice of the hearing. The witness list of either party may be amended at any time during the course of the hearing if notice of the change is given to the other party and the Hearing Committee or Hearing Officer.

C. Appointment of a Hearing Committee or Hearing Officer.

1. Hearing Occasioned By Action of the Medical Staff, Acting Through the Executive Committee. A hearing occasioned by an Executive Committee recommendation or action pursuant to Section 7.1(A)(2) above shall be conducted by any one of the following, in the sole discretion of the Executive Committee:
  - A. A Three-Member Hearing Committee: If a Hearing Committee structure is selected, the Members of the Hearing Committee shall be appointed by the President of the Medical Staff and composed of three (3) Members of the Medical Staff. One of the members so appointed shall be designated by the President of the Medical Staff as the Chair, whose duties are described below in Section 7.4(B). If specialty knowledge is required by the nature of the appeal, at least one voting member of the Appeals Committee shall practice in a specialty substantially similar to the specialty of the practitioner. Members of the Hearing Committee shall not be Practitioners in direct economic competition with the Practitioner. For purposes of this section, "direct economic competition" shall be



defined to mean those Practitioners who are actively engaged in practice in the primary medical community of the Hospital and who practice in the same medical specialty or subspecialty as the Practitioner. The Hearing Committee may utilize, on a consulting basis, members of the same medical specialty or subspecialty as the Practitioner in issue. If it is not possible to identify any or enough members of the Medical Staff to serve on the Hearing Committee, the Medical Staff President may appoint up to three physicians from outside the Medical Staff in order to obtain a three-member hearing committee to hear the matter at issue;

- B. A Three-Member Hearing Committee Plus a Presiding Officer: If a Hearing Committee plus Presiding Officer structure is selected, the Members of a Hearing Committee shall be appointed by the President of the Medical Staff in accordance with the requirements set forth in paragraph (A) immediately above, except that no Member of the Committee shall be designated as the Chair. In addition to the three Members of the Committee, the President of the Medical Staff will appoint a non-voting Presiding Officer, whose qualifications and duties are described below in Section 7.4(C); or
  - C. A Single Hearing Officer: If a single Hearing Officer structure is selected, the President of the Medical Staff shall appoint the single Hearing Officer, whose qualifications and duties are described below in Section 7.4(D), to hear the matter.
2. Hearing Occasioned By Action of the Board of Directors. A hearing occasioned by a professional review action of the Board of Directors pursuant to Section 7.1(A)(1) above shall be conducted by any of the following, in the sole discretion of the Board of Directors:
- A. A Three-Member Hearing Committee: If a Hearing Committee structure is selected, the members of the Hearing Committee shall be appointed by the Chair of the Board of Directors and composed of three (3) persons. At least two (2) Medical Staff Members shall be included on this Committee, and Medical Staff appointees shall not be in direct economic competition with the Practitioner. However, if no or not enough Members of the Medical Staff are able to serve on the Hearing Committee, the Board Chair may appoint one or more physicians from outside the Medical Staff to the Committee. One of the appointees to the Committee shall be designated by the Chair of the Board of Directors as the Chair, whose duties are described below in Section 7.4(B);
  - B. A Three-Member Hearing Committee Plus a Presiding Officer: If a Hearing Committee plus Presiding Officer structure is selected, the members of the Hearing Committee shall be appointed by the Chair of the Board of Directors in accordance with the requirements set forth in paragraph (A) immediately above, except that no Member of the Committee shall be designated as the Chair. In addition to the three Members of the Committee, the Chair of the Board of Directors will appoint a non-voting Presiding Officer, whose qualifications and duties are described below in Section 7.4(C); or

- C. A Single Hearing Officer: If a single Hearing Officer structure is selected, the Chair of the Board of Directors shall appoint a single Hearing Officer, whose qualifications and duties are described below in Section 7.4(D), to hear the matter.
3. Service on the Hearing Committee. Members of the Medical Staff or the Board of Directors shall not be disqualified from serving on a Hearing Committee because they have heard of the case or have knowledge of the facts involved or what they suppose the facts to be. No Member of the Medical Staff or Board of Directors who requested corrective action against the affected individual or served on a committee reviewing such request shall serve as a member of the Hearing Committee. Any Member of the Medical Staff or Board of Directors may appear before the Committee as a witness if requested by either of the parties concerned. All members of the Hearing Committee, or the Hearing Officer if applicable, shall not be in direct economic competition with the Practitioner involved, and shall be required to consider and decide the case with good faith objectivity.

#### **7.4 Hearing Procedure.**

- A. Personal Presence.

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived review rights in the same manner and with the same consequence as provided in Section 7.2(C) above.

- B. Chair of the Hearing Committee.

The Chair of the Hearing Committee, if any, shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The Chair shall be entitled to determine the order of procedure during the hearing and shall make all rulings on questions that pertain to matters of procedure and the admissibility of evidence. The Chair shall also vote on any final recommendations as well as on any other matters giving rise to a vote of the Hearing Committee. The Chair and the Hearing Committee may be advised by legal counsel to the Hospital; however, counsel may not influence the Hearing Committee's substantive review, other than to clarify its responsibilities.

- C. Presiding Officer.

If a Presiding Officer is appointed in addition to three Members of a Hearing Committee, the Presiding Officer shall act 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 shall be entitled to determine the order of procedure during the hearing and shall make all rulings on questions that pertain to matters of procedure and the admissibility of evidence. A Presiding Officer should be experienced in conducting hearings or similar meetings. The Presiding Officer shall act in an impartial manner, and if requested by the Hearing Committee, the Presiding Officer may participate in its deliberations and act as its advisor but shall not be entitled to vote. The Presiding Officer may be advised by legal counsel to the Hospital.

D. Hearing Officer Appointment and Duties.

In lieu of a three-member panel, the Board Chair or President of the Medical Staff, as applicable, may appoint a single Hearing Officer to preside over the hearing and to make all decisions, procedural and substantive. A Hearing Officer should be experienced in conducting hearings or similar meetings. The Hearing Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The Hearing Officer shall be entitled to determine the order of procedure during the hearing and shall make all rulings on questions that pertain to matters of procedure and the admissibility of evidence. The Hearing Officer shall also make any final recommendations as well as decisions on any other matters giving rise to the hearing. The Hearing Officer may be advised by legal counsel to the Hospital; however, counsel may not influence the Hearing Officer's substantive review, other than to clarify its responsibilities.

E. Representation.

The Practitioner for whom the hearing has been scheduled shall be entitled to be accompanied by and/or represented at the hearing by a Member in good standing of the Active Medical Staff. The Executive Committee, when its recommendation has prompted the hearing, shall appoint at least one (1) of its members, some other Medical Staff Member, or a person of its choosing to represent it at the hearing to present the facts and arguments in support of its professional review action. When a recommendation or action of the Board of Directors has prompted the hearing, the Board of Directors shall appoint at least one (1) of its members or another person of its choosing to represent it at the hearing.

F. Legal Counsel.

If the affected Practitioner desires to be represented by an attorney at any hearing or at any appellate review appearance, his/her request for such hearing or appellate review must so state. Such notice must also include the name, address and phone number of the attorney. Failure to notify the Chair of the Hearing Committee, Presiding Officer, or Hearing Officer, as applicable, in accord with this Section 7.4(F) shall permit such person to preclude the participation by legal counsel or to adjourn the hearing for a period not to exceed twenty (20) days. The Executive Committee or the Board of Directors may also be allowed representation by an attorney. While legal counsel may attend and assist the respective parties in proceedings provided herein, due to the professional nature of the review proceedings, it is intended that the proceedings will not be judicial in form but rather a forum for professional evaluation and discussion. Accordingly, the Chair, Presiding Officer, or Hearing Officer, as applicable, and/or appellate review body retains the right to limit the role of counsel's active participation in the hearing process. Any Practitioner who incurs legal fees in his/her behalf shall be solely responsible for payment thereof.

G. Rights of Parties.

Except as hereinafter provided, no right exists to discovery of documents or other evidence in advance of a hearing, but the Chair of the Hearing Committee, Presiding Officer, or Hearing Officer, as applicable, may confer with both parties to encourage and

advance mutual exchange of documents relevant to the issues to be presented at the hearing.

It shall be the duty of the Petitioner and the body whose action gave rise to a hearing, or its designee, to exercise reasonable diligence in notifying the Chair, Presiding Officer, or Hearing Officer, as applicable, of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, so that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be made at the hearing.

The body whose action gave rise to a hearing shall forward to the Petitioner a copy of, and/or shall provide access to, all evidence on which the charges or reasons are based or will be supported at the hearing.

During a hearing, each of the parties shall have the right to do the following, subject to limitation as determined appropriate by the Chair, Presiding Officer, or Hearing Officer, including, but not limited to, limiting the number of witnesses and the length of the testimony:

1. Call and examine witnesses (and if the individual requesting a hearing does not testify in his or her own behalf, (s)he may be called by the other party and examined as if under cross-examination);
2. Introduce exhibits and present relevant evidence;
3. Question any witness on any matter relevant to the issues;
4. Impeach any witness;
5. Rebut any evidence; and
6. Submit a written statement, in accordance with Section 7.4(G)(2).

“Parties” for the purpose of these Bylaws shall be the affected Practitioner and the body taking or recommending the professional review action.

#### H. Procedure and Evidence.

1. Evidence. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admissible if, in the judgment of the Hearing Committee Chair, Presiding Officer, or Hearing Officer, it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs.

The Committee shall be entitled to consider any pertinent material contained on file in the Hospital and all other information that can be considered, pursuant to the Medical Staff Bylaws and Policies, in connection with applications for appointment or reappointment to the Medical Staff and for Clinical Privileges. The focus of the Hearing Committee’s deliberation and review shall be on the professional review action prompting the Practitioner’s request for a hearing.

However, the Committee shall be entitled to consider evidence of prior events and/or actions to the extent they are relevant to the professional review action under review.

2. Written Submissions.

- a. The Practitioner shall be entitled to submit, prior to or during the hearing, memoranda concerning any issue of law or fact.
- b. In addition, the Chair of the Hearing Committee, Presiding Officer or Hearing Officer, as applicable, may require that the parties submit written, detailed statements of the case to the Hearing Committee or Hearing Officer and to each other prior to the hearing. If so done, the hearing can consist of clarification and explanation of the written statements of the case. If a party is ordered by the Hearing Committee Chair or Presiding Officer or Hearing Officer, as applicable, to supply a detailed statement of the case and fails to do so, the Hearing Committee or Hearing Officer can conclude that such failure constitutes a waiver of the party's case.

If the Hearing Committee Chair, Presiding Officer or Hearing Officer, as applicable, determines to require the parties to submit written statements of the case, notice to that effect shall be provided to both parties at least ten (10) days prior to any scheduled hearing. The written statements of the case shall be supplied both to the Hearing Committee or Hearing Officer, as applicable, and to the other party at least three (3) days prior to the commencement of the hearing.

- c. Statements from Members of the Medical Staff or others may be distributed to the Hearing Committee or Hearing Officer, as applicable, and the parties in advance of or at the hearing. Such shall be made a part of the record of the hearing and given such credence as may be appropriate. These statements must be available to all parties. When time and distance allow, the authors of the statements should be available at the hearing for questioning by either party if so requested.

3. Oral Evidence.

The Hearing Committee Chair, Presiding Officer, or Hearing Officer, as applicable, may, but shall not be required to, order that oral evidence be taken only on oath or affirmation.

4. Hearing Committee or Hearing Officer Independent Review.

The Hearing Committee or Hearing Officer shall be entitled to conduct independent review, research and interviews, but may utilize the products of such in its decision only if the parties are aware of such and have the opportunity to rebut any information so gathered.

5. Postponements and Extensions.

The Hearing Committee Chair, Presiding Officer, or Hearing Officer, as applicable, may adjourn the hearing and reconvene the same for the convenience of the participants in the hearing or to obtain new or additional evidence or consultation, without special notice, provided such adjournment shall not extend the time within which any action is required to be taken pursuant to these Fair Hearing and Appeal Procedures, without the express consent of the parties. Upon conclusion of the presentation of evidence, the hearing shall be closed. The Hearing Committee or Hearing Officer, as applicable, shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

I. Record of Hearing.

The Hearing Committee or Hearing Officer, as applicable, shall maintain a record of the hearing that is of sufficient accuracy to assure that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Hearing Committee or Hearing Officer, as applicable, may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. The Hospital shall bear the costs of production of the record, and a copy of the transcript shall be provided to the Practitioner requesting the hearing at the Hospital's expense.

I. Hearing Conclusion, Deliberations, and Recommendations.

1. Burden of Proof.

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

2. Deliberations and Recommendations.

Within thirty (30) days after final adjournment of the hearing, the Hearing Committee or Hearing Officer, as applicable, shall conduct its deliberations outside the presence of any other person and shall render a recommendation accompanied by a report, which shall contain a concise statement of the reasons justifying the recommendation made and shall deliver such report, along with all supporting documentation, to the Administrator, to the Practitioner, and to the body whose professional review action occasioned the hearing.

**7.5 Hearing Committee or Hearing Officer Report and Further Action.**

A. Action by Executive Committee or Board of Directors.

Within fifteen (15) days after receipt of the report of the Hearing Committee or Hearing Officer, as applicable, the Executive Committee or the Board of Directors, whichever

body's action occasioned the hearing, shall consider the same and affirm, modify, or reverse its recommendation or action in the matter. It shall transmit the result to the Administrator, the Practitioner and the Executive Committee or the Board of Directors.

B. Effect of Result.

1. Effect of Favorable Result.

- a. Adopted by the Board of Directors. If the Board of Directors result pursuant to Section 7.5(A) above is favorable to the Practitioner, such result shall become the final decision of the Board of Directors, and the matter shall be considered finally closed.
- b. Adopted by the Medical Staff Executive Committee. If the Medical Staff Executive Committee's result pursuant to Section 7.5(A) above is favorable to the Practitioner, the Board of Directors shall adopt or reject the Executive Committee's result in whole or in part, or refer the matter back to the Executive Committee for further reconsideration. Any such referral shall state the reasons therefor, set a time limit within which a subsequent recommendation to the Board of Directors must be made, and may include a directive that an additional hearing be conducted to clarify the issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board of Directors shall take final action. Favorable action shall become the final decision of the Board of Directors, and the matter shall be considered finally closed. The Administrator shall promptly send the Practitioner special notice informing him/her of each action taken pursuant to this Section 7.5(B).

2. Effect of Adverse Result.

If the result of the Executive Committee or of the Board of Directors pursuant to Sections 7.5(A) and 7.5(B) continues to be adverse to the Practitioner in any of the respects listed in Section 7.1, within five (5) days, a special notice shall inform the Practitioner of a right to request an appellate review by the Board of Directors as provided in Section 7.6 below. Such special notice shall be sent by certified or registered mail, return receipt requested, or be hand delivered to the Practitioner.

**7.6 Initiation and Prerequisites of Appellate Review.**

A. Request for Appellate Review.

A Practitioner shall have fifteen (15) days following receipt of a notice of adverse action pursuant to Section 7.5(A) (in the case of continued adverse Board of Directors or Executive Committee action following its receipt of the Hearing Committee or Officer report) or 7.5(B)(2) (in the case of adverse Board of Directors action following favorable Executive Committee result) to file a written request for appellate review. Such request

shall be delivered to the Administrator either in person or by certified or registered mail; it must include a brief statement of the reasons for appeal; it must indicate the name, address and telephone number of legal counsel representing the Practitioner if (s)he wishes to be represented by an attorney; and it may include a request for a copy of the record of the Hearing Committee or Officer and all other material, favorable or unfavorable, that was considered in making the adverse action or result.

B. Waiver by Failure to Request Appellate Review.

A Practitioner who fails to request an appellate review within the time and in the manner specified in Section 7.6(A) waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 7.2(C). When appropriate, stakeholders impacted by an adverse decision, will be notified.

C. Notice of Time and Place for Appellate Review.

Upon receipt of a timely request for appellate review, the President of the Hospital shall deliver such request to the Chair of the Board of Directors. Within ten (10) days after receipt of such request, the Chair of the Board of Directors shall schedule and arrange for an appellate review which shall be conducted not fewer than ten (10) nor more than thirty (30) days from the date of receipt of the appellate review request; provided, however, when a request for appellate review is from a Practitioner who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements for it may reasonably be made, but not later than fourteen (14) days from the date of receipt of the request for review. The Administrator shall send the Practitioner special notice of the time, place and date of the review. The time for the appellate review may be extended by the appellate review body for good cause. The appellate review may occur at a regular meeting of the Board of Directors.

D. Appellate Review Body.

The Chair of the Board of Directors shall determine whether the appellate review shall be conducted by the Board of Directors as a whole or by an Appellate Review Committee composed of three (3) to five (5) members of the Board of Directors appointed by the Chair, none of whom may be in direct economic competition with the affected Practitioner. If a Committee is appointed, one of its members shall be designated as the Chair. Knowledge of the matters under consideration does not preclude any person from serving on the Appeal Committee, provided that the person was not a member of an investigating committee involving the same matter.

## **7.7 Appellate Review Procedure.**

A. Nature of Proceedings.

The proceedings by the review body shall not be a new or additional hearing, but shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee or Hearing Officer, as applicable, the Hearing Committee's/Officer's report, and all subsequent results and actions thereon. The appellate review body shall also consider the written statements submitted pursuant to Section 7.7(B) and such other information as may be presented and accepted under Sections 7.7(D) and 7.7(E).



B. Written Statements.

The Practitioner seeking the review shall submit a written statement detailing the findings of fact, conclusions, and procedural matters with which the Practitioner disagrees and the reasons 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 appellate review body through the Administrator at least five (5) days prior to any scheduled appellate review date. A written statement in reply may be submitted by the Executive Committee or by the Board of Directors, as appropriate; and if submitted, the Administrator shall provide a copy thereof to the Practitioner at least two (2) days prior to the scheduled date of the appellate review. These advance filing dates will not apply to expedited review under Section 7.6(C).

C. Presiding Officer.

The Chair of the appellate review body shall be the presiding officer. The Chair shall determine the order of procedure during the review, make all required rulings, and maintain decorum. The Chair and appellate review body may be advised by legal counsel to the Hospital; however, counsel may not influence the appellate review body's substantive review, other than to clarify its responsibilities.

D. Oral Statements.

The appellate review body may in its sole discretion allow the parties to personally appear and make oral statements in favor of their positions. Any party so appearing shall be required to answer questions put to him/her by any member of the appellate review body. The Chair of the appellate review body may impose reasonable time limits on the parties' oral statements.

E. Consideration of New or Additional Matters.

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances. The appellate review body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

F. Powers.

The appellate review body shall have all powers granted to the Hearing Committee and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

G. Recesses and Adjournment.

The appellate review body 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 appellate review shall be closed. The appellate review body 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 finally adjourned.

H. Action Taken.

The appellate review body may recommend that the Board of Directors affirm, modify, or reverse the adverse result or action taken by the Executive Committee or by the Board of Directors pursuant to Section 7.5(A) or 7.5(B)(2) and shall so report in written form within fifteen (15) days of conclusion of its deliberations. If appellate review is conducted by the entire Board of Directors, its conclusions shall be the final action. If appellate review is conducted by an Appellate Review Committee, within thirty (30) days after the conclusion of the appellate review body's deliberations, the Board of Directors shall render its final decision in the matter in writing (either affirming, modifying or reversing the recommendations of the Appellate Review Committee) and shall send notice thereof to the Practitioner by special notice and by regular notice to the President of the Medical Staff and to the Executive Committee. The final decision of the Board of Directors shall be effective immediately. When appropriate, stakeholders impacted an adverse decision, will be notified.

**7.8 General Hearing Provisions.**

A. Failure to Comply with Procedure.

If at any time after receipt of special notice of an adverse recommendation, action or result, a Practitioner fails to make a required request or appearance or otherwise fails to comply with provisions of the Fair Hearing and Appeal Procedures contained in these Bylaws, he/she shall be deemed to have consented to such professional review action or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws or Policies and Procedures.

B. Limitation on Hearings and Appellate Reviews.

Notwithstanding any other provision of the Medical Staff Bylaws, no Practitioner shall be entitled as a right to more than one (1) evidentiary hearing and appellate review with respect to an adverse recommendation or action. Further, the Executive Committee and the Board of Directors need not conduct additional hearings or reviews upon reapplication or request for reconsideration by the Practitioner absent a clear and convincing indication of new or additional information.

C. Time Limits.

Any time limits set forth in the Fair Hearing and Appeal Procedures contained in these Bylaws may be extended or accelerated by mutual agreement between the Practitioner and the Chief Executive Officer or the Executive Committee. The time periods specified in these Bylaws for action by the Medical Staff, the Board of Directors and the committees are to guide those bodies in accomplishing their tasks and shall not be deemed to create any right for reversal of the professional review action if the hearing process is not completed within the time periods specified.

D. Deviations from Procedures.

Technical or insignificant deviations from the hearing procedures set forth in the Fair Hearing and Appeal Procedures contained in these Bylaws shall not be grounds for invalidating the action taken.

**ARTICLE VIII  
ALLIED HEALTH PROFESSIONALS**

**8.1 Independent Allied Health Professionals (“IAHPs”).**

A. Qualifications.

1. Individuals with PhDs in Clinical Psychology or PsyD’s, Advance Registered Nurse Practitioners, Certified Nurse Midwives or Certified Registered Nurse Anesthetists who are not otherwise qualified for Medical Staff appointment and who meet the qualifications set forth below and desire to provide professional services in the Hospital, are eligible to practice as IAHPs.
2. To be eligible to practice as an IAHP, an individual must:
  - a. Be licensed or registered by the appropriate agency or organization for his or her discipline; and
  - b. Be certified by a nationally recognized professional organization or be eligible and become certified within five (5) years of initial eligibility for certification and maintain such certification, if applicable; and
  - c. Maintain professional liability insurance coverage at a level acceptable to the Board of Directors.
  - d. Shall have a record that is free from any state or federal felony conviction or any “Caregiver Law” conviction, except as is otherwise permitted pursuant to the Pre-Application process set forth in these Bylaws.
  - e. Be eligible to participate in the Medicare/Medicaid programs.
3. Each individual desiring to practice as an IAHP must request an application from the Medical Staff Office. Such requests shall be reviewed and processed in accordance with the same Pre-Application Process used for Practitioners as set forth in these bylaws. If an application is provided and completed, the IAHP must file the application with the Medical Staff Office on a form provided by the Hospital, submit evidence of current professional liability insurance coverage in amounts that are satisfactory to the Hospital, and be recommended by a Member of the Medical Staff. When applicable, the Iowa license or registration will be primary source verified, and the NPDB will be queried. Information regarding the individual’s criminal background, education, employment, training, claims history, clinical competency, and other information requested by the Hospital shall also be verified with the primary source, to the extent such verification is feasible.
4. The Credentials Committee, on the recommendation of the appropriate department or section chairperson or designee, will evaluate the application and make a recommendation to the Executive Committee, which will then make a recommendation to the Board of Directors concerning the Scope of Practice that the applicant should be permitted to exercise at the Hospital. In addition, the Credentials Committee shall assign each IAHP to a department

of the Medical Staff appropriate to his or her discipline. IAHP Status may be granted for terms not to exceed two (2) years, subject to renewal.

B. Conditions of Practice.

1. Responsibilities of IAHPs include but are not limited to:
  - a. Providing care of generally recognized quality within the limits of practice established by the State of Iowa;
  - b. Adhering to the Scope of Practice approved by the Board of Directors;
  - c. Abiding by the Medical Staff Bylaws and all applicable Hospital and Medical Staff rules, regulations, policies, and procedures;
  - d. Complying with all requirements established by licensing, regulatory, and accrediting bodies;
  - e. Preparing accurate and timely medical and other records for all patients for whom the IAHP provides care;
  - f. Maintaining confidentiality of patient information;
  - g. Participating in quality improvement, utilization review, peer review, and other activities to improve the quality of patient care;
  - h. Refraining from conduct that jeopardizes patient safety or that disrupts efficient delivery of patient care or orderly Hospital operations;
  - i. Providing current proof of licensure or registration, proof of liability insurance coverage, and proof of continuing education to the Hospital as required by the Board of Directors or accreditation or regulatory authorities;
  - j. Adhering strictly to the Hospital's ethics and working cooperatively in a positive and professional manner; and
  - k. Notify the Administrator, Chief of Staff, Vice President of Medical Affairs or the Medical Staff Office within forty-eight (48) hours of, and provide such additional information as may be requested, regarding each of the following:
    - (i) The revocation, limitation, or suspension of his/her professional licensure or DEA registration, any reprimand or other disciplinary action taken by any state or federal government agency relating to his/her professional license or the imposition of terms of probation or limitation in any state;
    - (ii) Cancellation of or failure to maintain professional liability insurance coverage in accordance with requirements established by the Board of Directors;

- (iii) Receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction, or the commencement of a formal investigation of the filing of charges relating to health care matters by a Medicare peer review organization, the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or the State of Iowa.
- (iv) Receipt of notice of the filing of any suit against the IAHP alleging professional liability in connection with the treatment of any patient in or at the Hospital.
- (v) Termination of employment or other engagement by a Member of the Hospital's Medical Staff.
- (vi) Being charged with any violation of any state or federal felony or any Caregiver Law or if the IAHP becomes aware that he or she is the subject of any active investigation, involving his or her violation of any federal or state felony or violation of any Caregiver Law;
- (vii) Being convicted of any state or federal felony or any Caregiver Law.
- (viii) Termination, suspension or restriction of Scope of Practice or privileges, whether temporary or permanent, at any hospital or other health care facility, including without limitation any MercyOne Hospital.

Failure to timely make notification of any of the items (i) through (viii) above of this Section shall constitute an automatic withdrawal of an IAHP Applicant's pending application. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic withdrawal shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and IAHP Applicants whose applications are deemed to be automatically withdrawn pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

Failure to timely make the notifications of the items specified in (i) through (iv) of this Section shall result in automatic suspension hereunder. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic suspension shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and IAHP whose Scope of Practice is deemed to be automatically suspended pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

Failure to timely make the notifications of the items specified in (v) through (viii) above of this Section shall result in automatic termination hereunder. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic termination shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and IAHP whose Scope of Practice is deemed to be automatically terminated pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

2. IAHPs practice at the discretion of the Board of Directors and are afforded only those due process hearing and appeal rights set forth in this Article VIII of these Bylaws.
3. IAHPs are not Medical Staff Members and are not entitled to the rights and privileges of appointment to the Medical Staff and may only engage in acts within the Scope of Practice specifically granted by the Board of Directors.

## **8.2 Dependent Allied Health Professionals (“DAHPS”).**

### **A. Qualifications.**

1. Physician assistants not otherwise qualified for Medical Staff appointment who meet the qualifications set forth below and who desire to provide professional services in the Hospital are eligible to practice as DAHPs.
2. To be eligible to practice as a DAHP, an individual must:
  - a. Be licensed or registered by the appropriate agency or organization for his or her discipline;
  - b. Be certified by a nationally recognized professional organization or be eligible and become certified within five (5) years of initial eligibility for certification and maintain such certification, if applicable;
  - c. Be employed by a Physician Member of the Medical Staff, a professional corporation which includes Physician Members of the Medical Staff, MercyOne Northeast Iowa or its affiliates, or a not-for-profit organization providing health care services in the community;
  - d. Be supervised by a Physician Member of the Medical Staff who serves as the DAHP’s sponsoring Physician;
  - e. Maintain professional liability insurance coverage at a level acceptable to the Board of Directors;
  - f. Be eligible to participate in the Medicare/Medicaid programs; and
  - g. Shall have a record that is free from any state or federal felony conviction or any Caregiver Law conviction, except as is otherwise permitted pursuant to the Pre-Application process set forth in these Bylaws.
3. Each individual desiring to practice as a DAHP must request an application from the Medical Staff Office. Such requests shall be reviewed and processed in accordance with the same Pre-Application Process used for Practitioners as set forth in these bylaws. If an application is provided and completed, the DAHP must file the application with the Medical Staff Office on a form provided by the Hospital, submit evidence of current professional liability insurance coverage in amounts that are satisfactory to the Hospital, and be

recommended by a Member of the Medical Staff. When applicable, the Iowa license or registration will be primary source verified, and the NPDB will be queried. Information regarding the individual's criminal background, education, employment, training, claims history, clinical competency, and other information requested by the Hospital shall also be verified with the primary source, to the extent such verification is feasible.

4. DAHPs will receive the same or similar application as Medical Staff members and the application will be processed in the same manner, although DAHPs are not Medical Staff members. The Credentials Committee, on the recommendation of the appropriate department or section chairperson or designee, will make a recommendation concerning the Scope of Practice the applicant should be permitted to exercise at the Hospital. The sponsoring Physician seeking to supervise the DAHP at the Hospital shall have the opportunity to discuss the proposed Scope of Practice with the Credentials Committee before action is taken on it by the Executive Committee and the Board of Directors. A DAHP may act at the Hospital pursuant to the approved Scope of Practice only so long as (s)he is supervised by the sponsoring Physician. In addition, the Credentials Committee shall assign each DAHP to the same department as his or her sponsoring Physician. DAHP Status may be granted for terms not to exceed two (2) years, subject to renewal.

B. Conditions of Practice.

1. Responsibilities of DAHPs include but are not limited to:
  - a. Providing care of generally recognized quality within the limits of practice established by the State of Iowa;
  - b. Adhering to the Scope of Practice approved by the Board of Directors of the Hospital;
  - c. Abiding by the Medical Staff Bylaws and all applicable Hospital and Medical Staff rules, regulations, policies, and procedures;
  - d. Complying with all requirements established by licensing, regulatory, and accrediting bodies;
  - e. Preparing accurate and timely medical and other records for all patients for whom the DAHP provides care;
  - f. Maintaining confidentiality of patient information;
  - g. Participating in quality improvement, utilization review, peer review, and other activities to improve the quality of patient care;
  - h. Refraining from conduct that jeopardizes patient safety or that disrupts efficient delivery of patient care or orderly hospital operations;



- i. Providing current proof of licensure, registration, or certification, proof of liability insurance coverage, and proof of continuing education to the Hospital as required by the Board of Directors or accreditation or regulatory authorities;
- j. Adhering strictly to the Hospital's ethics and working cooperatively in a positive and professional manner; and
- k. Notify the Administrator, Chief of Staff, Vice President of Medical Affairs or the Medical Staff Office within forty-eight (48) hours of, and provide such additional information as may be requested, regarding each of the following:
  - (i) The expiration, revocation, limitation, or suspension of his/her professional licensure, DEA registration, CSA prescribing authority, or any reprimand or other disciplinary action taken by any state or federal government agency relating to his/her professional license or the imposition of terms of probation or limitation in any state;
  - (ii) Cancellation of or failure to maintain professional liability insurance coverage in accordance with requirements established by the Board of Directors;
  - (iii) Receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction, or the commencement of a formal investigation of the filing of charges relating to health care matters by a Medicare peer review organization, the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or the State of Iowa.
  - (iv) Receipt of notice of the filing of any suit against the DAHP alleging professional liability in connection with the treatment of any patient in or at the Hospital.
  - (v) Termination of employment or other engagement (including supervision) by a Member of the Hospital's Medical Staff
  - (vi) Being charged with any violation of any state or federal felony or any Caregiver Law or if the DAHP becomes aware that he or she is the subject of any active investigation, involving his or her violation of any federal or state felony or violation of any Caregiver Law;
  - (vii) Being convicted of any state or federal felony or any Caregiver Law.
  - (viii) Termination, suspension or restriction of Scope of Practice or privileges, whether temporary or permanent, at any hospital or other health care facility, including without limitation any MercyOne Hospital.

Failure to timely make notification of any of the items (i) through (viii) above of this Section shall constitute an automatic withdrawal of a DAHP Applicant's

pending application. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic withdrawal shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and DAHP Applicants whose applications are deemed to be automatically withdrawn pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

Failure to timely make the notifications of the items specified in (i) through (iv) of this Section shall result in automatic suspension hereunder. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic suspension shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and DAHP whose Scope of Practice is deemed to be automatically suspended pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

Failure to timely make the notifications of the items specified in (v) through (viii) above of this Section shall result in automatic termination hereunder. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic termination shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and DAHP whose Scope of Practice is deemed to be automatically terminated pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

2. Responsibilities of Physicians who sponsor DAHPs include but are not limited to:
  - a. Complying with all requirements for supervision and oversight established by the Hospital, applicable federal and state laws and regulations, and accrediting bodies;
  - b. For each DAHP sponsored, providing and maintaining practice protocols that have been acknowledged and signed by the DAHP;
  - c. Accepting ultimate responsibility for the actions of the DAHPs sponsored;
  - d. Promptly notifying the Hospital when the relationship with the DAHP has been terminated for any reason; and
  - e. Ensuring that the sponsored DAHPs have professional liability insurance in amounts required by the Board of Directors and furnishing evidence of such to the Hospital. The DAHP may act at the Hospital only while such coverage is in effect.
3. DAHPs shall be entitled only to those hearing and appeal rights set forth in Article VIII of these Bylaws; provided, however that (1) the Scope of Practice of a DAHP who ceases to be supervised by his or her sponsoring Physician or who ceases to be employed by his or her employer shall terminate immediately upon the termination of the DAHP's relationship with his or her sponsoring Physician or employer, and such DAHP shall not be entitled to any hearing and appeal rights under Article VIII and (2) a DAHP's

Scope of Practice shall terminate immediately upon the restriction or termination of the Clinical Privileges of his or her sponsoring Physician, and such DAHP shall not be entitled to any hearing and appeal rights under Article VIII.

4. DAHPs will not be entitled to rights and privileges of appointment to the Medical Staff and may only engage in acts within the Scope of Practice granted by the Board of Directors under the direct and immediate supervision of his/her sponsoring Physician. At all times the sponsoring Physician will remain responsible for all acts of the DAHP at the Hospital.
5. The number of DAHPs acting as employee of one (1) Physician, as well as the acts they may undertake, shall be consistent with applicable law, Medical Staff Bylaws, and rules, regulations, policies, and procedures of the Medical Staff and the Hospital.

### **8.3 Hearing and Appeal Process for Allied Health Professionals (“AHP”).**

#### **A. Triggering Events.**

Except as otherwise provided in these bylaws, the following recommendations or actions shall, if taken on the basis of an AHP’s professional competence or conduct and if deemed adverse under Section 8.3(B) below, entitle the AHP to a hearing and appeal, as described below, under timely and proper request:

1. Denial or restriction of requested Scope of Practice;
2. Reduction of Scope of Practice;
3. Suspension of Scope of Practice; or
4. Revocation of Scope of Practice.

#### **B. When Deemed Adverse.**

Except as otherwise provided in these bylaws, a recommendation or action listed in Section 8.3(A) above is adverse only when it has been recommended by the Executive Committee to the Board of Directors or taken by the Board of Directors under circumstances in which no prior right to request a hearing and appeal existed.

#### **C. Notice of Adverse Recommendation or Action.**

The Administrator or designee shall promptly give the AHP special notice of an adverse recommendation or action taken pursuant to Section 8.3(B). The notice shall:

1. Advise the AHP of the recommendation or action and of his or her right to request a hearing pursuant to the provisions of this Article;
2. Specify that the AHP has thirty (30) days after receiving the notice within which to submit a request for a hearing;

3. Indicate that the right to the hearing may be forfeited if the AHP fails to appear at the scheduled hearing without good cause;
4. State that, as part of the hearing, the AHP involved has the right to receive an explanation of the adverse recommendation or action made and to submit any additional information the AHP deems relevant to the review of this recommendation or action; and
5. State that, upon completion of the hearing, the AHP involved has the right to receive a written report of the Hospital's decision, including a statement of the basis for the decision.

D. Request for a Hearing.

The AHP has thirty (30) days after receiving notice under Section 8.3(C) to file a request for a hearing. The request must be delivered to the Administrator either in person or by certified or registered mail.

E. Waiver by Failure to Request a Hearing.

An AHP who fails to request a hearing within the time and in the manner specified in Section 8.3(D) waives his or her right to a hearing to which he or she might otherwise have been entitled. Such waiver applies only to the matters that were the basis for the adverse recommendation or action triggering the notice referenced in Section 8.3(C) above.

F. Hearing Procedure.

When an AHP requests a hearing, the hearing shall consist of a single meeting attended by the AHP, the Administrator (or his or her designee), and the President of the Medical Staff. During this meeting, the basis of the decision adverse to the AHP that gave rise to the hearing will be reviewed with the AHP, and the AHP will have the opportunity to present any additional information he or she deems relevant to the review of the decision. Following this meeting, the Administrator (or, if applicable, his or her designee) and the President of the Medical Staff will make a recommendation to the Executive Committee or the Board of Directors, as appropriate, which will then determine if the adverse action or recommendation will stand, be modified, or be reversed. The AHP will receive a written report of the Hospital's decision stating the result of the hearing and the basis for the decision.

G. Request for Appeal.

The AHP has thirty (30) days after receiving the notice of the result of the hearing under Section 8.3(F) to file a request for an appeal. The request must be delivered to the Administrator either in person or by certified or registered mail.

H. Waiver by Failure to Request an Appeal.

An AHP who fails to request an appeal within the time and in the manner specified in Section 8.3(G) above waives his or her right to an appeal to which he or she may otherwise have been entitled. Such waiver applies only to the matters that were the basis

for the adverse recommendation or action triggering the notice referenced in Section 8.3(C) above.

I. Appeal Procedure.

When an AHP requests an appeal, the appeal shall consist of a single meeting attended by the AHP, the Board of Directors Chairperson, and two Board of Directors members appointed by the Chairperson. During this meeting, the basis of the decision adverse to the AHP that gave rise to the appeal will be reviewed with the AHP, and the AHP will have the opportunity to present any additional information the AHP deems relevant to the review of the decision. Following this meeting, the Board of Directors Chairperson and the other two (2) Board of Directors members will make a recommendation to the full Board of Directors, which will then determine if the adverse action or recommendation will stand, be modified, or be reversed. The AHP will receive a written report of the Hospital's decision stating the result of the appeal and the basis of the decision.

J. Sole Remedy

This hearing and appeal process will be the sole remedy available to an AHP who experiences an adverse recommendation or action as defined in Section 8.3(B) above and who qualifies for this hearing and appeal process.

K. Allied Health Professional's Right to Legal Counsel.

Nothing in this policy shall be deemed to deny an AHP the right to engage or be advised by legal counsel. However, participation by legal counsel at the hearing or appeal meetings described in Sections 8.3(F) and 8.3(I) shall be at the sole discretion of the Hospital.

L. Automatic Termination and Automatic Suspension of AHPs.

1. Automatic Termination. An AHP's Scope of Practice shall automatically terminate upon any of the following events:

- (a) Termination of employment or other engagement by a Member of the Hospital's Medical Staff.
- (b) Conviction of any state or federal felony or conviction of any Caregiver Law.
- (c) The AHP's termination of their Scope of Practice at any other MercyOne Hospital (other than voluntary resignation by the AHP unrelated to any investigation).
- (d) The AHP's decertification, debarment or exclusion from participation in any state or federal health care program.
- (e) The termination or restriction of the Clinical Privileges of the AHP's sponsoring Physician (if applicable).

Notwithstanding any other term or condition of these Bylaws, automatic termination in the event of any of the above shall be administrative in nature and shall not entitle the AHP to any of the hearing or appellate review rights otherwise set forth below.

2. Automatic Suspension. An AHP's Scope of Practice shall be automatically suspended upon any of the following events:
  - (a) loss or restriction of licensure or certification to practice in the State of Iowa;
  - (b) failure to maintain professional liability insurance in amounts established by the Hospital applicable to AHPs;
  - (c) The existence of any of the following as they relate to patient abuse, neglect, misappropriation of patient property or similar offenses shall result in automatic suspension or termination of an AHP's clinical privileges to the extent required by Section 50.065 of the Iowa Statutes (Criminal Background Law): (a) pending criminal charges; or (b) pending investigation.
  - (f) An automatic suspension shall be imposed upon an AHP's failure without good cause to supply information or documentation requested by any of the following: the Administrator or his or her designee, the Credentials Committee, the Executive Committee or the Board. Such suspension shall be imposed only if: (1) the request was in writing, (2) the request was related to evaluation of the AHP's current qualifications for Scope of Practice, (3) the AHP failed to either comply with such request or to satisfactorily explain his or her inability to comply, and (4) the AHP was notified in writing that failure to supply the request information within 15 days from receipt of such notice would result in automatic suspension.

Notwithstanding any other term or condition of these Bylaws, automatic suspension in the event of any of the above shall be administrative in nature and shall not entitle the AHP to any of the hearing or appellate review rights otherwise set forth herein.

**ARTICLE IX  
DEPARTMENTS**

**9.1 Departmental Organization.**

- A. Each department shall be organized as a division of the Medical Staff as a whole and shall have a chairperson who is selected and has the authority, duties, and responsibilities as specified elsewhere in these Bylaws. Each department shall adopt rules and regulations as outlined in Article XIV and Medical Staff Policies.
- B. The creation of additional sections and the termination of sections shall be accomplished as the need arises upon the recommendation of the department in which the section falls, with the concurrence of the Executive Committee.

**9.2 Departments and Sections.**

The departments of the Medical Staff as of the effective date of these Bylaws shall be as follows, and a current list of all departmental sections shall be maintained in the Medical Staff Office.

- |                          |               |
|--------------------------|---------------|
| A. Anesthesiology        | E. Pediatrics |
| B. Emergency Medicine    | F. Psychiatry |
| C. Medicine              | G. Radiology  |
| D. Obstetrics/Gynecology | H. Surgery    |

**9.3 Functions of Departments and Sections.**

- A. Each department shall recommend to the Credentials Committee written criteria for the assignment of Privileges within the department and its sections, which shall be effective when approved by the Board of Directors.
- B. Each department or section will monitor and evaluate medical care on a retrospective, concurrent, and/or prospective basis in all major clinical activities of the department or section, and report the results of such monitoring and evaluation to the Executive Committee on a regular basis. This monitoring and evaluation will include:
  - 1. Routine collection of information about important aspects of patient care and about the clinical performance of department members; and
  - 2. Periodic assessment of this information to identify opportunities to improve care and to identify problems in patient care. When important problems in patient care or opportunities to improve care are identified, the department or section will document actions taken and evaluate effectiveness of such actions.
- C. Each department or section shall hold regular meetings, at least twice annually, at a time designated by the department/section. Department and section members who are Active, Provisional, Affiliate, or Courtesy Medical Staff members shall attend at least 50% of the meetings of the department and section to which they are assigned.

D. The Oral Maxillofacial/Dentistry Specialty.

1. Dentists granted membership on the Medical Staff in accordance with the procedures set forth in these Bylaws shall be assigned to the Oral Maxillofacial/Dentistry Specialty of the Department of Surgery.
2. Except as provided in subsection 4 below, patients admitted to the Hospital for dental care shall be given the same medical appraisal as those admitted for other services. Admission of a dental patient shall be the dual responsibility of the dentist and a Physician Member of the Medical Staff. The Physician shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of a dental patient.
3. Except as provided in subsection 4 below, dentists shall conform to the Policies, Bylaws, Rules, and Regulations of the Medical Staff and Hospital with the following additions:
  - a. Patients may be admitted for dental services by a dentist after obtaining the concurrence of the attending Physician.
  - b. Surgical procedures performed by dentists shall be done under the overall supervision of the Chairperson of the Department of Surgery or his/her designee.
  - c. At the time of admission, the name of the attending Physician must appear in the appropriate forms. This Physician shall be responsible for pre- and post-operative medical evaluation and care of the patient, except as provided below.
  - d. The dentist may discharge the patient after obtaining the concurrence of the attending Physician.
  - e. Complete records, both dental and medical, shall be required on each patient and shall be part of the Hospital record.
4. A medical history and physical examination of the patient shall be made and recorded by a Physician who holds an appointment to the Medical Staff before dental surgery shall be scheduled for performance, and a designated Physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

E. Podiatrists.

1. Podiatrists granted membership on the Medical Staff in accordance with the procedures set forth in these Bylaws may be members of any category of the Medical Staff for which they qualify and shall be assigned to the Department of Surgery.
2. Patients admitted to the Hospital for podiatric care shall be given the same medical appraisal as those admitted for other services. Admission of a



podiatric patient shall be the dual responsibility of the podiatrist and a Physician Member of the Medical Staff. The Physician shall be responsible for the care of any medical problems that may be present on admission or that may arise during the hospitalization of a podiatric patient.

3. Podiatrists shall conform to the Bylaws, Policies, Rules, and Regulations of the Medical Staff with the following additions:
  - a. Patients may be admitted for podiatric services by a podiatrist after obtaining the concurrence of the attending Physician.
  - b. Foot and ankle procedures performed by podiatrists shall be done under the overall supervision of the Chair of the Department of Surgery or his/her designee.
  - c. At the time of admission, the name of the attending Physician must appear in the appropriate forms. This Physician shall be responsible for pre- and post-operative medical evaluation and care of the patient.
  - d. The podiatrist may discharge the patient after obtaining the concurrence of the attending Physician.
  - e. Complete records, both podiatric and medical, shall be required on each patient and shall be part of the Hospital record.
  - f. A medical history and physical examination of the patient shall be made and recorded by a Physician who holds an appointment to the Medical Staff before podiatric surgery shall be performed, and a designated Physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

#### **9.4 Assignments to Departments.**

Each Member of the Medical Staff shall be assigned membership in one department but may be granted Clinical Privileges in one or more of the other departments. Medical Staff Members shall exercise only those Clinical Privileges approved by the Medical Staff and Board of Directors. The exercise of Clinical Privileges within any department shall be subject to the rules and regulations of that department and the authority of the department chairperson. Members with Clinical Privileges in more than one department are encouraged to attend meetings of all the departments in which they have clinical privileges.

#### **9.5 Department Officers.**

##### **A. Qualifications.**

Each department of the Medical Staff shall have a chairperson who shall be a Member in good standing of the Active Staff of that department, willing and able to faithfully discharge the functions of the office, and satisfy the following criteria:

1. Have no pending adverse recommendation concerning Medical Staff appointment or Clinical Privileges.

2. Have demonstrated interest in participating in Medical Staff affairs, including peer review/quality improvement activities.
3. Possess written and oral communication skills.
4. Possess an ability for harmonious interpersonal relationships.
5. Declare the Hospital as his or her primary hospital affiliation and refrain from serving as medical staff officer, corporate officer, department, or committee chair at another hospital during term of office.
6. The department chairperson or Medical Director of each department shall be certified by an appropriate specialty board or affirmatively establish comparable competence through the credentialing process.

B. Selection.

At least three (3) months prior to the end of the current department chair's term, each department shall recommend up to three (3) Members willing to serve as chair to the Executive Committee. The Executive Committee shall recommend one (1) of these nominees to the Board of Directors for approval as department chair. If the Members recommended by the department are unacceptable to the Executive Committee or Board of Directors, the department may either recommend three (3) different Members or decline to make more recommendations. If the department declines to make another recommendation, the Executive Committee shall make its own recommendation to the Board of Directors for approval as department chair.

C. Vacancies.

If there is a vacancy in the office of the chair, an interim chair will be appointed by the Executive Committee to serve until the next scheduled election. If such interim chair serves for less than six (6) months, he or she may be elected for up to two (2) additional two (2) year terms. If the interim chair serves for six (6) months or longer, he or she may only be elected for up to one (1) additional two (2) year term.

D. Term of Office.

The department and section chairs shall serve a two (2) year term or until a successor has been elected and approved. A department or section chair shall be eligible to succeed himself or herself if selected but may serve no more than four (4) consecutive years in office unless he or she served as an interim chair prior to his or her two (2) full two (2) year terms.

E. Duties.

Each Department Chair shall be responsible for:

- a. Clinically related activities of the department;
- b. Administratively related activities of the department, unless otherwise provided by the Hospital;

- c. Continuing surveillance of the professional performance of all individuals in the department who have delineated Clinical Privileges;
- d. Recommending to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the department;
- e. Recommending Clinical Privileges for each Member of the department;
- f. Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization;
- g. The integration of the department into the primary functions of the organization;
- h. The coordination and integration of interdepartmental and intradepartmental services;
- i. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services in the department;
- j. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services in the department;
- k. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide care, treatment, and services in the department;
- l. The continuous assessment and improvement of the quality of care, treatment, and services in the department;
- m. The maintenance of quality control programs in the department, as appropriate;
- n. The orientation and continuing education of all persons in the department;
- o. Recommending space and other resources needed by the department;
- p. Serving as a member of the Executive Committee;
- q. Assisting in the preparation of reports pertaining to department activity, quality of care, patient safety, patient satisfaction and other information, as may be required by the Executive Committee, the HAdministrator, or the Board of Directors;
- r. Arranging and securing appropriate emergency service on-call coverage;
- s. Responding to, and if necessary, appointing a departmental ad hoc committee to investigate specific concerns or complaints expressed by one or more Members of the department;

- t. Assisting in establishing, implementing, and promoting the effectiveness of any teaching, education, and research programs in the department; and
- u. Other duties commensurate with the office as may from time to time be reasonably requested by the President of the Medical Staff, the Medical Executive Committee, or the Board of Directors.

F. Removal of Chair.

Removal of a chair during his/her term of office for failure to perform the duties above may be initiated by a majority vote of all Members of the department, by the Executive Committee on its own motion, or by the Board of Directors on its own motion. If by department vote, the vote results shall be forwarded to the Executive Committee via the President of the Medical Staff, along with the reasons for requested removal, and the Executive Committee shall meet with the chair and then make recommendations to the Board of Directors. Removal will not be effective until ratified by the Board of Directors.

**ARTICLE X  
MEDICAL DIRECTORS**

**10.1 Designation and Qualifications.**

- A. The Hospital, through the Administrator, may contract for a Member of the Active Medical Staff to serve as the Medical Director of a specific service or special care unit within the Hospital, with the approval of the Executive Committee.
- B. Medical Directors shall be certified by one or more specialty boards that certify in a specialty that is relevant to the services provided in the service or unit, unless the Executive Committee has determined through the credentialing process that the candidate possesses comparable competence.
- C. The term of office and specific duties of each Medical Director shall be determined by the contract between the Hospital and the individual selected.
- D. Medical Directors shall report to the Vice President of Medical Affairs.

**10.2 Responsibilities.**

While the specific duties and term of office of each Medical Director shall be determined by the contract between the Hospital and the individual selected, in general the responsibilities of the Medical Director of a specific service or special care unit shall be to:

- A. Establish, together with the Medical Staff and Administration, the type and scope of services required to meet the needs of the patients in the Hospital;
- B. Working with Administration, develop and implement policies and procedures that guide and support the provision of services in the unit or program;
- C. Continually assess and improve the quality of care and services provided in the unit or program;
- D. Integrate the unit or program into the primary functions of the Hospital;
- E. Maintain quality control programs, as appropriate; and
- F. Perform other duties commensurate with the office of Medical Director as may be reasonably requested by the President of the Medical Staff, the Executive Committee, the Administrator, or the Board of Directors.

**ARTICLE XI  
OFFICERS OF THE MEDICAL STAFF**

**11.1 Officers.**

The officers of the Medical Staff shall be President, Vice President/President-Elect, and Immediate Past President.

**11.2 Qualifications of Officers.**

To be eligible for office, the candidate must be a Member in good standing of the Active Medical Staff, be willing and able to faithfully discharge the functions of the office, and satisfy the following criteria:

- A. Have no pending adverse recommendation concerning Medical Staff appointment or Clinical Privileges.
- B. Have demonstrated interest in participating in Medical Staff affairs, including peer review/quality improvement activities.
- C. Possess written and oral communication skills.
- D. Possess an ability for harmonious interpersonal relationships.
- E. Declare the Hospital as his/her primary hospital affiliation and refrain from serving as medical staff officer, corporate officer, department, or committee chair at another hospital during term of office.

**11.3 Election of Officers.**

- A. The Vice President/President-Elect shall be elected by vote of the active Medical Staff in odd-numbered calendar years at least 3 months prior to the end of the Medical Staff year and shall serve a two (2) year term. Upon the termination of the Vice President/President-Elect's term, (s)he shall automatically assume the office of President for a term of two (2) years.
- B. At least two (2) months prior to the Medical Staff vote for Vice President, the Executive Committee shall meet and prepare a ballot containing a slate of nominees for the office of Vice President/President-Elect. Department Chairs shall query eligible Physicians in the Department to determine interest in being a member. Prior to final approval of the ballot, the Administrator shall communicate with the Board of Directors, giving them the names of the nominees. If any nominee is not acceptable to the Board of Directors, a joint meeting of the Executive Committee and the Board of Directors shall be held to select nominees acceptable to both the Executive Committee and the Board of Directors.
- C. At least two (2) weeks before the Medical Staff vote for Vice President, the President of the Medical Staff shall notify Members of the Medical Staff eligible to vote of the nominees for Vice President/President-Elect.

- D. The ballots will be compiled and tabulated by Medical Staff personnel, under the supervision of the Vice President of Medical Affairs.

#### **11.4 Voting Eligibility Rules.**

A voting Member shall be an Active Staff Member in good standing and shall be deemed to be in good standing if, as of the time ballots are sent, he or she has not lost his or her admitting Privileges due to incomplete records or other disciplinary measures.

#### **11.5 Terms of Office.**

- A. Neither the President nor Vice President/President-Elect may succeed himself or herself in office, except as noted in Section 11.8 below. The President may not be elected to the office of Vice President/President-Elect until at least two (2) years after the conclusion of his or her term as President.
- B. The new officers shall assume office July 1st.

#### **11.6 Duties of Officers.**

- A. The President of the Medical Staff shall have the following duties and responsibilities:
  - 1. Work in coordination and cooperation with the Administrator in matters involving the Hospital of concern to the Medical Staff.
  - 2. Serve as Chairperson of the Executive Committee and as an ex-officio member, without vote, of all other Medical Staff committees.
  - 3. Preside at all regular and special Medical Staff and Executive Committee meetings.
  - 4. Appoint the members and designate the chairperson of all standing committees, with the exception of the Executive Committee and the Pre-Application Background Review Committee, except in those instances where membership or chairmanship is otherwise specified in these Bylaws.
  - 5. Be accountable to the Board of Directors, in conjunction with the Executive Committee, for:
    - a. The general levels of quality of patient care services and Medical Staff performance within the Hospital;
    - b. The Medical Staff's participation in the Hospital's continuous quality improvement activities, in accordance with accrediting body standards; and
    - c. Other functions as delegated to the Medical Staff.
  - 6. Be responsible to the Medical Staff for:
    - a. Enforcement of Medical Staff Bylaws, Rules, Regulations, and Policies;

- b. Implementation of sanctions where these are indicated; and
  - c. Compliance with procedural safeguards in all instances where corrective action has been requested regarding a Practitioner.
7. Present views, policies, and needs of the Medical Staff and report on the medical activities of the Medical Staff to the Administrator and the Board of Directors.
  8. Serve as the responsible representative of the Medical Staff who receives and interprets policies from the Board of Directors and who reports on and interprets to the Board of Directors the performance and maintenance of the Medical Staff's responsibility for providing good medical care.
  9. Act as a consultant and arbiter in Medical Staff matters, as appropriate.
  10. Perform such additional duties as may be assigned by the Executive Committee or the Board of Directors.
- B. The Vice President/President-Elect of the Medical Staff shall have the following duties and responsibilities:
1. In the absence of the President, assume all of his or her duties except ex-officio duties and have the same authority.
  2. Perform such duties as may be assigned by the President of the Medical Staff, the Executive Committee, or the Board of Directors.
  3. Serve as a voting member of the Executive Committee.
  4. Automatically succeed the President, should the office of President be vacant for any reason during the President's term of office.

### **11.7 Recall of Officers.**

The Executive Committee, by a two-thirds (2/3) majority vote, may remove any Medical Staff officer for conduct detrimental to the interest of the Hospital or if the officer is suffering from physical or mental infirmity that renders the individual incapable of fulfilling duties of the office, provided that notice of the meeting where such action will be decided is given in writing to the officer at least ten (10) days prior to the date of the meeting and the officer is given an opportunity to speak prior to a vote on his/her recall. In addition, if the Board of Directors, by resolution, finds that an officer has failed to adhere to the Hospital's Mission, Vision, and Values or otherwise no longer meets qualifications for office as set forth herein, the officer must automatically relinquish his/her office. Also, the Medical Staff may recall any officer by a petition signed by twenty-five percent (25%) of the Medical Staff Members eligible to vote and a subsequent two-thirds (2/3) majority vote at a Medical Staff meeting.

### **11.8 Vacancies.**

In the event there is a vacancy in the Office of the President during the Medical Staff year, the Vice President/President-Elect, shall assume all duties and responsibilities of the President of the



Staff for the remaining term. If the Vice President/President-Elect serves as President for less than six (6) months, he or she may be reelected for one (1) full term. Upon the succession of the Vice President/President-Elect to the presidency, a new Vice President/President-Elect shall be elected at a general Medical Staff meeting in accordance with section 11.3. If vacancies occur that are not covered by this section, the Executive Committee shall decide the procedure for filling the vacancy.

**ARTICLE XII  
MEDICAL STAFF COMMITTEES**

**12.1 Committee Rules.**

- A. Committees shall be standing or special.
- B. Except as otherwise provided for in these Bylaws, members of all committees shall be appointed by the President of the Medical Staff for a two (2) year term and shall report to the Executive Committee. There shall be no limitation on the number of terms members may serve. All appointed members may be removed and vacancies filled at the discretion of the President of the Medical Staff. In making appointment decisions, the President of the Medical Staff may confer with and obtain the views of the Hospital President or Vice President of Medical Affairs. Hospital employees who are not Members of the Medical Staff shall be non-voting members of any committees to which they attend.
- C. In appointing committees, the President of the Medical Staff shall designate a chairperson for each committee, unless otherwise specified in these Bylaws. Chairpersons must meet the qualifications for officers of the Medical Staff as set forth in section 11.2.
- D. Each committee shall conduct its business in accordance with this Article.
- E. The appointed committees shall confine their work to the purposes for which they were created. They shall:
  - 1. Submit a written report of their activities to the Executive Committee after each meeting.
  - 2. Make recommendations only, unless decision-making authority is so specifically granted by the Executive Committee.
- F. Unless otherwise expressed in these Bylaws, a quorum of a committee shall be as described in Section 13.3.
- G. All Medical Staff committees are a major component in the Hospital's overall quality improvement program, organized and operated to help maintain and improve the quality of health care in the Hospital, and committee activities will be conducted in a manner consistent with the provisions of Section 147.135 of the Iowa Code. The peer review protections of this statute, including protection of confidentiality of committee records and proceedings, are intended to apply to all activities of the committees relating to privileging and maintaining and improving the quality of health care and include activities of the individual members of the committee, as well as, other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee, including but not limited to, participation in monitoring plans.
- H. Those functions requiring participation of, rather than direct oversight by, the Medical Staff may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions.

## 12.2 Standing Committees.

### A. Executive Committee.

#### 1. Composition.

The Executive Committee shall consist of the following voting members: President of the Medical Staff; Vice-President/President-Elect of the Medical Staff; Past President of the Medical Staff; Chairpersons of the Medical Staff Departments; and a member of the Hospitalist Service.

The following shall be ex-officio, non-voting members: a representative of the Board of Directors, the Administrator, the Vice President of Medical Affairs, Vice President of the Medical Group, Chief Nursing Officer and the Chief Medical Executive

#### 2. Meetings, Reports, and Recommendations.

The Executive Committee shall meet in regular session at least eight (8) times per year, or more often if necessary, to transact pending business, and it shall maintain a permanent record of its proceedings and actions.

One third (1/3) of the voting membership shall constitute a quorum for the transaction of business.

A special meeting may be called at any time by the Chairperson of the Executive Committee.

Peer review activities are confidential and only Executive Committee Members, or the Executive Committee's invited agents or guests who the Executive Committee has requested to assist the Executive Committee in conducting peer review activities, or the practitioner at issue, if invited by the Executive Committee, may attend peer review meetings.

#### 3. Duties.

The duties of the Executive Committee shall be:

- a. To consider and act on all matters referred to it by Medical Staff committees, departments, the Administrator, the President of the Medical Staff, and/or the Board of Directors of the Hospital.
- b. To provide a liaison between the Medical Staff, the Hospital President, and the Board of Directors and to coordinate the activities and general policies of the various departments.
- c. To review the reports of the Credentials Committee regarding all applicants to the Medical Staff and to make recommendations to the Board of Directors regarding Medical Staff membership, assignment to departments, and delineation of Clinical Privileges.

- d. To periodically review all information available regarding the performance, Privileges, and clinical competence of Medical Staff Members and other Practitioners with Clinical Privileges and, as a result of such review, to make recommendations to the Board of Directors for appointment/reappointments and for renewal or changes in Clinical Privileges.
- e. To approve or promulgate rules, regulations, and procedures for the departments concerning all matters relative to the welfare of patients, the improvement of departmental organization, and the teaching program, and forward them to the Board of Directors for approval.
- f. To periodically review Bylaws, and propose amendments thereto, to the Medical Staff, and approve rules and regulations, policies, and associated documents of the Medical Staff not otherwise the responsibility of the departments.
- g. To fulfill the Medical Staff's accountability to the Board of Directors for the medical care rendered to patients in the Hospital.
- h. To keep the Medical Staff apprised of all applicable accreditation and regulatory requirements affecting the Hospital.
- i. To take all reasonable steps to provide for professionally ethical conduct and competent clinical performance on the part of all Members of the Medical Staff and affiliates including the initiation of, and/or participation in, Medical Staff corrective or review measures when warranted.
- j. To evaluate requests for new services or programs not previously provided at the Hospital.
- k. To organize the Medical Staff's quality/performance improvement activities and establish a mechanism to conduct, evaluate, and monitor such activities.
- l. To act for the Medical Staff between meetings of the Medical Staff within the scope of its responsibilities as defined herein.

B. Credentials Committee.

1. Composition.

The Credentials Committee shall consist of the following appointees: a chairperson appointed by the President of the Medical Staff, the Vice President of Medical Affairs, and at least three (3) other Medical Staff Members recognized as leaders and appointed by the President of the Medical Staff.

The following shall be ex-officio, non-voting members: a representative of the Board of Directors and the Administrator .

2. Meetings.

The Credentials Committee shall meet at least eight (6) times per year or more often if necessary to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Executive Committee and the Board of Directors. One third (1/3) of the voting membership shall constitute a quorum for the transaction of business.

3. Duties.

The duties of the Credentials Committee shall be:

- a. To review credentials of all Applicants for appointment, reappointment and Clinical Privileges as well as AHP applicants, to make investigations of and interview such Applicants, as indicated, and to make a report of its findings and recommendations (including assigned department, assigned section, Medical Staff category, and Clinical Privileges of initial applicants).
- b. To review, or supervise review of, credentials of individuals who wish to practice at the Hospital as AHPs, to make investigations of and interview such individuals, as indicated, and to make a report of its findings and recommendations.
- c. To review, as questions arise, all information available regarding the clinical competence and behavior of Medical Staff Members, and, as a result of its review, to make a report of its findings and recommendations to the Executive Committee.
- d. To develop professional criteria for Clinical Privileges for all Practitioners associated with the Hospital and direct the establishment of ad hoc working groups to address the definition of procedure-specific privileging criteria for new or unusual treatments.

C. Other Standing Committees.

1. Cancer Committee.

- A. Composition. The Cancer Committee shall consist of Practitioners from the diagnostic and treatment specialties, and non-physician administrative and support services involved in the care of cancer patients.
- B. Purpose. The Cancer Committee shall provide multidisciplinary leadership to the MercyOne Waterloo Medical Center Cancer Program in order to improve the quality of care provided to patients diagnosed and treated within the program. The Committee will insure that consultative services are available from all major disciplines and will be responsible for goal setting, planning, initiating, implementing, and improving all cancer-related activities in the Cancer Program.

- C. Duties. The duties of the Cancer Committee shall be:
1. Monitor and assess Cancer Program activities and identify changes as needed to meet compliance standards for a Commission on Cancer (CoC) accredited cancer program.
  2. Annually review and appoint membership for the Cancer Committee. Monitor attendance at Committee meetings to assure participation and policy requirements
  3. Develop, implement, and evaluate programmatic goals
  4. Establish and implement a plan to evaluate the quality of cancer registry data and activities.
  5. Establish and evaluate Cancer Conference frequency and format. Monitor Cancer Conference activities to ensure compliance with established policies.
  6. Monitor accrual of patients into clinical trials.
  7. Monitor the effectiveness of Community Outreach Activities
  8. Coordinate cancer-related educational activities for physicians, nurses, and allied health professionals. Monitor the success and attendance at offered educational sessions.
  9. Develop and disseminate public reports of programmatic or cancer patient outcomes related to the activities of the Cancer Program.
  10. Coordinate Cancer Prevention and Screening Programs based on the needs of the community.
  11. Review the quality of patient care of these patients treated by the Cancer Program each year, assuring that patients are evaluated and treated according to evidence-based national treatment guidelines
  12. Direct the implementation of quality or performance actions, process, or services targeted at improving care for patients treated by the Cancer Program.
  13. Review and approve Cancer Program policies.
  14. Oversee the structure and operations of the Breast Program Leadership (BPL) committee, a sub-committee of the Cancer Committee. The BPL meets four times a year and reports quarterly to the Cancer Committee

- D. Meetings. The Cancer Committee shall meet at least quarterly, in accordance with CoC designation of a Comprehensive Community Cancer Program. Documentation of attendance, proceedings, and actions shall be maintained and shall report to the Executive Committee and the Board of Directors upon request. The Cancer Committee shall prepare and present a report annually to the Outcomes Improvement Committee. One third (1/3) of the required voting membership shall constitute a quorum for the transaction of business.
2. Infection Prevention Committee.
- A. Composition. The Infection Prevention Committee shall consist of Practitioners from the Hospital, MercyOne Cedar Falls Medical Center and MercyOne Oelwein Medical Center. Additional members may include representatives from nursing services, administration, and quality services.
  - B. Duties. The duties of the Infection Prevention Committee shall be:
    - 1. To develop and distribute to appropriate personnel written standards for MercyOne Northeast Iowa sanitation and medical asepsis.
    - 2. To determine the type of surveillance and reporting programs to be used. Such programs will include a mechanism for reporting, evaluating and keeping of records of infections among patients and other personnel to assist in: (a) discovering the endemic level of nosocomial infections and (b) identifying epidemics or potential epidemics.
    - 3. To develop, evaluate and review techniques for meeting established sanitation and asepsis standards, including evaluation of materials used in MercyOne Northeast Iowa's sanitation program and of any major change in cleaning products or techniques.
    - 4. To coordinate with the Medical Staff on action relative to the findings from the regular review of the clinical use of antibiotics accomplished through the Pharmacy and Therapeutics Committee. The ongoing monitoring of antibiotic usage in MercyOne Northeast Iowa a Medical Staff responsibility.
    - 5. To assist in monitoring the clinical aspects of the employee health service.
    - 6. To conduct ongoing reviews to assess the effectiveness of the MercyOne Northeast Iowa's infection control program.
    - 7. To investigate clusters of infection above the expected levels and single cases of unusual infections.

8. To conduct orientation for all new employees as to the importance of infection control, personal hygiene and their responsibilities in the infection control program and to provide documented in-service education for all departments and services regarding infection prevention and control.
  - C. Meetings. The committee, including representatives from Cedar Falls and Oelwein, will meet quarterly or as required by the chair. The committee shall maintain a permanent record of its proceedings and actions and shall report its recommendations to the Executive Committee and the Board of Directors upon request.
3. Pharmacy and Therapeutics Committee.
    - A. Composition. The Pharmacy and Therapeutics Committee shall consist of Medical Staff Members who represent the clinical departments. The Director of Pharmacy Services shall also serve on this committee. Others who may serve on the committee, as deemed necessary by the chair, include representatives from nursing services, social services, administration, infection control and nutritional services.
    - B. Duties. The duties of the Pharmacy and Therapeutics Committee shall be:
      1. To assist in the formulation of professional policies regarding the evaluation, selection, distribution, handling and safe administration of drugs.
      2. To establish policies and procedures to ensure accountability and safe use of medications within the Hospital in compliance with federal and state requirements.
      3. To review adverse drug reactions and medication.
      4. To initiate medication usage programs and studies.
      5. To sponsor educational activities related to medication use.
    - C. Meetings. The committee meets every other month jointly with Cedar Falls' Pharmacy and Therapeutics Committee and additionally as needed. The committee shall maintain a permanent record of its proceedings and actions and shall report its recommendations to the Executive Committee and Board of Directors upon request.

The Medical Staff delegates the development, review, update and approval of the drug formulary for use in the Hospital to the Trinity Health System Formulary Management Committee or a successor committee provided such committee contains physician representation from the Medical Staff of the Hospital. The Medical Staff reserves the right to utilize non-formulary medications with the approval of the MEC if not having the non-formulary medication available is



determined to cause hardship for patients or could compromise high quality patient care.

4. Radiation Safety Committee.
  - A. Composition. In accordance with applicable regulations, the Radiation Safety Committee is composed of the Hospital's radiation safety officer, a Practitioner from each discipline covered by the radioactive material license (Currently, the license covers diagnostic and therapeutic use and this encompasses diagnostic radiology, nuclear medicine, radiation oncology and cardiac catheterization.), a member of the Hospital's administration, a member of patient care/nursing services, as well as directors, managers, and staff from disciplines covered by the radioactive material license.
  - B. Duties. The Radiation Safety Committee operates in accordance with Iowa Department of Public Health regulations, specifically Iowa Admin. Code r. 641-41.2(9), (10). The duties of the Radiation Safety Committee shall be:
    1. To monitor the Hospital's program to maintain occupational doses as low as reasonably achievable.
    2. To review, on the basis of safety and with regard to the training and experience standards contained in applicable regulations, and approve or disapprove any individual who is to be listed as an authorized user, an authorized nuclear pharmacist, the radiation safety officer or teletherapy physicist before submitting a license application or request for amendment or renewal.
    3. To review on the basis of Board of Directors certification the license or permit identifying an individual and to approve or disapprove any individual prior to allowing that individual to work as an authorized user or authorized nuclear pharmacist.
    4. To review, on the basis of safety, and approve or disapprove each proposed method of use of radioactive material.
    5. To review, on the basis of safety, and approve with the advice and consent of the radiation safety officer and the management representative, or disapprove procedures and radiation safety program changes prior to submittal to the agency for licensing action.
    6. To review quarterly, with the assistance of the radiation safety officer, occupational radiation exposure records of all personnel working with radioactive material.
    7. To review quarterly, with the assistance of the radiation safety officer, all incidents involving radioactive material with respect to cause and subsequent actions taken.

8. To review annually the radioactive material program.
  9. To establish a table of investigational levels for occupational dose that, when exceeded, will initiate investigations and considerations of action by the radiation safety officer.
- C. Meetings. In accordance with applicable regulations, the committee meets on a quarterly basis. In addition to the quarterly meetings, the committee conducts an annual review of the radiation safety program. Minutes of the meetings are distributed to each committee member and are kept on file in the Hospital's Quality Services Department and by the Hospital's radiation safety officer. The committee shall report its recommendations to the Executive Committee and the Board of Directors upon request.
- To establish a quorum and to conduct business, one-half (1/2) of the committee's membership shall be present, including the radiation safety officer and a representative from Hospital administration.
5. Perinatal Committee.
    - A. Composition. Members of the committee should represent, but not be limited to, the fields of obstetrics, pediatrics, family medicine, nursing, administration, laboratory, respiratory therapy, anesthesia and social services.
    - B. Duties. The duties of the Perinatal Committee shall be:
      1. To develop policies for the perinatal unit including provisions to ensure adequate patient care by qualified providers.
      2. To conduct a meeting at least semi-annually to resolve problems related to the perinatal unit.
      3. To review educational activities conducted by the perinatal unit.
      4. To serve as a general liaison on the issue of perinatal care between the various groups represented on the committee.
    - C. Meetings. The Perinatal Committee meets quarterly, as required by the State of Iowa Perinatal Guidelines. The committee shall maintain a permanent record of its proceedings and actions and shall report its recommendations to the Executive Committee and the Board of Directors upon request. Minutes of the meetings are kept in the Quality Services Department.
  6. Trauma Committee.
    - A. Composition. The Trauma Committee is comprised of a Trauma Surgeon, the Medical Director of Trauma Services, and the Trauma Coordinator, with representatives from Hospital administration and

departments that work directly in the care of trauma patients, including, but not limited to, surgery, emergency medicine, anesthesia, intensive care, rehabilitation, blood bank, laboratory, radiology, EMS and the operating room.

- B. Duties. The duties of the Trauma Committee shall be as follows:
  - 1. To identify and correct identified concerns/problems and verbal complaints.
  - 2. To review all program related services and correct overall program deficiencies and to optimize patient care.
  - 3. To propose and approve policies for trauma care and patient care.
  - 4. For Practitioner members of the group, to examine patient charts to review care and identify areas that need improvement.
- C. Meetings. The Hospital Trauma Committee is a joint committee with Cedar Falls' Trauma Committee. The committee meets jointly at least three (3) times per year, with one (1) additional meeting, if necessary, held independently of each other.

7. Utilization Review Committee.

- A. Composition. The Utilization Review Committee is comprised of the Vice President of Medical Affairs, the Director of Case Management, at least two physicians (MD/DO) who will represent the Medical Staff, and other Hospital employees such as Case Management nurses. The Chairman position is an assigned position, reserved for the Vice President of Medical Affairs

- B. Duties. The duties of the Utilization Review Committee shall be as follows:

To ensure appropriate utilization of resources related to the provision of care to patients. The objective of the Utilization Review Committee is to foster the maintenance of high quality patient care while promoting appropriate and efficient utilization of hospital resources. The program will address over utilization, under utilization, inefficient scheduling of resources and will apply to all patients regardless of financial class. This is accomplished through ongoing utilization review activities and education.

The specific duties, responsibilities, and process followed by the committee is located in the Utilization Review Committee policy and plan, which is maintained by the Case Management office.

- C. Meetings. The committee shall meet at least quarterly, jointly with MercyOne Cedar Falls Medical Center, or as needed, with additional meetings held as deemed necessary by the Chairman.
8. Pre-Application Background Review Committee:
- A. Composition. The Pre-Application Background Review Committee (the “PBR Committee”) shall be composed of the Vice President of Medical Affairs of the Hospital, the Chief of Staff of the Medical Staff, the Administrator, the MercyOne Northeast Iowa Chief Medical Officer, and the President of MercyOne Northeast Iowa (or his or her designee). The MercyOne Northeast Iowa Chief Medical Officer shall serve as the Chair of the Committee or in his or her absence, the President of MercyOne Northeast Iowa (or his or her designee) shall chair the PBR Committee. If any of the above titles changes, the individuals in the comparable positions shall serve on this committee, as determined by the President of MercyOne Northeast Iowa (or his or her designee).
  - B. Meetings. The PBR Committee shall meet if and as needed in the event that a potential Applicant’s conviction record is required to be reviewed hereunder as part of the Pre-Application Process set forth in these Bylaws.
  - C. Duties. The duties of the PBR Committee shall be to review a potential Applicant’s background record if and as required hereunder and make a final determination as to whether such conviction is a bar to the Prospective Applicant’s receipt of an application for membership to the Medical Staff as specified above in the Pre-Application Process described in these Bylaws. The PBR Committee may review any and all information as it deems relevant and necessary to make the determinations specified hereunder. The decision of this committee is binding and not appealable.
9. MercyOne Professional Review Committee (MOPRC)
- A. Composition. The Chair of the MercyOne Professional Review Committee (PRC) shall be a physician who is an Active Member of the MercyOne Waterloo Medical Center, MercyOne Cedar Falls Medical Center, or MercyOne Oelwein Medical Center in full time clinical practice. Other members shall include Active Members of the 3 respective hospitals and may include representatives from the following clinical departments: Medicine, Emergency Medicine, Pediatrics, OB/ GYN, Surgery, Anesthesia, and Behavioral Health as well as the Director of Quality Services (ex-officio and resource), the Manager of Medical Affairs (ex-officio and resource) and the Vice President of Medical Affairs. Additional members may be added on an ad hoc basis by approval of the Committee when a particular need arises.

- B. Meetings. The MOPRC shall meet regularly according to the needs of the review activity, but no less than quarterly.
- C. Duties.
  - 1. Monitor Medical Staff performance through the use of prospective quality indicators;
  - 2. Review all cases that vary from screening indicators; Determine compliance with established standards of care;
  - 3. Make recommendations for corrective action to the Department Chair or Hospital MEC (as appropriate) when standards of care are not met;
  - 4. Reports to the MECs following each MOPRC meeting; reports the results of aggregated and profiled quality review findings to the MEC and the Medical Staff Office quarterly, and more frequently as indicated or requested;
  - 5. Provide specific feedback to a referring Department Chair for each referred situation, that addresses the issues raised;
  - 6. Provide acknowledgement to referring entities other than a Department Chair, indicating only that the referral was received, will be reviewed and appropriately acted upon;
  - 7. To assure that issues of quality related to individual physician performance have been identified in the peer review process and that appropriate and fair corrective action has been taken to address those quality issues;
  - 8. To create an appropriate reporting process to the Board of Directors no less than annually; and
  - 9. To regularly review the peer review activities to ensure the quality of the peer review process is uniformly high and occurs in a timely manner.

### **12.3 Special Committees.**

Special Committees may be created through appointment by the President of the Medical Staff with the Executive Committee's approval to address any matter pertaining to credentialing and/or quality assessment functions. Such committees shall confine their activities to the purposes for which they were created and shall report to the Executive Committee. For other matters not related to credentialing or quality assessment functions, ad hoc task force committees may be created by the President of the Medical Staff.

## **ARTICLE XIII MEETINGS**

### **13.1 Staff Meetings.**

The President of the Medical Staff may schedule meetings as needed. Meetings of the Medical Staff may be scheduled at any time at the written request of the Board of Directors, the Executive Committee, or ten percent (10%) of the Active Medical Staff Members. Notice of a meeting shall be posted conspicuously and given to each Active Member of the Medical Staff in writing at least ten (10) days before the date set for the meeting. A special departmental or committee meeting may be called at the request of the President of the Medical Staff, chairperson of the department or committee, or any two (2) Members of the Active Medical Staff in the department.

### **13.2 Attendance at Meetings.**

- A. All Members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Specific attendance requirements for Department and Committee meetings are listed in Article V.
- B. Unless excused by the Executive Committee, the failure of Medical Staff Members to meet the attendance requirements set forth above may constitute grounds for either non-reappointment to the Medical Staff or change in Medical Staff category. Department chairpersons may report such failures to the Executive Committee.
- C. Any Medical Staff Member whose clinical work is scheduled for discussion at a department/section meeting shall be notified in advance and expected to attend. If suspected deviation from standard clinical practice is involved, the notice to the individual shall so state, and the individual's attendance at the meeting where the matter is to be discussed shall be mandatory. In such circumstances, if such individual fails to attend, the department/section chairperson may so notify the Executive Committee, and, unless excused by the Executive Committee upon a showing of good cause, such failure shall constitute voluntary relinquishment of all or such portion of the individual's Privileges and/or Medical Staff membership as the Executive Committee may direct.

### **13.3 Quorum.**

The presence of ten percent (10%) of the total membership of the Active Medical Staff who can vote shall constitute a quorum for meetings of the Medical Staff. Unless otherwise required by applicable law or these Bylaws, a quorum for all regular committee and department/section business meetings shall consist of two (2) of the members of such committee or department/section who are entitled to vote. Unless otherwise required by applicable law or these Bylaws, a quorum for all special committee and department/section business meetings shall consist of three (3) of the members of such committee or department/section who are entitled to vote. For the Medical Executive Committee and the Credentials Committee, the presence of one-third (1/3) of voting members shall constitute a quorum. Once a quorum is established, the business of the meeting may proceed and actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

**13.4 Minutes.**

Minutes of each meeting of the Medical Staff, a committee, department, or section shall be prepared and shall include a record of attendance of members and the result of the vote taken on each matter. The minutes shall be reviewed and signed by the presiding officer, chairperson, or designee, and copies thereof shall be promptly submitted to attendees for approval. After such approval is obtained, the minutes shall be forwarded to the Executive Committee. Each committee, department, and section shall maintain a permanent file of the minutes of each meeting.

**13.5 Rules of Order.**

Unless otherwise indicated herein or in applicable Medical Staff policies, rules, or regulations, Robert's Rules of Order shall be the official rules used for meetings of the Medical Staff and to arbitrate questions regarding rules of order.

**13.6 Voting**

Unless otherwise provided in these Bylaws or by law, action shall be taken at a meeting by vote of a majority of a quorum. When voting is conducted by ballot, then action shall be taken based on the ballot selection that receives the most votes.

**ARTICLE XIV**  
**MEDICAL STAFF AND DEPARTMENTAL POLICIES, RULES, AND REGULATIONS**

Medical Staff Bylaws, Rules and Regulations and policies must be compatible with each other.

**14.1 Medical Staff Policies, Rules, and Regulations.**

A. Policies: There are two methods by which Policies may be adopted or amended:

1. By the Executive Committee:

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

2. By the Medical Staff:

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

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

1. By the Executive Committee:

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

A. Regular adoption or amendment:

When the Executive Committee proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff with enough time to allow the Medical Staff to respond.



Upon review and comment by the Medical Staff, rules and regulations may be adopted, amended, or repealed at any regular or special meeting of the Executive Committee, or by mail ballot, provided that copies of the proposed amendments, additions or repeals are made available to members of the Executive Committee fourteen (14) days before being voted on, and that written comments on the proposed changes are brought to the attention of the Executive Committee before the vote. Rules and regulations will be adopted, amended, or repealed by a majority of a quorum of the Executive Committee at a meeting, or by a majority of the votes cast by mail ballot; or

B. Urgent adoption or amendment:

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

2. By the Medical Staff:

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

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

## 14.2 Department Level Policies, Rules, and Regulations.

Each department may adopt policies, rules, and regulations pertinent to the practice of medicine, dentistry, or podiatry within the department, and these policies, rules, and regulations shall

become effective after review by the Executive Committee and approval by the Board of Directors, provided however, that such policies, rules, and regulations must not conflict with these Bylaws or the Medical Staff Rules and Regulations. All department members will be advised in writing of changes to the policies, rules, and regulations implemented pursuant to the procedure described above, and they will be provided with revised texts or copies of revised affected pages, as appropriate.

**ARTICLE XV  
AMENDMENTS AND REVISIONS**

**15.1 Medical Staff Responsibility and Authority.**

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and directly propose recommendations to the Board of Directors regarding Medical Staff Bylaws and Amendments thereto, which shall be effective when approved by the Board of Directors. Such responsibility and authority shall be executed in good faith and in a reasonable, timely, and responsible manner, so as to have Bylaws of generally recognized quality, to provide a basis for acceptance by accreditation agencies, to comply with supervising licensing authorities, and to provide a system of ongoing effective professional review. These Bylaws shall be reviewed as needed by the Executive Committee and the Vice President of Medical Affairs to determine if any amendments are necessary. However, approval of amendments to these Bylaws may not be delegated to the Executive Committee.

**15.2 Methodology.**

- A. These Bylaws may be revised or amended by a majority of votes cast by the Active Medical Staff Members eligible to vote who are present at any Medical Staff meeting called for such purposes, or by a majority of the votes cast by the Active Medical Staff Members eligible to vote in a mail or email ballot, provided that fourteen (14) days prior written notice accompanied by the proposed alterations has been given to the voting Members of the Medical Staff by the Executive Committee. The rules regarding voting eligibility shall be the same as those set forth in Section 11.4, relative to voting eligibility for officers of the Medical Staff. Once approved by the Active Medical Staff members eligible to vote, the amendments shall be forwarded to the Board of Directors for approval.
- B. Amendments may be proposed by written petition to the Medical Staff President by ten percent (10%) of the eligible voting Active Medical Staff Members, by an Executive Committee member, or by any standing committee. The Medical Staff President shall present the petition for discussion to the Medical Staff Executive Committee within sixty (60) days. Following its review and comment, the Medical Staff Executive Committee shall present the proposed Amendment in writing to the Active Medical Staff Members eligible to vote as herein required.
- C. The Executive Committee has the power to adopt such amendments to the Bylaws as are, in the Committee's judgment, technical modifications or clarifications; reorganization or renumbering; or amendments necessary because of spelling, punctuation, or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff, the Vice President of Medical Affairs, or the Board of Directors within ninety (90) days of adoption by the Executive Committee. The action to amend, in such circumstances, may be taken by motion acted upon in the same manner as any other motion before the Executive Committee.
- D. Amendments to Medical Staff Bylaws are accomplished through a cooperative process involving both the Medical Staff and the Board of Directors and are effective upon approval by the Board of Directors. The Board of Directors gives full consideration to the recommendations and views of the Medical Staff before taking final action.

- E. All Medical Staff Members shall be advised in writing of Medical Staff Bylaws changes that are implemented pursuant to the procedure described above, and they will be provided with revised texts or copies of the revised affected pages, as appropriate.

**ARTICLE XVI  
ADOPTION**

These Bylaws, together with any referenced Medical Staff Policies, shall be adopted at any regular meeting of the Active Medical Staff, shall replace any previous Bylaws, shall become effective when approved by the Board of Directors, and shall be equally binding on the Medical Staff and the Board of Directors. Adoption or amendment of these Bylaws cannot be delegated.

Medical Executive Committee Adopted Date: November 17, 2022

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