**BYLAWS OF THE**

**UNIVERSITY OF IOWA HEALTH CARE MEDICAL CENTER DOWNTOWN**

**Action Requested:** Approve adoption of medical staff bylaws for the University of Iowa Health Care Medical Center Downtown to be effective upon closing of the acquisition of the licensed hospital currently known as Mercy Hospital. The bylaws are included in Attachment A.

**Executive Summary:**

On August 8, 2023, the Board of Regents approved the acquisition of specific assets of Mercy Hospital in Iowa City, Iowa, an Iowa nonprofit corporation engaged in the provision of health care services in southeast Iowa. On November 7, 2023, the United States Bankruptcy Court for the Northern District of Iowa approved the acquisition of those assets by the University of Iowa, and authorized the parties to complete the transaction in accordance with the Court’s Sale Order and the Asset Purchase Agreement.

After the sale is complete, UI Health Care will operate two hospitals with two separate licenses—University of Iowa Health Care Medical Center located at 200 Hawkins Drive, Iowa City, Iowa (including Stead Family Children’s Hospital) and University of Iowa Health Care Medical Center Downtown located at 500 East Market Street, Iowa City, Iowa. The Clinical Systems Committee, via authority delegated by the University of Iowa President and the Vice President for Medical Affairs, is responsible for the clinical operations of UI Health Care at all locations.

Under the terms of the Asset Purchase Agreement, the University of Iowa agreed to: 1) maintain an open medical staff at the downtown location; 2) that existing medical staff privileges will remain in place; and 3) that the new bylaws will contain modifications necessary to better align with the medical staff bylaws of UI Health Care and to ensure that processes and information-sharing between medical staffs at each location are as consistent as reasonably possible.

The Clinical Systems Committee approved the proposed bylaws contained in Attachment A during its meeting of January 17, 2024. University President Wilson also approved the proposed bylaws on January 17. Board of Regents approval of the attached bylaws is now requested.

The proposed UI Health Care Medical Center Downtown bylaws are based on Mercy Hospital's original documents and include: (A) the Medical Staff Bylaws; (B) the Credentialing Policy (Article 10 of the Medical Staff Bylaws); and (C) the Advanced Practice Provider Credentialing Policy (collectively, referred to as “the bylaws”).

A. **Medical Staff Bylaws, Overview**

Appointees or members on the organized medical staff of UI Health Care Medical Center Downtown will be classified as either Active Staff, Associate Staff, Affiliate Staff, Consulting Staff, or Honorary Staff. Language was added to clarify existing call coverage responsibilities.

There are four (4) officers of the medical staff: President, President-Elect, Secretary-Treasurer, and Immediate Past President. Each officer is elected by a Nominating Committee consisting of the three (3) immediate Past Presidents of the medical staff. The slate of officers is submitted to
the medical staff for a vote and, if elected, serve in the position for two (2) years beginning January 1 of the medical staff year.

There were four (4) named departments at Mercy Hospital, and include (1) Medicine, (2) Surgery, (3) Maternal and Child Health Care, and (4) Family Practice/Emergency Medicine. Each department is led by a Department Head appointed by the Medical Staff President. After appointment and confirmation by the Clinical Systems Committee, the Department Head will serve for two (2) years. The new bylaws do not alter this structure.

There will be two main committees of the medical staff: the Medical Executive Committee and the Credentials Committee. Membership on the Medical Executive Committee consists of eleven (11) members, including the four (4) elected officers, the four (4) appointed Department Heads, and three (3) at-large members elected by medical staff appointees permitted to vote. At-large members on the Medical Executive Committee serve for a period of two years after election. UI Health Care Medical Center Downtown representatives will participate in the Clinical Systems Committee subcommittees and working groups on a variety of substantive matters.

B. **Credentialing Policy (Article 10 of the Medical Staff Bylaws), Overview**

The Credentialing Policy is referred to as Article 10 of the Medical Staff Bylaws and delineates detailed processes and procedures for application, appointment, and reappointment to the medical staff of UI Health Care Medical Center Downtown. Individuals meeting the qualifications and criteria for appointment to the medical staff will be given an application for appointment. An application will be submitted to the Department Head for the department in which the applicant seeks privileges. The Department Head will review the application to determine if the application is complete and the individual possesses the education, knowledge, experience and training for appointment to the medical staff and to exercise the clinical privileges requested.

After review by the applicable Department Head, the Department Head forwards its recommendation to the Credentials Committee for further review. Afterwards, the Credentials Committee submits such application to the Medical Executive Committee for comment. The Credentials Committee’s recommendation and the Medical Executive Committee’s recommendation are sent through the Chief Executive Officer of UI Health Care Medical Center to the Clinical Systems Committee for further action. The Clinical Systems Committee may either accept the recommendation, request additional information regarding the recommendation, or reject the recommendation. If the recommendation is accepted by the Clinical Systems Committee, such individual is granted appointment to the medical staff and clinical privileges. All initial appointments and grant of clinical privileges are provisional for a period of twelve (12) months.

Article 4 of the Credentialing Policy summarizes Downtown’s hearing and appeals procedures for those medical staff appointees or members who are entitled to an appeal or hearing, such as those denied initial medical staff appointment, reappointment, initial clinical privileges, increase in clinical privileges, etc.

C. **Advanced Practice Provider Credentialing Policy, Overview**

UI Health Care Medical Center Downtown will privilege advanced practice providers, including physician assistants (“PAs”), advanced registered nurse practitioners (“ARNPs”) (collectively, “APPs”), and other practitioners under the Advanced Practice Provider Credentialing Policy (the “APP Credentialing Policy”). For those APPs permitted to practice at the downtown location, their
supervising or employing physician will maintain full responsibility for the actions of the APP at the UI Health Care Medical Center Downtown.

After completing the application to practice at UI Health Care Medical Center Downtown, an APP applicant will submit the application to the Medical Staff Office who will forward it to the appropriate Department Head. The Department Head will evaluate the APP applicant’s education, training and experience and provide a written report to the Credentials Committee on such applicant’s qualifications for the requested privileges, including a recommendation of whether to grant. The Credentials Committee submits its recommendation along with the completed application to the Clinical Systems Committee for final approval.

APPs that practice at UI Health Care Medical Center Downtown are permitted to practice only under the direct supervision of the physician that is designated as their supervising physician or is designated as their employing physician. Unless required by law or applicable Iowa or federal regulations, direct supervision does not require the physical presence of the APP’s supervising or employing practitioner.
UNIVERSITY OF IOWA HOSPITALS AND CLINICS d/b/a
UNIVERSITY OF IOWA HEALTH CARE MEDICAL CENTER DOWNTOWN
500 E. Market Street, Iowa City, Iowa 52245
MEDICAL STAFF BYLAWS

January 31, 2024
PREAMBLE

WHEREAS, the University of Iowa Hospitals and Clinics is a state institution and part of the University of Iowa whose existence is predicated upon the provisions contained in Chapters 225, 262, and 263 of the Code of Iowa;

WHEREAS, Chapter 262 of the Code of Iowa, which authorizes and identifies the responsibilities of the Iowa Board of Regents (hereinafter referred to as the “Board of Regents”), delineates the authority given to the Board of Regents to act as the ultimate governing body of the University of Iowa Hospitals and Clinics;

WHEREAS, the University of Iowa Hospitals and Clinics is a component of the University of Iowa Health Care (“UIHC”), which is comprised of the University of Iowa Hospitals and Clinics, the University of Iowa Carver College of Medicine, and the faculty practice plan referred to as University of Iowa Physicians;

WHEREAS, the Board of Regents delegates through the President of the University of Iowa and the Vice President for Medical Affairs of the University of Iowa to the Clinical Systems Committee the responsibility to act as an internal governing body of the clinical operations of University of Iowa Hospitals and Clinics;

WHEREAS, the Clinical Systems Committee recognizes that each physician, dentist and podiatrist appointed to the Medical Staff of the hospital located at 500 E Market Street, Iowa City, Iowa 52245, commonly referred to as University of Iowa Health Care Medical Center Downtown (hereafter the “Downtown Campus”) has responsibility for the exercise of professional judgment in the care and treatment of patients;

WHEREAS, the Clinical Systems Committee in accordance with legal and accreditation requirements, has delegated to the Medical Staff through its committees and departments, the duties and responsibilities set forth in these Medical Staff Bylaws, the Credentialing Policy under Article 10, and the Policy on Credentialing Advanced Practice Providers (collectively the “Bylaws” or “Medical Staff Bylaws”) for supervising and monitoring the quality of care provided by physicians, dentists, podiatrists and others at the Downtown Campus, and for making recommendations concerning appointment, for reappointment, and for clinical privileges;

WHEREAS, the Medical Staff recognizes and accepts its role and responsibilities in the efforts of the Downtown Campus to foster prevention, amelioration and cure of illness, disease and injury, and to provide or assist in providing medical education and continuing medical education for Medical Staff appointees, and other health care professionals; and

THEREFORE, to discharge those duties and responsibilities, and to provide for an orderly process concerning matters of election, meetings, duties and procedures, the officers, committees and departments of the Medical Staff as described in these Bylaws assume responsibility for fulfilling those duties and functions delegated to them by the Clinical Systems Committee.
ARTICLE 1

DEFINITIONS

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

(1) “Advanced Practice Providers” means practitioners other than physicians, dentists and podiatrists who function at the Downtown Campus in accordance with the Advanced Practice Providers Credentialing Policy;

(2) “Board of Regents” is defined in the Preamble;

(3) “Chief Administrative Officer” means the individual selected by University of Iowa Health Care to act on its behalf in the overall management of the Downtown Campus.

(4) “Chief Executive Officer” means the individual appointed by University of Iowa Health Care to act on its behalf in the overall management of University of Iowa Hospitals and Clinics;

(5) “Clinical Systems Committee” or “CSC” means the Clinical Systems Committee of University of Iowa Health Care, who has the overall responsibility for the conduct of the Downtown Campus and acts as its internal governing body;

(6) “Dentist” shall be interpreted to include a doctor of dental surgery and doctor of dental medicine;

(7) “Downtown Campus” means the University of Iowa Hospitals and Clinics licensed hospital located at 500 E Market Street, Iowa City, Iowa 52245;

(8) “Medical Executive Committee” means the Medical Executive Committee of the Downtown Campus’ Medical Staff;

(9) “Medical Staff” means all physicians, dentists and podiatrists who are given campus-specific privileges to treat patients at the Downtown Campus in accordance with these Bylaws;

(10) “Physicians” shall be interpreted to include both doctors of medicine (M.D.s) and doctors of osteopathy (D.O.s);

(11) “Podiatrist” shall be interpreted to mean a doctor of podiatric medicine; and

(12) “Supervision” shall refer to the responsibility of one or more persons for the activities of someone else. Supervision shall not be construed as requiring the personal presence of the supervising person except as made necessary through law or as provided through the Bylaws or rules and regulations.

Words used in these Bylaws shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope of effect of any provision of these Bylaws.
ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Clinical Systems Committee and shall be to one of the following categories of the Medical Staff. All appointees shall be assigned to a specific department, but shall be eligible for clinical privileges in other departments as applied for and recommended pursuant to these Bylaws and the Credentialing Policy and approved by the Clinical Systems Committee.

2.A  ACTIVE STAFF

2.A.1 Qualifications:

The Active Staff shall consist of those physicians, dentists, and podiatrists who have demonstrated an interest in and commitment to the Downtown Campus through patient care activities as well as the Downtown Campus and Medical Staff services. Specifically, the Active Staff shall consist of individuals who:

(a) have served no longer than five (5) years on the Associate Staff and have been approved for advancement to the Active Staff, including, but not limited to, having obtained board certification (or actively participating in the exam process leading to board certification within five (5) years after the date of first becoming eligible to take the board certification exam) from the appropriate specialty board of the American Board of Medical Specialties; the Advisory Board for Osteopathic Specialist; the American Board of Podiatric Orthopedics and Medicine or Surgery; or the American Board of Dental/Surgery, unless such requirement is waived by the Clinical Systems Committee in exceptional cases after considering the specific competence, training and experience of the applicant;

(b) maintain an active office (i.e., one where patients are seen at least one day per week) within the geographic service area of the Downtown Campus as defined by the Clinical Systems Committee and also reside close enough to the Downtown Campus to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients at the Downtown Campus. The Downtown Campus’ anesthesiologists, emergency department physicians, pathologists, hospitalists, and radiologists are exempt from the foregoing active office requirement;

(c) admit, treat, or are involved in the care of patients at the Downtown Campus;

(d) are active in Medical Staff activities and responsibilities, such as committee and department assignments, unless exempted elsewhere in these Bylaws; and

(e) agree to personally fulfill all responsibilities in providing inpatient consultations, emergency room consultations and inpatient attending coverage for those patients who are not under the ongoing care of an
appointee to the Medical Staff, according to on-call coverage mechanisms and requirements as described in applicable Medical Staff policies and procedures.

2.A.2 Responsibilities:

Each appointee to the Active Staff, by accepting appointment, shall:

(a) assume all the functions and responsibilities of appointment to the Active Staff, including, but not limited to, care for unassigned patients, emergency service care, and consultation;

(b) attend Medical Staff and department meetings;

(c) serve on Medical Staff committees, as assigned;

(d) faithfully perform the duties of any office or position to which elected or appointed;

(e) participate in quality assessment and monitoring activities as may be assigned by Department Heads or committee chairs, including the evaluation of provisional appointees;

(f) consistent with his/her granted privileges and applicable Medical Staff policies, participate in the on-call coverage of the emergency department or in other hospital coverage programs as determined by the Medical Executive Committee and the Clinical Systems Committee, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community;

i. before any appointee may, under special circumstances, be excused from taking call, seeing patients in the emergency department and/or routinely admitting patients after office hours, such appointee must first provide the Credentials Committee with (i) a written statement, in a form acceptable to the Credentials Committee, indicating which of these services the appointee is not providing and containing the agreement of one or more other Medical Staff appointees who will provide such coverage for the appointee, which statement/agreement is to be signed by the appointee and by the Medical Staff appointee(s) agreeing to provide such coverage; or (ii) such other evidence, satisfactory to the Credentials Committee, establishing that the appointee has made arrangements acceptable to the Credentials Committee for such coverage. After receiving a written statement or other evidence from an appointee, the Credentials Committee shall submit such information and its recommendation on the appointee’s request to be excused from call coverage to the Clinical Systems Committee for final approval; and

(g) pay all staff dues and assessments.

2.A.3 Prerogatives:
Active Staff appointees shall:

(a) be entitled to vote, hold office, serve on Medical Staff committees and serve as chairpersons of such committees;

(b) be entitled to admit and treat patients within the limits of their assigned clinical privileges; and

(c) be entitled to priority with respect to non-emergency admissions to the Downtown Campus and use of ancillary services (ahead of other staff categories).

2.A.4 Reserved.

2.A.5 Reserved.

2.B ASSOCIATE STAFF

2.B.1 Qualifications:

All appointments to the Associate Staff shall be provisional and shall be limited to those physicians, dentists and podiatrists who:

(a) meet the basic qualifications for staff appointment;

(b) maintain an active office located within the geographic service area of the Downtown Campus as defined by the Clinical Systems Committee, close enough to provide timely care for their patients;

(c) admit, treat, or are involved in the care of patients at the Downtown Campus;

(d) agree to personally fulfill all responsibilities in providing inpatient consultations, emergency room consultations and inpatient attending coverage for those patients who are not under the ongoing care of an appointee to the Medical Staff, according to on-call coverage mechanisms and requirements as described in applicable Medical Staff policies and procedures; and

(e) are appointed for an initial term of two years. Upon expiration of such initial term: i) if board certified, the individual becomes eligible for appointment to the Active Staff; or ii) if not board certified, the individual may be eligible for an extension as Associate Staff for up to three (3) more years to obtain board certification or be then actively participating in the exam process leading to board certification within five (5) years after the date of first becoming eligible to take the board certification exam. (The board certification requirements may be waived by the Clinical Systems Committee in exceptional cases after considering the specific competence, training, and experience of the individual in question).

2.B.2 Responsibilities:
Each appointee to the Associate Staff, by accepting appointment, shall agree to:

(a) assume all the functions and responsibilities of appointment to the Associate Staff, including, but not limited to, care for unassigned patients, emergency service care, and consultation;

(b) consistent with his/her granted privileges and applicable Medical Staff policies, participate in the on-call coverage of the emergency department or in other hospital coverage programs as determined by the Medical Executive Committee and the Clinical Systems Committee, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community;

   i. before any appointee may, under special circumstances be excused from taking call, seeing patients in the emergency department, and/or routinely admitting patients after office hours, such appointee must first provide the Credentials Committee with (i) a written statement, in a form acceptable to the Credentials Committee indicating which of these services the appointee is not providing and containing the agreement of one or more other Medical Staff appointees who will provide such coverage for the appointee, which statement/agreement is to be signed by the appointee and by the Medical Staff appointee(s) agreeing to provide such coverage; or (ii) such other evidence, satisfactory to the Credentials Committee, establishing that the appointee has made arrangements acceptable to the Credentials Committee for such coverage responsibilities. After receiving a written statement or other evidence from an appointee, the Credentials Committee shall submit such information and its recommendation on the appointee’s request to be excused from call coverage to the Clinical Systems Committee for final approval;

(c) participate in quality assurance and monitoring activities;

(d) serve on committees of the Medical Staff except the Medical Executive Committee and the Credentials Committee;

(e) attend Medical Staff, department and committee meetings as required; and

(f) pay all staff dues and assessments.

2.B.3 Prerogatives:

Associate Staff appointees shall:

(a) be entitled to admit and treat patients within the limits of their assigned clinical privileges;
(b) be eligible to serve on Medical Staff committees except the Medical Executive Committee and the Credentials Committee; and

(c) be eligible to vote, but ineligible to hold office or serve as Department Head or committee chairpersons unless approved by the Medical Executive Committee and the Clinical Systems Committee.

2.B.4 Reserved.

2.B.5 Reserved.

2.C **AFFILIATE STAFF**

2.C.1 **Qualifications:**

(a) The Affiliate Medical Staff shall consist of practitioners who do not attend inpatients at the Downtown Campus. Current board certification or active participation in the examination process leading to certification within five (5) years after the date of first becoming eligible to take the board certification exam shall be required.

2.C.2 **Prerogatives and Responsibilities:** Affiliate Staff appointees:

(a) shall attend meetings of the Medical Staff Departments;

(b) may be appointed to Medical Staff committees except the Medical Executive Committee and the Credentials Committee;

(c) shall be encouraged to attend education programs of the Medical Staff;

(d) shall be entitled to refer patients to Active and Associate Staff appointees at the Downtown Campus, visit those patients when hospitalized, and review such patient’s medical records, but may not write orders or make medical record entries;

(e) shall be permitted to use the Downtown Campus’ diagnostic facilities without limitation;

(f) may perform admission histories and physicals for inpatients attended in the Downtown Campus by a member of the Active Staff or Associate Staff;

(g) shall pay all staff dues and assessments;

(h) shall not be granted clinical privileges and shall not admit or treat patients at the Downtown Campus;

(i) failure to be appointed to or terminated from the Affiliate Staff category does not entitle the individual to any of the hearing and appeals rights contained in these Bylaws; and

(j) Affiliate Staff appointees shall not be eligible to vote, hold office or serve
as a Department Head or committee chairperson.

Any Affiliate Staff appointee who wishes to transfer to another staff category shall complete and submit an application requesting such change. That application will then be processed pursuant to the terms and conditions set forth in these Bylaws.

2.D CONSULTING STAFF

2.D.1 Hospital-Based Consulting Staff:

(a) Qualifications

The Hospital-Based Consulting Staff shall consist of specialists of recognized professional ability and expertise not otherwise available on the Medical Staff, who are appointed for the specific purpose of providing on-site consultation in the diagnosis and treatment of patients.

(b) Responsibilities

Hospital-Based Consulting Staff Appointees:

i. are encouraged to attend Clinical Department meetings;

ii. shall have no Medical Staff committee responsibilities; and

iii. shall pay all staff dues and assessments.

(c) Prerogatives

Hospital-Based Consulting Staff appointees:

i. are permitted to use the Downtown Campus’ diagnostic facilities without limitation;

ii. in conjunction with another Medical Staff appointee, are entitled to treat patients within the limits of their assigned clinical privileges; but

iii. are not entitled: to admit patients, to vote, to hold staff offices, or to serve on Medical Staff committees.

2.D.2 Telemedicine Consulting Staff:

(a) Qualifications

The Telemedicine Consulting Staff shall consist of physicians who will be providing patient care, treatment and services only through an electronic communication link and have been granted privileges by the medical staff and governing body of another Medicare participating hospital or telemedicine entity (a “Distant-Site Hospital” or “Telemedicine Entity”) with which the Downtown Campus has a written telemedicine services agreement that meets applicable regulatory requirements and provides for delegated credentialing. For all Distant-Site Hospital Campus or Telemedicine Entity physicians that will provide
telemedicine services under the agreement, the Distant-Site Hospital or Telemedicine Entity’s medical staff and governing body will be responsible for (i) conducting an evaluation of each physician’s licensure and qualifications pursuant to the provision of the Distant-Site Hospital or Telemedicine Entity’s medical staff and hospital bylaws, rules and regulations, and granting membership and clinical privileges at the Distant-Site Hospital or Telemedicine Entity in accordance with those provisions, (ii) providing the Downtown Campus with a list of those physicians covered by the agreement that includes the licensure information and clinical privileges that have been granted to each physician, and (iii) providing the Downtown Campus with an updated list of physicians covered by the agreement when necessary to reflect additions, deletions, and changes. Upon receipt from the Distant-Site Hospital or Telemedicine Entity of the information required by this Section 2.D.2, each physician may be admitted as a member of the Telemedicine Consulting Staff and granted clinical privileges. A physician who has privileges limited or terminated at the Distant-Site Hospital or Telemedicine Entity will have his/her privileges similarly limited or terminated at the Downtown Campus without a right of hearing or appeal under these Bylaws. A physician who is not board certified or whose board certification is revoked is not eligible for telemedicine privileges.

(b) Responsibilities

Telemedicine Consulting Staff appointees:

i. need not attend Medical Staff meetings;

ii. shall have no Medical Staff committee responsibilities; and

iii. shall not be required to pay any Medical Staff dues or assessments.

(c) Prerogatives

The prerogatives of the Telemedicine Consulting Staff shall be to:

i. Exercise such clinical privileges as are granted to him/her, but shall not admit patients and shall only provide services through electronic communication link and not on site at the Downtown Campus; and

ii. may attend meetings of the Medical Staff but is not required to.

2.E Reserved.

2.F HONORARY STAFF

2.F.1 Qualifications:

The Honorary Staff shall consist of Medical Staff appointees who have served as an appointee in the Active Staff category at least 5 years and retired from active practice at the Downtown Campus in good standing or other Physicians, Dentists or Podiatrists who are of outstanding reputation, not necessarily residing in the community.
2.F.2 Prerogatives and Responsibilities:

Persons appointed to the Honorary Staff shall not be eligible to admit or to attend patients, to vote, to hold office, or to serve on standing Medical Staff committees, but may be appointed to special committees. They may, but are not required to attend any Medical Staff meetings. They shall not be required to pay any dues or assessments.

ARTICLE 3

STRUCTURE OF THE MEDICAL STAFF

3.A GENERAL

3.A.1 Medical Staff Year:

For the purpose of these Bylaws, the Medical Staff year commences on the 1st day of January and ends on the 31st day of December each year.

3.A.2 Dues:

Except as otherwise provided in these Bylaws, all persons appointed to the Medical Staff shall pay annual staff dues to the Downtown Campus’s Medical Staff account only as may be required by the Medical Executive Committee. Signatories to this account shall be the President, President-Elect, and the Secretary-Treasurer of the Medical Staff. Disbursements from this account may be made only pursuant to these Bylaws, a resolution of the Medical Staff, or a resolution of the Medical Executive Committee.

3.B OFFICERS

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

3.B.1 Qualifications of Officers and Chairpersons:

Only those Active Staff appointees who satisfy the following criteria shall be eligible to serve as Medical Staff officers, department heads, or as chairpersons of the Credentials and other Medical Staff Committees:

(a) are members in good standing on the Active Staff and continue so during their term of office;

(b) have no pending adverse recommendations concerning staff appointment or clinical privileges;

(c) are not presently serving as a Medical Staff or corporate officer, or department head at another hospital, and shall not so serve during the term of office;

(d) have constructively participated in Medical Staff affairs, including peer review activities, and
are willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected or appointed.

All Medical Staff officers, department heads and committee chairpersons, described in Article 5 of these Bylaws must possess at least the above qualifications and maintain such qualifications during their term of office. Failure to do so shall automatically create a vacancy in the position involved.

3.B.2 President of the Medical Staff:

The President shall:

(a) act in coordination and cooperation with the Vice President of Medical Staff Affairs and the Chief Executive Officer or their designee in matters of mutual concern involving the Downtown Campus;

(b) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

(c) appoint committee chairpersons and members, in accordance with the provisions of these Bylaws, to all standing and special Medical Staff committees, except the Medical Executive Committee;

(d) serve as Chairperson of the Medical Executive Committee;

(e) Reserved;

(f) serve as an ex officio member, without vote, on all Medical Staff committees other than the Medical Executive Committee;

(g) represent the views, policies, needs, and grievances of the Medical Staff and report on the medical activities of the staff to the Vice President of Medical Staff Affairs, Chief Executive Officer or designee, and Clinical Systems Committee;

(h) provide day-to-day liaison on medical matters with the Vice President of Medical Staff Affairs, the Chief Executive Officer, the Chief Administrative Officer, and the Clinical Systems Committee;

(i) receive and interpret the policies of the Clinical Systems Committee to the Medical Staff and report to the Clinical Systems Committee on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care; and

(j) be the spokesperson for the Medical Staff in external professional and public relations.

3.B.3 President-Elect of the Medical Staff:

The President-Elect shall:
(a) assume all the duties and have the authority of the President in the event of the President’s temporary inability to perform due to illness, absence from the community, or unavailability for any other reason;

(b) serve as a member of the Medical Executive Committee and chair the Quality Improvement Committee;

(c) automatically succeed the President upon completion of the President’s term or if the office of President becomes vacant for any reason during the President’s term of office; and

(d) perform such additional duties as are assigned by the President or the Medical Executive Committee.

3.B.4 Secretary-Treasurer:

The Secretary-Treasurer shall:

(a) serve on the Medical Executive Committee;

(b) cause to be kept accurate and complete minutes of all regular and special meetings of Medical Executive Committee and Medical Staff meetings;

(c) collect any authorized staff dues and assessment, cause to be made disbursements authorized by the Medical Executive Committee or its designees, and supervise the preparation of annual financial reports or interim reports as may be requested by the President or the Medical Executive Committee;

(d) call meetings if so requested by the President, attend to correspondence and perform such other duties as pertain to the office of Secretary-Treasurer; and

(e) perform such additional duties as are assigned by the President or the Medical Executive Committee.

3.B.5 Immediate Past President:

The Immediate Past President shall:

(a) serve on the Medical Executive Committee;

(b) be an advisor to the other Medical Staff officers and the Medical Executive Committee; and

(c) perform such additional or special duties as shall be assigned by the President or the Medical Executive Committee.

3.B.6 Nomination and Election of Officers:

(a) A Nominating Committee consisting of the three (3) most immediate Past Presidents of the Medical Staff with then Active Staff status, chaired by
the most recent past president so serving, shall prepare a ballot of candidates for all the offices to be filled at a pending election. The Nominating Committee shall offer one or more nominees for each office. All nominees must possess all of the qualifications set forth in Section 3.B.1. The chairperson shall present the Nominating Committee’s report to the Medical Executive Committee at least thirty (30) days in advance of the annual meeting of the Medical Staff.

(b) The slate of candidates for Medical Staff office shall be prepared and posted by the Medical Executive Committee no later than ten (10) days prior to the date of the annual meeting. The Medical Executive Committee shall report the slate of nominees at the annual Medical Staff meeting and, at that time, nominations shall be received from the floor. Such nominees from the floor, if any, shall possess all of the qualifications set forth in Section 3.B.1. and shall agree orally or in writing at the same meeting that they will serve if elected. All nominations shall be closed.

(c) Officers shall be elected by a majority vote of those Medical Staff appointees eligible to vote and present at the meeting at the time the vote is taken. The vote shall be by written secret ballot, unless by motion duly made, seconded and approved by a majority of attending eligible voters, an open floor vote of the slate is authorized. Each officer shall then serve from the start of the next Medical Staff year for a term of two (2) years or until a successor has been elected.

(d) In any election, if there are three or more candidates for an office and no candidate receives a majority vote, there shall then be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one (1) candidate.

3.B.7 Conflict of Interest:

(a) In any instance where an officer, Department Head, committee chairperson, or member of any Medical Staff committee has a conflict of interest or is biased in any matter involving another Medical Staff appointee that comes before such individual or committee, or in any instance where any such individual or committee member brought the complaint against that appointee, such individual or member shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time, although that individual or committee member may be asked, and may answer, any questions, concerning the matter before leaving. As a matter of procedure, the chairperson of that committee designated to make such a review shall inquire, prior to any discussion of the matter, whether any member has any conflict of interest or bias. Any committee member with knowledge of the matter may call the existence of a potential conflict of interest or bias on the part of any committee member to the attention of the chairperson.

(b) A Department Head shall have a duty to delegate review of applications for appointment, reappointment, or clinical privileges, or questions that
may arise to another member of the department, if the Department Head has a conflict of interest with or is biased against the individual under review.

3.B.8 Removal of Officers and Other Elected Committee Members

The Medical Executive Committee, by a two-thirds vote, may remove any Medical Staff officer for conduct detrimental to the interest of the Downtown Campus or Medical Staff, or if the officer is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office, provided that notice of the meeting at which such actions shall be decided is given in writing to such officer at least ten (10) days prior to the date of the meeting. The officer shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

3.B.9 Vacancies in Office:

If there is a vacancy in the office of the President of the Medical Staff prior to the expiration of the President’s term, the President-Elect shall assume the duties and authority of the President for the remainder of the unexpired term and shall thereafter serve a full term as President. A vacancy in the Office of Immediate Past President shall be filled by the next most Immediate Past President. If there is a vacancy in the office of President-Elect or Secretary-Treasurer, the Medical Executive Committee shall appoint another appointee possessing the qualifications set forth in Section 3.B.1 to serve out the remainder of the unexpired term.

3.C MEETINGS OF THE MEDICAL STAFF

3.C.1 Regular Staff Meetings:

The Medical Staff shall hold two (2) regular meetings per year, one on the second Saturday of May and the other at the Annual Staff Meeting or on such dates as may be set at the beginning of the year by the President, for the purpose of reviewing and evaluating departmental and committee reports and recommendations, and to act on any other matters placed on the agenda by the President.

3.C.2 Annual Staff Meeting:

The last regular Medical Staff meeting before the end of the staff year shall be the annual meeting at which officers for the ensuing year shall be elected. This meeting shall be held on the first Saturday in December or at such other times as may be set by the President of the Medical Staff.

3.C.3 Special Staff Meetings:

Special meetings of the Medical Staff may be called at any time by the President, a majority of the Medical Executive Committee, or a petition signed by not less than one-fourth of the voting staff.
3.C.4  **Quorum:**

At any regular or special meeting of the Medical Staff, a quorum shall consist of those present.

3.C.5  **Agenda:**

The President shall set the agenda at any regular or special Medical Staff meeting and its conduct.

3.C.6  **Conflict Management:**

In the event that a conflict arises between the Medical Staff and the Medical Executive Committee pertaining to issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, the Medical Staff and Medical Executive Committee shall make use of the regular and special meeting processes and related procedures, as set forth in Sections 3.C, 3.E and elsewhere in these Bylaws, to manage such conflict.

3.D  **DEPARTMENT AND COMMITTEE MEETINGS**

3.D.1  **Department Meetings:**

Clinical departments shall hold meetings as needed, at least four times per year, as determined by the Department Head, to review and evaluate the clinical work of the department, to consider the findings of ongoing quality assessment, monitoring and evaluation activities, and to discuss any other matters concerning the department. The Department Head shall set the agenda for the meetings and their general conduct. Each department shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof, after each meeting to the Medical Executive Committee.

3.D.2  **Committee Meetings:**

All committees shall meet at least semi-annually, unless otherwise specified, at a time set by the chairperson of the committee. The chairperson shall set the agenda for the meeting and its general conduct. Each committee shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof, after each meeting to the Medical Executive Committee.

3.D.3  **Special Department and Committee Meetings:**

A special meeting of any department or committee may be called by or at the request of the appropriate Department Head or chairperson, the President, or by a petition signed by not less than one-fourth of the members of the departments or committee. As much prior notice as is reasonable under the circumstances shall be given to the members of the department or committee.

3.D.4  **Quorum:**

Those present at any department or committee meeting shall constitute a quorum,
but in no event less than two (2) members. However, for the Medical Executive Committee and the Credentials Committee meetings, the presence of at least one-half of the total membership eligible to vote is necessary for a quorum.

3.D.5 Minutes:

Minutes of each meeting of each department and each committee shall be prepared and shall include a record of the attendance of members, of the recommendations made, and of the votes taken on each matter. Copies thereof shall be promptly forwarded to the Medical Executive Committee and to certain other committees as may be specified elsewhere in these Bylaws. A permanent file of the minutes of each department and each committee meeting shall be maintained by the Downtown Campus.

3.E PROVISIONS COMMON TO ALL MEETINGS

3.E.1 Notice of Meetings:

Notice of all meetings of the Medical Staff and regular meetings of departments and committees shall be posted on the Medical Staff bulletin board, and delivered, either in person, by mail, or by e-mail, to each Medical Staff appointee in advance of such meetings. The notice shall state the date, time and place of the meeting and when mailed, the notice shall be deemed delivered when (1) deposited, postage prepaid, in the United States mail addressed to each appointee at the address as it appears on the records of the Downtown Campus; (2) given to a Downtown Campus courier; (3) put in the appointee’s staff mailbox; (4) deposited with the Downtown Campus’s in-house mail delivery; or (5) by e-mail when sent to the address as it appears in the records of the Downtown Campus. Such posting and mailing shall be deemed to constitute actual notice to the persons concerned. The attendance of any individual at any meeting shall constitute a waiver of that individual’s objection to improper notice of said meeting.

3.E.2 Attendance Requirements:

(a) Each Active, Associate, and Affiliate Staff appointee is expected to attend all regular Medical Staff meetings and applicable regular department, general staff and committee meetings in each year.

(b) Except as set forth herein, each Associate and Active Staff appointee is required to attend not less than one-half of all Medical Staff, assigned department, and/or assigned committee meetings. Provided, however, the attendance requirements shall not apply to Medical Staff members engaged by the Downtown Campus on a part-time basis to cover scheduling needs for hospital-based physicians (ECU; Adult and Pediatric Hospitalists). Attendance by the physicians is encouraged and welcomed. Failure to meet the foregoing attendance requirement (1) may result in the appointee’s voluntary relinquishment of voting rights for the ensuing year, and (2) may constitute grounds for non-reappointment to the Medical Staff.

(c) Any Medical Staff appointee whose clinical work is scheduled for
discussion at a regular department meeting shall be notified that his/her attendance is expected and shall be invited to present the case. The Department Head shall give the individual advance written notice of the time and place of the meeting at which attendance is expected. If the individual makes a timely request for postponement, supported by an adequate showing that his/her absence will be unavoidable, the presentation may be postponed by the Department Head (or by the Medical Executive committee if the Department Head is the individual involved) until not later than the next regularly scheduled meeting. Otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

(d) However, whenever there is an apparent or suspected deviation from standard clinical practice involving any appointee, the appropriate Department Head shall notify the individual that he/she is required to attend a special conference to consider the matter. The conference shall be held with the Department Head, the President of the Medical Staff, and/or a committee of the Medical Staff. The notice to the appointee regarding this conference shall be given by certified mail, return receipt requested, at least five (5) days prior to the conference and shall inform the appointee that attendance at the conference is mandatory. Failure of the appointee to attend the conference shall be reported to the Medical Executive Committee.

Unless excused by the Medical Executive Committee upon showing of good cause, such failure shall constitute voluntary relinquishment of all or such portion of the appointee’s admitting privileges as the Medical Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

(e) Persons appointed to the Honorary Staff and Consulting Staff categories of the Medical Staff shall be encouraged to attend and participate in department meetings, but shall not be required to do so as a condition of continued Medical Staff appointment.

3.E.3 Reserved.

3.E.4 Voting:

Any individual who, by virtue of position, attends a meeting in more than one (1) capacity shall be entitled to only one (1) vote.

3.F CONDUCTING BUSINESS ELECTRONICALLY

The business and affairs of the Medical Staff may be conducted electronically. By submitting an application for Medical Staff membership or privileges, the individual consents to the submission of documents electronically and to the use of an electronic signature. Pursuant to state and federal law, electronic documents and electronic signatures shall have the same effect, validity, and enforceability as manually generated records and wet-ink signatures. “Electronic signature” means any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature.
ARTICLE 4

CLINICAL DEPARTMENTS

4.A  CLINICAL DEPARTMENTS

4.A.1  Organization of Departments:

(a) Each department shall be organized as a separate part of the Medical Staff with primary responsibility for the review and improvement of the quality of care. Each department shall have a head that has the authority, duties, and responsibilities as set forth in these Bylaws.

(b) The clinical departments of Medical Staff shall be: (1) Medicine, (2) Surgery, (3) Maternal and Child Health Care, and (4) Family Practice/Emergency Medicine.

(c) Hospital-based physicians, including those in Anesthesiology, Pathology, Radiology, Emergency Department, and Hospitalists shall be assigned, by the Medical Staff President, in consultation with the Vice President of Medical Staff Affairs, to a single clinical department. All hospital-based physicians may choose the department meeting they wish to attend, but are encouraged to attend their assigned clinical department meeting and shall fulfill the attendance requirements as specified in Section 3.E.2. of these Bylaws.

4.A.2  Creation and Dissolution of Departments:

(a) The Medical Executive Committee will periodically assess the Downtown Campus’s departmental structure and recommend to the Clinical Systems Committee whether any action is desirable for better organizational efficiency and improved patient care (i.e., creating new or combining departments, eliminating departments). In addition, any group or staff appointees who satisfy the criteria for department designation set forth below may petition the Medical Executive Committee in writing and with appropriate supporting documentation for such a designation. The Medical Executive Committee will consider the request and forward its recommendation to the Clinical Systems Committee for final action. Action taken by the Clinical Systems Committee pursuant to this section shall be effective on the date of Clinical Systems Committee action and shall not require formal amendment of these Bylaws. In no event shall the Clinical Systems Committee take such action unless it has received a prior recommendation from the Medical Executive Committee.

(b) The following factors shall be considered by the Medical Executive Committee and the Clinical Systems Committee in determining whether the creation of a department is warranted:

(1) there exists a number of Medical Staff appointees who are available for appointment to and are reasonably expected to actively participate in the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in these Bylaws); and
(2) the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish departmental functions on a routine basis.

(c) The following factors shall be considered by the Medical Executive Committee and the Clinical Systems Committee in determining whether the elimination of a department is warranted:

(1) there is no longer an adequate number of Medical Staff appointees in the department to enable it to accomplish the functions set forth in these Bylaws;

(2) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the appointees in the department;

(3) the department fails to meet often enough to accomplish the functions set forth in these Bylaws;

(4) the department fails to fulfill all department or section responsibilities and functions; or

(5) no qualified individual is willing to serve as department head.

4.A.3 Functions of Departments:

(a) Each Department Head shall recommend to the Credentials Committee written criteria for the assignment of clinical privileges within the department and each of its sections. Such criteria shall be consistent with and subject to the Bylaws, policies, rules and regulations of the Medical Staff and the Downtown Campus. These criteria shall be effective when approved by the Clinical Systems Committee. Clinical privileges shall be based upon demonstrated competence, training, and experience within the specialties covered by the department.

(b) Each department shall monitor and evaluate medical care in all major clinical activities of the department. This monitoring and evaluation must at least include:

(1) the identification and collection of information about important aspects of patient care provided in the department;

(2) the identification of indicators used to monitor the quality and appropriateness of the important aspects of care; and

(3) the periodic assessment of patient care information to evaluate the quality and appropriateness of care, to identify opportunities to improve care, and to identify important problems in patient care.

Each department shall recommend, subject to approval and adoption by the Credentials Committee, objective criteria that reflect current knowledge and clinical experience. These criteria shall be used by each department and by the Downtown Campus’s quality assessment program to monitor and evaluate patient care.
care, as set forth in section 3.B.3 of the Credentialing Policy, entitled, *Ongoing Professional Practice Evaluation (OPPE)*. When important problems in patient care and clinical performance or opportunities to improve care are identified, each department shall document the actions taken and evaluate the effectiveness of such actions.

(c) In discharging these functions, each department shall report after each meeting to the appropriate utilization and/or quality assessment committee detailing its analysis of patient care and to the Credentials Committee whenever further investigation and action is indicated, involving any individual member of the department.

4.A.4 **Department Head:**

(a) The Department Head shall be an appointee to the Active Staff who possess the qualifications set forth in Section 3.B.1. of these Bylaws and shall be certified by an appropriate specialty board or actively participating in the examination process leading to certification within five (5) years after the date of first becoming eligible to take the board certification exam, unless the Clinical Systems Committee determines that he/she possesses comparable competence.

(b) The President of the Medical Staff shall appoint each head with the concurrence of the Executive Committee for a term of two years subject to confirmation by the Clinical Systems Committee. Department Heads are eligible for repeated appointment to annual terms as long as they continue to possess the qualifications set forth in Section 3.B.1. of these Bylaws.

(c) Removal of a Department Head during a term of office may be initiated by a two-thirds vote of all Active Staff appointees in the department, but no such removal shall be effective until it has been ratified by the Medical Executive Committee and approved by the Clinical Systems Committee.

4.A.5 **Functions of Department Heads:**

Each Department Head shall:

(a) be responsible for all administrative and clinical activities within the department;

(b) be responsible for the coordination and integration of interdepartmental and intradepartmental services;

(c) be responsible for the development and implementation of policies and procedures that guide and support the provision of services within the department;

(d) serve as a member of the Medical Executive Committee;

(e) recommend criteria for clinical privileges in the department;

(f) make a report to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for all applicants seeking privileges in the department;
(g) be responsible for the evaluation of all provisional appointees and report thereon to the Credentials Committee;

(h) assist the Downtown Campus, in accordance with the provisions of the Credentialing Policy, with respect to the granting of temporary, or *locum tenens* privileges within the department, and with the evaluation of requests for temporary privileges;

(i) monitor the professional performance of all individuals who have delineated clinical privileges in the department, and report thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;

(j) Completion of exit reference form upon cessation of medical staff membership;

(k) be responsible for the orientation and continuing education of all persons in the department;

(l) be responsible for enforcement within the department of the Downtown Campus policies and bylaws and the Medical Staff Bylaws, Policies, Rules and Regulations;

(m) be responsible for implementation within the department of actions taken by the Clinical Systems Committee, the Credentials Committee, and the Medical Executive Committee;

(n) make reports regarding the qualification and competence of all Advanced Practice Providers who provide patient care services within the department;

(o) report and recommend to Downtown Campus management when necessary with respect to matters affecting patient care in the department, including personnel, supplies, space, other resources, special regulations, standing orders, and techniques;

(p) 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 Downtown Campus;

(q) assist the Downtown Campus management in the preparation of annual reports and such budget planning pertaining to the department as may be required by the Chief Executive Officer or designee or the Clinical Systems Committee;

(r) delegate to other members of the department such duties as appropriate, but most notably the review of applications for appointment, reappointment, or clinical privileges or questions that may arise if the Department Head has a conflict of interest with the individual under review, or could be reasonably perceived to be biased;

(s) recommend sufficient number of qualified and competent individuals to provide care/clinical services;
be responsible for the integration of the department into the primary functions of the Downtown Campus;

serve on Medical Staff committees as directed by the President;

continuously assess and improve the quality of care, treatment, and services; and

maintain quality control programs, as appropriate.

ARTICLE 5

COMMITTEES OF THE MEDICAL STAFF

5.A APPOINTMENT

5.A.1 Chairpersons and Members:

(a) Except as otherwise provided for in these Bylaws, chairpersons and members of each committee shall be appointed annually by the President of the Medical Staff, not more than ten (10) days after the end of the Medical Staff year, and there shall be no limitation on the number of terms they may serve. All chairpersons shall be selected based on the criteria set forth in Section 3.B.1 of these Bylaws. All appointed members may be removed and vacancies filled at the discretion of the President of the Medical Staff.

(b) Except as set forth in the description of the composition of the Committee, the President of the Medical Staff or his/her designee shall be a member, ex officio, without vote, on all committees.

5.B MEDICAL EXECUTIVE COMMITTEE

5.B.1 Composition:

(a) The Medical Executive Committee shall consist of the officers of the Medical Staff; the Department Heads of each clinical department; and three (3) members of the Active Staff for the at-large members of the Medical Executive Committee. For the at-large members of the Medical Executive Committee, all members of the organized medical staff in the Active Staff category, or any discipline or specialty, are eligible for membership. The at-large positions on the Medical Executive Committee shall be elected to two-year terms, one (1) of whom shall be a hospital-based physician. The Vice President of Medical Staff Affairs and the Downtown Campus’s Chief Administrative Officer shall be ex officio members of the Executive Committee without vote. The Chairperson of the Credentials Committee shall be a member of the Executive Committee, ex officio, without vote.

(b) the President of the Medical Staff shall be the chairperson of the Medical
Executive Committee with voting rights.

(c) The Past President of the Medical Staff shall be a member of the Executive Committee, *ex officio*, with voting rights.

5.B.2 Duties:

The duties of the Medical Executive Committee shall be:

(a) to represent and to act on behalf of the Medical Staff in all matters, without requirement of subsequent approval by the staff, subject only to any limitations imposed by these Bylaws;

(b) to coordinate the activities and general policies of the various departments;

(c) to receive and to act upon those committee reports as specified in these Bylaws and the Credentialing Policy, and to make comments or recommendations concerning them to the Chief Executive Officer or designee, and the Clinical Systems Committee in accordance with the Bylaws;

(d) to implement or oversee the implementation of policies of the Downtown Campus that affect the Medical Staff;

(e) to provide liaison among the Medical Staff, the Vice President of Medical Staff Affairs, the Chief Administrative Officer, and the Clinical Systems Committee;

(f) to keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the Downtown Campus;

(g) to monitor the correction of any cited deficiencies resulting from inspection by the Joint Commission, and compliance with Joint Commission directives;

(h) to enforce Downtown Campus and Medical Staff rules in the best interest of patient care and of the Downtown Campus, with regard to all persons who hold appointment to the Medical Staff in accordance with the Credentialing Policy;

(i) to be responsible to the Clinical Systems Committee of the implementation of the Downtown Campus’s quality assessment plan as it affects the Medical Staff;

(j) to review the Bylaws, policies, rules and regulations, and associated documents of the Medical Staff at least once every three years, generally using a once-in-every-three-year rotating review cycle for each such document, and recommend such changes as may be necessary or desirable and submit such recommended changes to the Clinical Systems Committee for approval;
(k) to review the credentials of all applicants and to make appropriate comments concerning the Credentials Committee’s recommendations for appointment to the Medical Staff, assignment to departments, and delineation of clinical privileges in accordance with the Credentialing Policy;

(l) to review all information available regarding the performance and clinical competence of persons who hold appointments to the Medical Staff and as a result of such review to make appropriate comments concerning the Credentials Committee recommendations for reappointments or changes in clinical privileges in accordance with the Credentialing Policy; and

(m) to take such other actions as may be described in these Bylaws, the Credentialing Policy, other Downtown Campus and Medical Staff policies and procedures and as may be assigned to the Medical Executive Committee from time to time.

5.B.3 Meetings, Reports, and Recommendations:

The Medical Executive Committee shall meet at least eight times per year or more often if necessary to transact pending business. The Medical Staff Office, under the supervision of the Secretary-Treasurer, will maintain reports of all meetings, which reports shall include the minutes of the various committee and departments of the Medical Staff. Copies of all minutes and reports of the Medical Executive Committee shall be transmitted to the Chief Executive Officer routinely as prepared.

Recommendations of the Medical Executive Committee shall be transmitted to the Clinical Systems Committee with a copy to the Chief Administrative Officer. The chairperson of the Medical Executive Committee shall be available to meet with the Clinical Systems Committee or its applicable committee on all recommendations that the Medical Executive Committee may make.

5.C CREDENTIALS COMMITTEE

5.C.1 Composition:

(a) The Credentials Committee shall consist of five (5) physician members of the Medical Staff who possess the qualifications set forth in Section 3.B.1. of these Bylaws, who have an interest in credentialing activities and who are not currently serving as a member of the Medical Executive Committee. The Medical Executive Committee shall appoint individuals who possess the qualifications set forth in Section 3.B.1. of these Bylaws to the Committee for staggered five (5) year terms. The most senior member of the Credentials Committee shall be designated to serve as chairperson for the calendar year, with voting rights.

(b) All new members of the Credentials Committee, either prior to beginning to serve on the Credentials Committee or while serving on the Credentials Committee, must obtain specific education and training regarding the credentialing process.
5.C.2 Duties:

The duties of the Credentials Committee shall be:

(a) to review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations;

(b) to review the credentials of all applicants who request to practice at the Downtown Campus as Advanced Practice Providers, to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations;

(c) to review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and of those practicing as Advanced Practice Providers and, as a result of such review, to make a written report of its findings and recommendations in accordance with the Credentialing Policy on Credentialing Advanced Practice Providers; and

(d) to take such other actions as may be described in these Bylaws, the Credentialing Policy, other Downtown Campus and Medical Staff policies and procedures, and as may be assigned to the Credentials Committee from time to time.

5.C.3 Meeting, Reports and Recommendations:

The Credentials Committee shall meet quarterly 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 Medical Executive Committee, the Chief Executive Officer, and the Clinical Systems Committee. The chairperson of the Credentials Committee shall be available to meet with the Medical Executive Committee or the Clinical Systems Committee (or its applicable committee) on all recommendations that the Credentials Committee may make.

5.D QUALITY IMPROVEMENT AND OTHER FUNCTIONS PERFORMED BY MEDICAL STAFF COMMITTEES

A description of other Medical Staff committees that carry out quality improvement and other functions delegated to the Medical Staff, including their composition, duties, and reporting requirements, is contained in the Medical Staff Committee Manual. Notwithstanding anything to the contrary in the Bylaws, the Clinical Systems Committee
may determine that a Medical Staff committee or subcommittee report directly to the Clinical Systems Committee or a subcommittee of the Clinical Systems Committee. At a minimum, the Medical Staff shall carry out the following functions:

(a) quality improvement evaluation function;
(b) surgical case review function;
(c) drug usage evaluation function;
(d) medical records review function;
(e) blood usage review function;
(f) pharmacy and therapeutics review function;
(g) risk management function;
(h) infection control review function;
(i) utilization review function;
(j) radiation safety function;
(k) hospital safety, including disaster planning, function; and
(l) investigate requested new procedures.

5.E CREATION OF STANDING COMMITTEES

In accordance with the Medical Staff Committee Manual, the Medical Executive Committee of the Medical Staff may, upon approval of the Clinical Systems Committee and without amendment of these Bylaws, establish such committees as are necessary to perform one or more of the staff functions described in Section 5.D. In the same manner, except for the Medical Executive Committee and Credentials Committee, the Medical Executive Committee may dissolve or rearrange committee structure, duties or composition as needed to better accomplish Medical Staff functions. Any functions required to be performed by these Bylaws; which are not assigned to a standing or special committee shall be performed by the Executive Committee.

5.F SPECIAL COMMITTEES

Special committees may be created, and the President of the Medical Staff shall appoint their members and chairpersons. Any such special committees shall be submitted to the Clinical Systems Committee for approval. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Medical Executive Committee.
ARTICLE 6
Reserved

ARTICLE 7
RULES AND REGULATIONS OF THE MEDICAL STAFF

(a) Medical Staff rules and regulations, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws, shall be adopted in accordance with this Article. Rules and regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the Downtown Campus, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and regulations shall have the same force and effect as the Bylaws.

(b) Particular rules and regulations except those pertaining to histories and physicals, may be adopted, amended, repealed, or added by vote of the Medical Executive Committee at any regular or special meeting, provided that copies of the proposed amendments, additions, or repeals are posted on the Medical Staff bulletin board and made available to all members of the Medical Executive Committee fourteen (14) days before being voted upon, and further provided that all written comments on the proposed changes by persons holding current appointments to the Medical Staff are brought to the attention of the Medical Executive Committee before the change is voted upon. Adoption of and changes to the rules and regulations shall become effective only when approved by the Clinical Systems Committee. Particular rules and regulations pertaining to histories and physicals may only be adopted, amended, repealed, or added in accordance with Sections (c) and (d) of this Article 7.

(c) Rules and regulations may also be adopted, amended, repealed, or added by the Medical Staff at a regular meeting or special meeting called for that purpose provided that the procedure used in amending the Medical Staff Bylaws is followed. All such changes shall become effective only when approved by the Clinical Systems Committee.

(d) In cases of a documented need for an urgent amendment to the rules and regulations necessary to comply with a law or regulation, the Medical Executive Committee shall have the power to make such amendments without prior notification to the Medical Staff. The Medical Executive Committee, however, shall notify the Medical Staff upon making such amendments. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Clinical Systems Committee within sixty (60) days after adoption by the Medical Executive Committee.

(e) Each Member of the Medical Staff shall abide by the requirements for completing and documenting medical histories and physical examinations as set forth in the Medical Staff Rules and Regulations and Policy Manual under the heading Medical Records. The medical history and physical examination are completed and documented by a physician or other qualified licensed individual in accordance with State law and Downtown Campus policy. The following are required: (i) A medical history and physical examination shall be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oromaxillofacial surgeon, or other qualified licensed individual, in accordance with State law and Downtown Campus policy; (ii) an updated examination of the patient, including any
changes in the patient’s condition, shall be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oromaxillofacial surgeon, or other qualified licensed individual, in accordance with State law and Downtown Campus policy.

ARTICLE 8

AMENDMENTS

(a) All proposed amendments of these Bylaws initiated by the Medical Staff shall, as a matter of procedure, be referred to the Medical Executive Committee. Amendments shall then be effectuated in one of two ways:

(1) The Medical Executive Committee shall report on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. They shall be voted upon at that meeting provided that they shall have been posted on the Medical Staff bulletin board at least fourteen (14) days prior to the meeting. An amendment must receive a majority of the votes cast by the voting staff who are present at the time of such vote and who do vote; or

(2) Proposed amendments may also be presented to the voting staff by email or mail. Along with the proposed amendments, the Medical Executive Committee may, in its discretion provide a written report on them either favorably or unfavorably. In addition, the proposed amendment shall be posted on the Medical Staff bulletin board at least fourteen (14) days prior to the return date requested for the vote. An amendment must receive a majority of the votes cast, so long as the amendment is voted on by a majority of the staff eligible to vote.

(b) If the proposed amendments of the Bylaws receives a majority of the votes cast as described in subsections (a)(1) or (a)(2) of this Article 8, the proposed amendments must be presented in writing to the Clinical Systems Committee by a member of the Clinical Systems Committee. Such proposals shall require the approval of the Clinical Systems Committee by a majority vote of a quorum of the Committee.

(c) Amendments to these Bylaws, including the Credentialing Policy and the Credentialing Policy on Advanced Practice Providers, shall also require approval by a majority of the Board of Regents upon recommendation by the President of the University of Iowa, and shall take effect upon approval by the Clinical Systems Committee, the President of the University of Iowa, and the Board of Regents.

ARTICLE 9

ADOPTION OF MEDICAL STAFF BYLAWS

(a) These Bylaws are adopted and made effective upon approval of the Clinical Systems Committee, the President of the University of Iowa, and the Board of Regents superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges at the Downtown Campus shall be taken
under and pursuant to the requirements of these Bylaws.

(b) The present rules and regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws.

APPROVED BY THE CLINICAL SYSTEMS COMMITTEE:

APPROVED BY THE PRESIDENT OF THE UNIVERSITY OF IOWA:

APPROVED BY THE BOARD OF REGENTS:
UNIVERSITY OF IOWA HEALTH CARE MEDICAL CENTER
DOWNTOWN
MEDICAL STAFF BYLAWS
ARTICLE 10 CREDENTIALING POLICY

January 31, 2024
ARTICLE 1

DEFINITIONS

The definitions in Article 1 “Definitions” of the Medical Staff Bylaws shall apply to terms used in this Credentialing Policy (“Policy”).

ARTICLE 2

APPOINTMENT TO THE MEDICAL STAFF

2.A. QUALIFICATIONS FOR APPOINTMENT

2.A.1. General:

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent physicians, dentists and podiatrists who continuously meet the qualifications, standards, and requirements set forth in this Policy and in such policies as are adopted from time to time by the Clinical Systems Committee. All individuals practicing medicine, dentistry and podiatry in this Downtown Campus, unless accepted by specific provisions of this Policy, must first have been appointed to the Medical Staff. Appointments to the Medical Staff shall not exceed a period of two (2) years.

2.A.2. Specific Qualifications:

Only physicians, dentists and podiatrists who satisfy the following conditions shall be qualified for appointment to the Medical Staff:

(a) are currently licensed to practice in this state;

(b) maintain an active office (i.e., one where patients are seen at least one day per week) within the geographic service area of the Downtown Campus as defined by the Clinical Systems Committee and also reside close enough to the Downtown Campus to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Downtown Campus (the Downtown Campus’s emergency department physicians, anesthesiologists, pathologists, radiologists, and hospitalists are exempted from the foregoing active office requirement);

(c) possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Downtown Campus;

(d) have successfully completed an accredited ACGME/AOA/APMA/ADA (Accreditation Council for Graduate Medical Education/American Osteopathic Association/American Podiatric Medical Association/American Dental Association) residency and/or fellowship training program in the specialty in which the applicant seeks clinical privileges, unless such requirement is waived by the Clinical Systems Committee in exceptional cases after considering the specific competence, training, and experience of the individual in question;

(e) current board certification or active participation in the exam process leading to board certification within five (5) years after the date of first becoming eligible to take the board certification exams as administered by the appropriate specialty board of the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialists, the American Board of Podiatric Orthopedics and Medicine or Surgery, or the American Board of Dental/Surgery, unless such requirement is waived by the Clinical Systems Committee in exceptional cases after considering the specific competence, training, and experience of the individual in question (This requirement shall be applicable only to those individuals who apply for initial staff appointment...
and initial clinical privileges from or after April 2009. Those having initially applied before April 2009 were required to have been board certified within five (5) years after initial staff appointment).

(f) have never been convicted of a felony crime; and

(g) can document their:

(1) background, experience, training, and demonstrated professional competence;

(2) adherence to the ethics of their profession;

(3) good physical health and mental and emotional stability; and

(4) good reputation, character and demonstrated ability to work harmoniously with others sufficiently to establish a commitment to quality patient care and working cooperatively with Downtown Campus personnel and its Medical Staff.

2.A.3. No Entitlement to Appointment:

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the Downtown Campus merely by virtue of the fact that such individual:

(a) is licensed to practice a profession in this or any other state;

(b) is a member of any particular professional organization;

(c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital; or

(d) resides in the geographic service area of the Downtown Campus as defined by the Clinical Systems Committee.

2.A.4. Nondiscrimination Policy:

No individual shall be denied appointment on the basis of sex, race, creed, religion, color or national origin, or on the basis of any criteria unrelated to the delivery of quality patient care at the Downtown Campus, to professional qualifications, or to the Downtown Campus’s purposes, needs, and capabilities.

2.A.5. Reserved.

2.A.6. Telemedicine Privileges:

The Downtown Campus shall determine which patient care, treatment and services may be provided through an electronic communication link. The clinical services offered must be consistent with commonly accepted quality standards. Physicians providing care, treatment and services to patients via telemedicine link are subject to the Downtown Campus’s credentialing and privileging process and must apply for, and be granted privileges to provide telemedicine services to patients at the Downtown Campus. If the Downtown Campus has arranged for telemedicine services to be provided by a Distant-Site Hospital or Telemedicine Entity, upon the Clinical Systems Committee’s approval, the Downtown Campus may rely on the credentialing and privileging decisions of the Distant-Site Hospital or Telemedicine Entity with respect to a telemedicine physician if Downtown Campus has a written agreement with the Distant-Site Hospital or Telemedicine Entity which requires it to: (a) determine in accordance with Iowa law
which categories of practitioners are eligible candidates for privileges or membership on its medical staff; (b) appoint members and grant medical staff privileges after considering the recommendations of the existing members of its medical staff; (c) ensure its medical staff has bylaws; (d) approve its medical staff bylaws and other medical staff rules and regulations; (e) ensure the medical staff is accountable to the governing body of such hospital for the quality of care provided to patients; (f) ensure the listed criteria for granting medical staff privileges includes the individual’s character, competence, training, experience and judgement; (g) ensure under no circumstances its medical staff membership or privileges are dependent solely upon certification, fellowship or membership in a specialty body or society; (h) participate in the Medicare program; and (i) ensure all physicians providing telemedicine services are appropriately licensed. The Downtown Campus’s reliance on the credentialing and privileging decision of the Distant-Site Hospital or Telemedicine Entity will be appropriately documented in the individual’s Medical Staff file.

Notwithstanding the foregoing, a physician must be board certified to have privileges and telemedicine privileges will not be granted regardless of the Distant-Site Hospital or Telemedicine Entity’s privileges if the physician does not have and maintain board certification. An individual’s telemedicine privileges at the Downtown Campus will change automatically with any change in the privileges at the Distant-Site Hospital or Telemedicine Entity and will terminate without the right to any hearing or appeal upon (i) the termination of the services agreement or delegated credentialing agreement between the Downtown Campus and Distant-Site Hospital or Telemedicine Entity or (ii) termination of board certification.

2.B: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

2.B.1 Information:

(a) Applications for appointment to the Medical Staff shall be in writing, or electronic, and shall be submitted on forms approved by the Clinical Systems Committee upon recommendation of the Credentials Committee. These forms shall be obtained from the office of the Chief Executive Officer or a designee.

(b) The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant’s professional qualifications, including:

(1) the names and complete addresses of at least three (3) physicians, dentists, podiatrists, or other practitioners, as applicable, who have had recent extensive experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant’s present professional competence and character. At least one reference may not be from individuals associated or about to be associated with the applicant in professional practice or personally related to the applicant. At least one (1) reference shall be from the same specialty area as the applicant.

These references will be requested to assess the following areas of proficiency:

- Patient care (compassion, appropriateness and effectiveness);
- Medical and clinical knowledge and their application;
- Practice-based learning and improvement in patient care;
- Interpersonal and communication skills with patients, families and other healthcare team members;
• Professionalism, ethical behavior and responsible attitude; and
• Understanding of the context of health care provision and its application to improve care.

(2) the names and complete addresses of the chiefs of each department of any and all hospitals or other institutions at which the applicant has worked or trained (i.e., the individuals who served as chiefs at the time the applicant worked in the particular department). If the number of hospitals the applicant has worked in is great or if a number of years have passed since the applicant worked at a particular hospital, the Credentials Committee and the Clinical Systems Committee may take into consideration such factors;

(3) information as to whether the applicant’s medical staff appointment or clinical privileges have ever been relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced or not renewed at any other hospital or health care facility;

(4) information as to whether the applicant has ever withdrawn his/her application for appointment, reappointment, and clinical privileges, or resigned from the medical staff before final decision by a hospital’s or health care facility’s governing board;

(5) information as to whether the applicant’s license to practice any profession in any state, or Drug Enforcement Administration license is or has ever been suspended, modified, terminated, restricted or is currently being challenged. (The submitted application shall include a list or copy of all the applicant’s current licenses to practice, as well as copies of Drug Enforcement Administration license, medical or dental school diploma, and certificates from all post-graduate training programs completed);

(6) information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company, and the amount and classification of such coverage, and whether said insurance coverage covers the clinical privileges the applicant or appointee seeks to exercise at the Downtown Campus;

(7) information concerning the applicant’s professional liability litigation experience, specifically information concerning pending matters, final judgments, or settlements: (i) the substance of the allegations, (ii) the findings, (iii) the ultimate disposition, and (iv) any additional information concerning such proceedings or actions as the Credentials Committee may deem appropriate;

(8) a consent to the release of information from the applicant’s present and past professional liability insurance carriers;

(9) information concerning any professional misconduct proceedings involving the applicant in this state or any other state, whether such proceedings are closed or still pending;

(10) information concerning the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid, any other governmental sponsored program, or any private or public medical insurance program, and information as to whether the applicant is currently under investigation;
current information regarding the applicant’s physical, emotional, and mental health status;

information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime with details about any such instance;

a complete chronological listing of the applicant’s professional and educational appointments, employment, or positions;

information on the citizenship and/or visa status of the applicant;

current photo identification (current picture hospital ID card, valid picture ID issued by a state or federal agency (e.g., drivers license or passport);

the applicant’s signature (the use of electronic signature for the execution of the application documentation shall be legal and binding, and shall have the same full force and effect as if originally signed by the applicant); and

such other information as the Clinical Systems Committee may require.

(c) The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as criteria for appointment, reappointment, and the granting of clinical privileges. However, the mere presence of verdicts, settlements, or claims shall not, in and of themselves, be sufficient to deny appointment or particular clinical privileges. The evaluation shall consider the extent to which verdicts, settlements, or claims evidence a pattern of care that raises questions concerning the individual’s clinical competence, or whether a verdict, settlement, or claim in and of itself, represents such deviation from standard medical practice as to raise overall questions regarding the applicant’s clinical competence, skill in the particular clinical privilege, or general behavior.

2.B.2. Basic Responsibilities and Requirements for Applicants and Appointees:

As a condition of consideration of an application for Medical Staff appointment or reappointment, and as a condition of continued Medical Staff appointment, if granted, every applicant and appointee shall specifically agree to the following:

(a) to provide appropriate continuous care and supervision to all patients within the Downtown Campus for whom the individual has responsibility;

(b) to abide by all bylaws, policies, and rules and regulations of the Medical Staff and Downtown Campus as shall be in force during the time the individual is appointed to the Medical Staff;

(c) to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned;

(d) to provide, with or without request, new or updated information to the Chief Executive Officer or designee, as it occurs, that is pertinent to any question on the application form;

(e) to attest that the applicant has had an opportunity to read a copy of the bylaws of the UI Health Care Medical Center, Articles I through III; this Policy; and the Bylaws, rules and regulations of the Medical Staff as are in force at the time of application, and that the applicant has agreed to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment to the Medical Staff and/or clinical privileges are granted;
(f) to appear, if requested, for personal interviews in regard to the application;

(g) to agree that any misrepresentation or misstatement in, or omission from the application whether intentional or not, shall constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and clinical privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omissions, such discovery shall result in immediate dismissal from the Medical Staff without rights to hearing and appeal procedures under Article 4 of this Policy;

(h) to use the Downtown Campus and its facilities sufficiently to allow the Downtown Campus, through assessment by appropriate Medical Staff committees and Department Heads, to evaluate in a continuing manner the current competence of the appointee, or provide other evidence of professional competency that is satisfactory to the Credentials Committee and the Clinical Systems Committee;

(i) to agree that the hearing and appeal procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken at the Downtown Campus;

(j) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(k) to refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

(l) to refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

(m) to seek consultation whenever necessary;

(n) to promptly notify the Chief Executive Officer, or a designee, and the President of the Medical Staff of any change in eligibility for payments by third-party payors or for participation in Medicare, including any sanctions imposed or recommended by the federal Department of Health and Human Services and/or the receipt of a PRO citation and/or quality denial letter concerning alleged quality problems in patient care;

(o) to abide by generally recognized ethical principles applicable to the applicant’s or appointee’s profession;

(p) to participate in the monitoring and evaluation activities of clinical departments;

(q) to complete in a timely manner the medical and other required records for all patients as required by the Medical Staff bylaws, rules and regulations, this policy and other applicable policies of the Downtown Campus;

(r) to work cooperatively with Medical Staff appointees, medical associates, medical assistants, nurses and other Downtown Campus personnel so as not to adversely affect patient care;

(s) to promptly pay any applicable Medical Staff dues and assessments;

(t) to participate in continuing education programs at the Downtown Campus (both for his or her own benefit and for the benefit of other professionals and Downtown Campus personnel);

(u) to appropriately satisfy the requirements for Medical Staff appointees;
(v) to authorize the release of all information necessary for an evaluation of the individual’s qualifications for initial or continued appointment, reappointment, and/or clinical privileges;

(w) to agree not to sue the Downtown Campus, the Medical Staff, or anyone acting by or for the Downtown Campus and its Medical Staff for any matter relating to the application for appointment, reappointment, or clinical privileges; or relating to the evaluation of the applicant’s qualifications on any matter related to appointment, reappointment, or clinical privileges; and

(x) to extend absolute immunity to the Downtown Campus, its Medical Staff, and all individuals acting by or for the Downtown Campus and/or its Medical Staff for all matters relating to appointment, reappointment, and clinical privileges or the individual’s qualifications for the same.

2.B.3. Burden of Providing Information:

(a) The applicant shall have the burden of producing information deemed adequate by the Downtown Campus, on electronic and/or paper forms provided by and approved by the Downtown Campus, for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.

(b) The applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.

(c) Until the applicant has provided all information requested by the Downtown Campus, the application for appointment or reappointment will be deemed incomplete and will not be further processed. Should information provided in the initial application for the appointment change during the course of the term of the appointment, the appointee has the burden to provide information about such change to the Credentials Committee sufficient for the Credentials Committee’s review and assessment.

2.B.4. Grant of Immunity and Authorization to Obtain/Release Information:

The following statements, which shall be included on the application form and which form a part of this Policy, are express conditions applicable to any Medical Staff applicant, any appointee to the Medical Staff, and to all others having or seeking clinical privileges at the Downtown Campus. 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 clinical privileges are granted. This acceptance also applies during the time of any appointment or reappointment.

(a) **Immunity:**

   To the fullest extent permitted by law, the applicant or appointee releases from any and all liability, extends absolute immunity to and agrees not to sue the Downtown Campus, its authorized representatives, and any third parties as discussed in this section, with respect to any acts, communications or documents, recommendations or disclosures involving the applicant or appointee, concerning the following:

   (1) applications for appointment or clinical privileges, including temporary privileges;

   (2) evaluations concerning reappointment or changes in clinical privileges;

   (3) proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction;
(4) precautionary suspensions;
(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 or inquiries concerning the applicant’s or appointee’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 appointee’s competence, to patient care, or to the orderly operation of this or any other hospital or health care facility.

(b) Authorization to Obtain Information:

The applicant or appointee specifically authorizes the Downtown Campus and its authorized representatives to consult with any third party who may have information bearing on the individual’s professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the applicant’s or appointee’s satisfaction of the criteria for initial and continued 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 questions. The individual also specifically authorizes said third parties to release said information to the Downtown Campus and its authorized representatives upon request.

(c) Authorization to Release Information:

The applicant or appointee specifically authorizes the Downtown Campus and its authorized representatives to release such information to other hospitals, health care facilities and their agents, who solicit such information for the purpose of evaluating the applicant’s or appointee’s professional qualifications pursuant to a request for appointment and/or clinical privileges.

2.C: PROCEDURE FOR INITIAL APPOINTMENT

2.C.1. Pre-Application Process:

(a) An application for appointment to the Medical Staff shall only be provided, upon request, to those individuals who:

1) are eligible for appointment and are eligible for clinical privileges because they meet the threshold criteria contained the Medical Staff Bylaws and this Credentialing Policy, all as from time to time amended;

2) desire to provide care and treatment to patients for conditions and diseases for which the Downtown Campus has facilities and personnel; and

3) who indicate an intention to utilize the Downtown Campus in compliance with the policy and rules, as from time to time amended, applicable to the Medical Staff category.
An individual requesting an application for appointment shall initially be sent the steps to complete (1) a letter that outlines the threshold criteria for appointment and clinical privileges consideration and explains the review process, and (2) a pre-application form which requests proof that the threshold criteria for appointment and clinical privileges consideration can be met by the individual. A completed submission of the pre-application form must be returned to the Chief Executive Officer or designee within thirty (30) days after receipt of same if the individual desires further consideration. This Pre-Application process will be waived for applicants recommended for medical staff membership through Downtown Campus’s internal recruitment department, and/or those applying for non-Medical Staff membership categories of Locum Tenens or Temporary Non-Applicant.

Those individuals who meet the threshold criteria for consideration for appointment to the Medical Staff and clinical privileges shall be given an application. Individuals who fail to meet these criteria shall not be given an application and shall be so notified.

2.C.2. Submission of Application:

(a) The application for Medical Staff appointment shall be submitted by the applicant to the Chief Executive Officer or a designee. It must be accompanied by payment of such processing fees as may be recommended by the Credentials Committee and approved by the Clinical Systems Committee. After reviewing the application to determine that all questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with the primary sources, the Chief Executive Officer or designee or the Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate Department Head. Such transmittal shall be no sooner than one week or more than 90 days after the application submittal is complete, unless another time frame is approved by the Vice President of Medical Staff Affairs.

(b) An application shall be deemed to be complete when all questions on the application have been answered, all supporting documentation has been supplied, and all information verified. Under no circumstances may a curriculum vitae be used in place of a formal application. An application shall become incomplete if the need arises for new, additional, or clarifying information anytime during the evaluation. Any application that continues to be incomplete ninety (90) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

2.C.3. Department Head Procedure:

(a) The Chief Executive Officer or designee or the Medical Staff Office, as applicable, shall transmit the complete application and all supporting materials to the Department Head of the department of the Downtown Campus in which the applicant seeks clinical privileges. Each Department Head shall complete and submit to the Credentials Committee a written form regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested. As part of the process the Department Head has the right to meet with the applicant to discuss any aspect of the application, qualifications, and requested clinical privileges. The Department Head shall be assured that resources, equipment, personnel and space to support all requested privileges are or will be available.

(b) The Department Head, or the individual within the department to which the head has assigned
this responsibility, shall evaluate the applicant’s education, training, and experience, and make inquiries with respect to the same to the applicant’s past or current department head(s), residency training director, and others who may have knowledge about the applicant’s education, training, experience, and ability to work with others.

(c) The Department Head shall be available to the Credentials Committee to answer any questions.

(d) The Department Head may recommend that an application raises no questions and should be considered for expedited processing under section 2.C.7.

(e) For all other applications, the full Credentials Committee shall review and consider the review form submitted by the relevant Department Head and shall make a recommendation in compliance with the Credentials Committee Procedure under section 2.C.4.

2.C.4. Credentials Committee Procedure:

(a) The Credentials Committee shall examine evidence of the applicant’s character, professional competence, qualifications, prior behavior, and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including the recommendations and findings from the respective Department Head in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.

(b) As part of the process of making its recommendation to the extent and in the manner permitted by law, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee. The results of any such examination shall be made available to the Credentials Committee for its consideration. Failure of an applicant to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary withdrawal of the application for appointment and clinical privileges, and all processing of the application shall cease.

(c) As part of the process of making its recommendation, the Credentials Committee may meet with the applicant to discuss the applicant’s application, qualifications, and clinical privileges requested.

(d) The Credentials Committee may use the expertise of the Department Head, or any member of the department, or an outside consultant, if additional information is required regarding the applicant’s qualifications.

(e) The Credentials Committee will recommend a period of focused professional practice evaluation (“FPPE”) for all new applicants for Active, Associate, and Affiliate status on the Medical Staff, and for Temporary and Locum Tenens appointments. The Credentials Committee will decide, and so notify the applicant, on criteria for evaluation, establishment of a monitoring plan and its duration, and criteria indicating need for additional performance monitoring, or other satisfactory evidence of professional competency (see Medical and Dental Staff Peer Review/FPPE/OPPE Processes Policy).

2.C.5. Credentials Committee Recommendations:

(a) Except as set forth herein, not later than 60 days from the date the application is deemed complete, the Credentials Committee shall make a recommendation on the applicant to the Clinical Systems Committee, through the President and Chief Executive Officer, providing a copy of the recommendation to the Medical Executive Committee for its information and recommendation.
(b) If the recommendation of the Credentials Committee is delayed longer than 60 days after the application is deemed complete, the chairperson of the Credentials Committee shall send a letter or email to the applicant, with copies to the Clinical Systems Committee through the President and Chief Executive Officer and to the Medical Executive Committee explaining the delay.

2.C.6 Procedure Thereafter:

(a) The Medical Executive Committee shall receive the Credentials Committee’s recommendation in sufficient time for the Medical Executive Committee to comment on that recommendation to the Clinical Systems Committee prior to Clinical Systems Committee action on the recommendation. If the Medical Executive Committee disagrees with the Credentials Committee’s recommendation, it shall specify to the Clinical Systems Committee in writing the reasons for that disagreement.

(b) If the recommendation of the Credentials Committee is favorable to the applicant, it shall transmit the complete application along with its recommendation through the Chief Executive Officer to the Clinical Systems Committee (or its committee), including the findings and comments of the Medical Executive Committee. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.

(c) Any recommendation of the Credentials Committee that would entitle the applicant to request a hearing pursuant to this Policy, shall be forwarded to the Chief Executive Officer or designee who shall promptly notify the applicant in writing, certified mail, return receipt requested. The Chief Executive Officer or designee shall then hold the application until after the applicant has exercised or waived the right to a hearing as provided in this Policy, after which the Chief Executive Officer or designee shall forward the recommendation of the Credentials Committee, together with the complete application and all supporting documentation, through the Chief Executive Officer or designee to the Clinical Systems Committee for further action.

(d) Upon receipt of a favorable recommendation from the Credentials Committee that the applicant be granted appointment and the requested clinical privileges, the Clinical Systems Committee (or its designated committee) may:

1) appoint the applicant and grant clinical privileges as recommended; or

2) refer the matter back to the Credentials Committee or to another source inside or outside the Downtown Campus for additional research or information; or

3) reject the recommendation. If the Clinical Systems Committee determines to reject the favorable recommendation, it should first discuss the matter with the chairperson of the Credentials Committee and the President of the Medical Staff. If the Clinical Systems Committee’s determination remains unfavorable to the applicant, that determination and the reasons in support thereof, shall be sent to the Chief Executive Officer or designee, who shall promptly notify the applicant in writing, certified mail, return receipt requested. The Clinical Systems Committee shall make no final decision until the applicant has exercised or waived the right to a hearing and appeal as outlined in this Policy.

2.C.7 Expedited Process:

(a) If the expedited process is recommended by the applicable Department Head, an application for initial appointment may be processed as set forth in this section in a timeframe of no less than one week or no more than 90 days, unless another time frame is approved by the Vice President...
of Medical Staff Affairs, so long as the applicant meets the following conditions:

1) the applicant has successfully completed a residency in the specialty for which privileges are requested with no disciplinary actions or conditions imposed during training;

2) the applicant has not changed practice locations more than three times in the past 10 years;

3) all reference evaluations are completed and received within a reasonable time of the initial request;

4) all references received should contain only favorable evaluations, including unqualified recommendations for appointment and clinical privileges (the Department Head has the discretion to recommend for expedited credentialing if an unfavorable evaluation is received);

5) the applicant’s claims activity (including past malpractice claims and settlements) is reasonable in light of his or her specialty and there have been no adverse malpractice judgments;

6) there are no current or previously successful challenges to licensure or registration;

7) there has been no involuntary termination, limitation, restriction, reduction, denial or loss of medical staff appointment or clinical privileges at any hospital or other entity;

8) there has been no investigation into and no disciplinary action taken relating to appointment or clinical privileges at any hospital or other entity for clinical competence; and

9) no member of the Medical Staff has raised a question about the applicant’s qualifications.

An applicant for privileges is ineligible for the expedited process if either of the following has occurred:

(i) the applicant submits an incomplete application; or

(ii) the Medical Executive Committee makes a final recommendation that is adverse or has limitations.

The following circumstances will be evaluated on a case-by-case basis and may result in ineligibility for the expedited process:

(a) The Downtown Campus determines that there has been an unusual pattern of, or an excessive number of, professional liability actions resulting in one or more final judgements against the applicant.

(b) The chairperson of the Credentials Committee, acting on behalf of the committee, shall review the recommendation from each Department Head and all relevant information and prepare in writing a recommendation on appointment, clinical privileges and department assignment. This recommendation shall be forwarded to the President of the Medical Staff.

(c) The President of the Medical Staff, acting on behalf of the Medical Executive Committee, shall review the recommendation form made by the chairperson of the
Credentials Committee. If the President of the Medical Staff concurs with the recommendation, the recommendation shall be forwarded to the Chief Executive Officer.

(d) If the Department Head, the chairperson of the Credentials Committee, the President of the Medical Staff, or the Chief Executive Officer has any questions about the applicant, the questions shall be noted and the matter shall be referred to the full Credentials Committee for further action.

(e) The Chief Executive Officer may grant the individual interim clinical privileges for a period not to exceed 120 days.

(f) A report regarding all applicants who are granted interim appointment and privileges shall be forwarded to the Credentials Committee for its information, the Executive Committee for review and comment, and to the Clinical Systems Committee for final action.

2.D: PROVISIONAL STATUS

2.D.1. Duration of Initial Provisional Appointment:

(a) All initial appointments to the Medical Staff (regardless of the category of the Medical Staff to which the appointment is made), and all initial clinical privileges shall be provisional for a period of twelve (12) months from the date of the appointment or longer if recommended by the Credentials Committee, pending completion of the evaluation detailed in 2.C.4 (e).

(b) All grants of increased clinical privileges to existing Medical Staff appointees are also provisional. The duration and/or terms of this provisional period will be recommended by the Credentials Committee, after consulting with the appropriate Department Head, and approved by the Clinical Systems Committee.

(c) During the term of this provisional appointment, the individual shall be evaluated, per the Credentials Committee’s recommendation by the Department Heads or departments in which the individual has clinical privileges, and by the relevant committees of the Medical Staff and the Downtown Campus as to the individual’s clinical competence and general behavior and conduct in the Downtown Campus.

(d) Provisional clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional period, or sooner if warranted.

(e) Continued appointment and/or clinical privileges after the provisional period shall be conditioned on an evaluation of the factors to be considered for reappointment as set forth in Section 3.A.2 of this Policy.

2.D.2. Duties of Provisional Appointees:

(a) Appointment to the Medical Staff shall require that each appointee assume such reasonable duties and responsibilities as the Clinical Systems Committee or the Medical Staff shall require.

(b) During the provisional period, an appointee must demonstrate all of the qualifications, may exercise all of the prerogatives, and must fulfill all of the obligations attendant to his or her Medical Staff category.

(c) Each appointee must arrange or cooperate in the arrangement of the required numbers and types of cases to be reviewed/observed by the Department Head and/or designated proctors.
(d) Failure of the provisional appointee during the provisional period to admit, treat, or attend to the number of patients established by the Credentials Committee (sufficient to permit observation and assessment), or failure of the appointee, during the provisional period, to fulfill all requirements of appointment relating to meeting attendance, completion of medical records, and/or cooperation with monitoring or proctoring conditions, may render the provisional appointee ineligible to apply for reappointment. In that event, at the expiration of provisional appointment, all clinical privileges shall terminate. The appointee may be permitted to reapply for initial appointment in accordance with this Policy, if the individual evidences a greater interest in or intention to use the Downtown Campus in the future. This provision may be waived, at the discretion of the Credentials Committee and the Clinical Systems Committee, for appointees in specialties that do not require use of Downtown Campus facilities or treatment of hospitalized patients.

2.E. CLINICAL PRIVILEGES

2.E.1. General:

(a) Medical Staff appointment or reappointment as such shall not confer any clinical privileges or right to practice at the Downtown Campus.

(b) Each individual who has been appointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Clinical Systems Committee.

(c) The grant of clinical privileges shall carry with it acceptance of the obligations of such privileges, including emergency service and other rotational obligations established to fulfill the Downtown Campus’s responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.

(d) Clinical privileges shall be voluntarily relinquished only in the manner that provides for the orderly transfer of such obligations.

(e) The clinical privileges recommended to the Clinical Systems Committee shall be based upon consideration of the following:

1) the applicant’s education, training, experience, demonstrated current competence and judgment, references, utilization patterns, and health status;

2) the applicant’s ability to meet all current criteria for the requested clinical privileges;

3) availability of qualified physicians or other appropriate appointees to provide medical coverage for the applicant in case of the applicant’s illness or unavailability;

4) adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;

5) the Downtown Campus’ available resources and personnel;

6) any previously successful or currently pending challenges to any licensure or registration, or the voluntary relinquishment of such licensure or registration;

7) any information concerning professional review actions, voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and
8) other relevant information, including a written report and findings by the Department Head of each of the clinical departments in which such privileges are sought.

(f) The applicant shall have the burden of establishing qualifications for and competence to exercise the clinical privileges requested.

1) appointees* requesting procedural sedation privileges must provide proof of their ability to manage airways via the following method:

   i) providing documentation of current ACLS, ATLS, PALS or NRP certification and complete the Downtown Campus’s approved Moderate Sedation Online Course or such other course as designated by Downtown Campus. Documentation of successful completion must be provided with Hospital Sedation Privilege requests. (*exemption: anesthesiologists, Iowa Board of Dental Examiners General Anesthesia Permit or American Board of Emergency Medicine certified Emergency Medicine physicians.)

(g) The reports of the Department Head in which privileges are sought shall be forwarded to the Credentials Committee and processed as a part of the initial application for Medical Staff appointment in accordance with this Policy.

2.E.2. Clinical Privileges for Dentists and Oral Surgeons:

   (a) The scope and extent of surgical procedures that a dentist or an oral surgeon may perform in the Downtown Campus shall be delineated and recommended in the same manner as other clinical privileges and in accordance with the provisions of the policies governing such practitioners as may be adopted by the Clinical Systems Committee from time to time.

   (b) Surgical procedures performed by dentists or oral surgeons shall be under the overall supervision of the Department Head of the Department of Surgery.

   (c) Dentists shall not have admitting privileges or be privileged to perform history and physicals examinations.

   (d) In order to be privileged to perform “history and physicals” an oral surgeon must:

      1) have successfully completed a post-graduate program in oral surgery that included training in performing history and physicals and was accredited by the Commission on Dental Accreditation; and

      2) provide documented evidence from the accredited training program of competency in the performance of history and physical examinations.

   (e) Admission privileges may be granted to oral surgeons who provide documented evidence of completing an approved training program and competency in the performance of history and physical examinations.

2.E.3. Clinical Privileges for Podiatrists:

   (a) The scope and extent of surgical procedures that a podiatrist may perform in this Downtown Campus shall be delineated and recommended in the same manner as other clinical privileges and in accordance with the provisions of the policies governing such practitioners as may be adopted by the Clinical Systems Committee from time to time.
(b) Surgical procedures performed by podiatrists shall be under the overall supervision of the Department Head of the Department of Surgery.

(c) Before podiatric surgery shall be performed a medical history and physical examination of each patient shall have taken place and been recorded in the medical record. Unless the podiatrist has been granted privileges to perform patient histories and physicals, a history and physical shall be performed by a physician who holds an appointment to the Medical Staff.

(d) In order to be privileged to perform “history and physicals” a podiatrist must:

1) have successfully completed a post-graduate program in podiatric surgery that included training in performing medical history and physicals and was accredited by the Council on Podiatric Medical Education (“CPME”); and

2) provide documented evidence from the accredited training program of competency in the performance of history and physical examinations.

(e) Podiatrists shall not have admitting privileges, unless granted as specified in paragraph (f) below. A physician member of the Medical Staff shall admit all podiatry patients and serve as the attending physician during the period of hospitalization.

(f) Admission privileges may be granted to Podiatrists who provide documented evidence of completing an approved training program and competency in the performance of history and physical examinations.

2.E.4. Residents, Interns and Non-Medical Staff Practicing Physicians: Clinical privileges allowed to residents, interns, and non-medical staff practicing physicians (practicing through hospital or member sponsorship) shall be as authorized and supervised by a member of the Medical Staff.

For residents, interns, medical students and non-medical staff physicians, the Medical Staff Office requires advance notification (of at least three weeks) for the scheduled visit and must approve the visiting professional by verification of credentials as detailed below:

1. Non-Medical Staff Physicians, Residents, Interns

(a) If the visiting physician, resident or intern will be solely observing a procedure/patient care, the following items will be requested prior to the visit: copy of current medical license, current resume, and a written statement detailing date(s) of the visit, name of the physician Medical Staff appointee with whom the visiting physician, resident, or intern will be working with, and purpose of visit. The medical license will be primary verified by the Medical Staff Office.

(b) If the visiting physician, resident or intern will, at any time during the visit, provide any services or have any direct patient contact, the visiting physician, resident, or intern must be fully credentialed and privileged in accordance with the Procedure for Initial Appointment (2.C). Such service or contact must be clearly outlined by the sponsoring physician on the Medical Staff with the understanding that they (the sponsoring physician) will have direct supervision of all procedures and contact of the visiting individual.

2. Medical Students or Advanced Practice Provider Students

(a) If the visiting student will be solely observing a procedure/patient care, the following items need to be provided to the Medical Staff Office reasonably in advance of the intended visit: copy of current license (if applicable), current resume, and a written statement detailing...
date(s) of the visit, name of the physician on the Medical Staff with whom the visiting student will be working with, and purpose of visit. The license (if applicable) will be primary verified by the Medical Staff Office.

(b) If the visiting student will, at any time during the visit, provide any services or have any direct patient contact, this request must go before the Credentials Committee for approval. The visiting student must be credentialed appropriately for the activities he or she may perform under the direct supervision of the sponsoring physician. Such service or contact must be clearly outlined by the sponsoring physician with the understanding that they (the sponsoring physician) will have direct supervision of all procedures and contact of the visiting individual. Any request for temporary privileges (for a visiting physician) must be forwarded to the Credentials Committee for review and consideration of approval.

2.E.5. Clinical Privileges for New Procedures:

When a Medical Staff appointee requests clinical privileges to perform a new procedure or service not currently being performed at the Downtown Campus, the following process shall be followed:

(a) The matter shall first be referred to the Clinical Systems Committee who, after receiving recommendations from the Credentials Committee, shall make a preliminary determination whether the new procedure or service is one that will be offered to patients. One factor to be considered in reaching this determination is whether the Downtown Campus has the capabilities to perform the procedure in question.

(b) Should the Clinical Systems Committee determine to offer the procedure, the next step is for the Credentials Committee to investigate the new procedure and to develop criteria for those individuals who should be permitted to perform the new procedure. Specifically, the Credentials Committee shall conduct research and shall consult with experts—both those on the Downtown Campus’s Medical Staff and those outside the Downtown Campus—and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the procedure in question; (2) the extent of monitoring and supervision that should occur; and (3) the adequate space, equipment, staffing and financial resources to support each requested privilege. The Medical Staff Office will query both the National Practitioner Data Bank, Office of Inspector General (OIG) and Iowa Board of Medicine databanks for applicants requesting new privileges. The Credentials Committee shall forward its recommendations to the Clinical Systems Committee for final action.

(c) The Clinical Systems Committee shall then establish the minimum criteria and qualifications necessary to be able to perform the procedure in question.

(d) Once the foregoing steps are accomplished, specific requests from Medical Staff appointees who wish to perform the procedure in question shall be handled in accordance with Section 3.B of this Policy (“Procedures for Requesting Increase in Clinical Privileges”).

2.E.6 Focused Professional Practice Evaluation (FPPE)

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

2.F: VOLUNTARY RELINQUISHMENT OF PRIVILEGES
2.F.1. Request to Relinquish Clinical Privileges:

(a) A Medical Staff appointee who desires to voluntarily relinquish any one (1) or more of the clinical privileges granted at any time during the appointment period may submit a written request to the Credentials Committee or Vice President of Medical Staff Affairs specifying the clinical privilege(s) to be relinquished.

(b) Likewise, relinquishment of clinical privileges while under an investigation or in exchange for not conducting an investigation shall be considered a “surrender” of such privileges, and shall be so reported when so required.

(c) If, physicians simply seek not to continue to practice in a certain clinical area, relinquishment of such clinical privileges, or for that matter failure to apply for reappointment for certain clinical privileges, will not be grounds for a disciplinary action or reporting.

2.G: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

2.G.1. Temporary Clinical Privileges for Applicants:

Temporary privileges shall not be routinely granted to applicants. Temporary admitting and clinical privileges may only be granted by the Chief Executive Officer, for a period not to exceed ninety (90) days and only after there has been a favorable recommendation made by the Department Head, Credentials Committee, and Medical Staff President regarding the applicant’s application for Medical Staff appointment and clinical privileges. In exercising such privileges, the applicant shall act under the supervision of the Department Head or appropriate designee of the department in which the applicant has requested primary privileges.

2.G.2. Temporary Clinical Privileges for Non-Applicants (other than Locum Tenens):

(a) Temporary admitting and clinical privileges to treat patients may be granted to non-applicants by the Chief Executive Officer, with the concurrence of the President of the Medical Staff regarding professional competency and clinical privileges, when there is a compelling patient care, treatment or service need. Specifically, temporary privileges may be granted in situations such as the following:

1) for the care of a specific patient and/or to perform a specific procedure, with such temporary appointment typically not being for more than ninety (90) days;

2) to make available one or more practitioners needed to prevent a lack or lapse of services resulting from (i) one or more Medical Staff Members retiring from or leaving the Medical Staff; or (ii) there otherwise being insufficient practitioners in a specialty as needed or desirable for providing inpatient, outpatient and/or emergency coverage for healthcare services, as such need may be reasonably determined by the Chief Executive Officer or the Clinical Systems Committee, with such temporary appointment typically not being for more than three hundred sixty-five (365) days; or

3) Such other temporary, special, and non-ongoing circumstance appropriate to the community health mission of the Downtown Campus as determined by the Chief Executive Officer or designee or the Clinical Systems Committee, with such temporary appointment for so long as needed for such special temporary purpose normally not anticipated to be for more than ninety (90) days.

(b) Prior to granting such temporary privileges, the practitioner shall provide, and the Downtown Campus shall verify, appropriate information regarding the individual’s licensure, DEA
certification, relevant training or experience, ability to perform the privileges requested, query and evaluation of the National Practitioner Data Bank (NPDB) information, completed application, no current or previously successful challenge to licensure or registration, no subject to involuntary termination of medical staff membership at another organization, no subject to involuntary limitation, reduction, denial or loss of clinical privileges, current competence, character, ethical standing, health status, and professional liability insurance coverage. The Chief Executive Officer or designee shall also obtain such individual’s signed acknowledgment to be bound by all of the Bylaws, policies, and rules and regulations of the Medical Staff and the Downtown Campus then in force. Additionally, the review process specified in 2.G.2(c) shall be completed.

(c) The applicable Department Head shall review all relevant information regarding the practitioner seeking temporary privileges and make a report as to the professional competency and recommended temporary clinical privileges to the chairperson of the Credentials Committee. The chairperson of the Credentials Committee, acting on behalf of such Committee, shall review the report from the Department Head and all relevant information and prepare a report containing a recommendation on professional competency, appropriate temporary clinical privileges and department assignment. This report shall be forwarded to the President of the Medical Staff. The President of the Medical Staff, acting on behalf of the Medical Executive Committee, shall review the report and recommendation made by the chairperson of the Credentials Committee along with relevant information, and then shall supplement such report and recommendation with his/her recommendation, and then forward that recommendation to the Chief Executive Officer or designee. The foregoing review process shall be completed in an expedited manner. If the Department Head, the chairperson of the Credentials Committee, the President of the Medical Staff, or the Chief Executive Officer or designee has any questions regarding the professional competency of, or appropriate temporary privileges for, the practitioner proposed for temporary privileges, the matter shall be referred to the full Credentials Committee for further action.

(d) Under special circumstances, an extension of temporary privileges may be granted. A practitioner wishing to extend his/her temporary privileges may make such a request in writing. The following information must be re-verified: license, DEA/CSA certification, professional liability insurance, National Practitioner Data Bank, all online regulatory queries. The Quality Focused Questions of the application and clinical privileges must be resubmitted. All approval signatures must be obtained.

2.G.3. Locum Tenens Privileges:

(a) For the purposes of this Policy, a Locum Tenens practitioner shall be a non-applicant practitioner who receives temporary clinical privileges to provide services, which are not expected to be for an indefinite or ongoing basis, to substitute for an appointee of the Active Staff or Associate Staff who by reason of (i) health-related or other incapacity, or (ii) vacation, professional education or other absence, is temporarily not able to: 1) attend his/her patients; 2) admit new patients consistent with his/her admitting privileges; or 3) perform emergency coverage responsibilities attendant to his/her Medical Staff appointee responsibilities.

(b) The Chief Executive Officer or designee may grant an individual serving as a locum tenens temporary admitting and clinical privileges to attend patients for a period of up to one hundred twenty (120) days, consecutive or not, during the twenty-four (24) month period following the date such privileges are initially granted, subject to the following:

I) the Medical Staff appointee and/or the locum tenens practitioner shall notify the Medical Staff Office at least ten (10) days (or such shorter maximum time as may be feasible under the specific circumstances) prior to each time the locum tenens practitioner will
be exercising his/her temporary privileges; and

II) along with the notice, the practitioner must inform the Medical Staff Office of any change that has occurred to any of the information provided on the initial application for *locum tenens* privileges.

(c) The Chief Executive Officer may grant *locum tenens* privileges after receiving a completed *locum tenens* application and a request for clinical privileges form and after the application has been processed in accordance with the guidelines detailed in Article 2, Application for Initial Appointment & Clinical Privileges. The Chief Executive Officer shall also obtain such individual’s signed acknowledgment that the individual has had an opportunity to read copies of the bylaws of University of Iowa Health Care Medical Center, Articles I through III; this Policy; Medical Staff Bylaws; and rules and regulations which are then in force, and agrees to be bound by the terms thereof.

(d) The individual serving as a *locum tenens* must have in force and effect a current license to practice in this state, a DEA license, if applicable, and professional liability insurance in an amount and terms acceptable to the Downtown Campus.

(e) Under special circumstances, an extension of the period of *locum tenens* privileges may be granted. A provider wishing to extend his/her *locum tenens* privileges may make such a request in writing and describe therein the special circumstances that create the need for the extension. The request will be verified with the office in which the physician is practicing. The following information will be re-verified: license, DEA/CSA certification, professional liability insurance, National Practitioner Data Bank, all online regulatory queries. The Quality Focused Questions of the application and clinical privileges must be resubmitted. All approval signatures must be obtained.

2.G.4. Medical Staff Status:

Practitioners granted temporary privileges shall not have membership in the Medical Staff.

2.G.5. Special Requirements:

Special requirements of supervision and reporting may be imposed by the Department Head concerned on any individual granted temporary clinical privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer or a designee upon notice of any failure by the individual to comply with special conditions.

2.G.6. Focus Professional Practice Evaluation:

Individuals who are granted temporary privileges will be subject to the Downtown Campus’s policies regarding Focused Professional Practice Evaluation (see policy “Medical and Dental Professional Practice Evaluation Processes”).

2.G.7. Termination of Temporary Clinical Privileges:

(a) The Chief Executive Officer or designee may, at any time after consulting with the President of the Medical Staff, the Credentials Committee chairperson, or the Department Head responsible for the individual’s supervision, terminate temporary admitting privileges. Clinical privileges shall then be terminated when the individual’s inpatients are discharged from the Downtown Campus. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual granted temporary privileges, a termination of temporary clinical privileges may be imposed by the Chief Executive Officer or
designee, the Department Head or the President of the Medical Staff, and such termination shall be immediately effective.

(b) The appropriate Department Head, or the President of the Medical Staff shall assign to a Medical Staff appointee responsibility for the care of such terminated individual’s patients until they are discharged from the Downtown Campus, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

(c) The granting of any temporary admitting and clinical privileges is a courtesy on the part of the Downtown Campus and any or all may be terminated if a clinical question or concern has been raised. Neither the granting, denial, nor termination of such privileges shall entitle the individual concerned to any of the hearing and appeal rights provided in this Policy.

2.H: EMERGENCY DISASTER PRIVILEGES

(a) For the purpose of this section, an “emergency” is defined as a natural or man-made event that significantly disrupts the environment of care; that significantly disrupts care and treatment; or that results in sudden, significantly changed or increased demands for the Downtown Campus’s services. Some emergencies are called “disasters” or “potential injury creating events” (“PICE”).

(b) Similarly, in an emergency, a currently appointed Medical Staff physician may be permitted by the Downtown Campus to exercise clinical privileges to the extent permitted by his or her license, regardless of that individual’s department status or specific grant of clinical privileges.

(c) In the case that such an Emergency Operation Plan is initiated by the Chief Executive Officer or designee, or the designated Administrator on call, the Emergency Privileging Authority (Chief Executive Officer or designee, Medical Staff President, or Vice President of Medical Staff Affairs) may grant emergency disaster privileges to licensed independent practitioners (LIP) who are not currently Medical Staff appointees.

(d) Non-licensed independent practitioners (“NLIP”) (i.e., retired physicians who no longer hold a current medical license) may be granted emergency disaster privileges if it is determined necessary by any of the above Emergency Privileging Authorities. For the purpose of this section, “emergency clinical privileges” are defined as basic emergency procedures such as stabilizing and triaging patients; NLIP emergency disaster privileges, if granted, may be further limited as is appropriate under the circumstances. Emergency disaster privileges may be granted to an LIP or NLIP only after the Emergency Privileging Authority or designee has verified a valid government-issued photo identification (issued by a state or federal agency) (e.g., driver’s license or passport) and at least one of the following:

1) Current picture ID card from a health care organization that clearly identifies professional designation (i.e., hospital photo ID card);

2) Current medical license to practice;

3) Primary source verification of medical licensure;

4) ID certifying member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;

5) ID that indicates the LIP or NLIP (collectively “Volunteer Practitioners”) has been...
granted authority by a government entity to provide patient care, treatment or services
in disaster circumstances; or

6) Presentation by a current Downtown Campus or Medical Staff appointee who can vouch
for the LIP’s or NLIP’s identity and current competence to practice medicine.

(e) Once the Volunteer Practitioner’s identity has been verified (in accordance with the above), the
Volunteer Practitioner should be directed to the Medical Director or designee in the Emergency
Department.

(f) The Volunteer Practitioner shall be assigned to a department of the Medical Staff, and a member
of the Active Staff designated to whom the Volunteer Practitioner shall report for assignment for
the treatment of patients. This mentor will provide direct observation of the Volunteer
Practitioner’s performance and will review records of patients seen by the Volunteer Practitioner
(once circumstances permit). This review will be documented on a Disaster Emergency Privilege
Application Form.

(g) Volunteer Practitioners will be readily identified by an approved disaster identification badge.

(h) Once the immediate emergency situation is under control, the Medical Staff Office will begin to
verify a Volunteer Practitioner’s credentials in accordance with the “Application for Initial
Appointment and Clinical Privileges” and “Expedited Process” policies as set forth in sections
2.B and 2.C.7. Primary source verification of licensure begins as soon as the immediate situation
is under control, and is completed within 72 hours from the time the Volunteer Practitioner
presents to the Downtown Campus. If a primary source verification is not possible within 72
hours, the reason will be documented, evidence of demonstrated ability will be noted on the
Volunteer Practitioner Review Form, and an attempt to perform the primary source verification
will be done as soon as possible.

(i) Emergency disaster privileges will be immediately terminated in the event that any information
received through the verification process and/or through the Disaster Emergency Privilege
Application Form indicates any adverse information or suggests the person is not capable of
rendering services in a disaster.

(j) Emergency disaster privileges shall be granted only for the duration of the Emergency
Operations Plan and such privileges shall cease upon official declaration from the Chief
Executive Officer, Medical Staff President, or Vice President of Medical Staff Affairs or
designee that the Emergency Operations Plan has been cancelled.

(k) Volunteer LIPs shall not carry out any clinical activities for which they do not already hold
privileges at another institution.

(l) If any problems are uncovered during a full credentials verification of a Volunteer Practitioner,
the Volunteer Practitioner may have his/her emergency disaster privileges immediately
terminated. Such termination shall not trigger any hearing or appeal rights for the Volunteer
Practitioner under the Bylaws.

After the Emergency Operations Plan has been cancelled, patients shall be assigned (by the
President of the Medical Staff) to an appointee with appropriate clinical privileges. The wishes
of the patient shall be considered in the selection of a physician.

2.1. EMERGENCY PRIVILEGES:

(a) For the purpose of this section, an “emergency” is defined as situations where clinical privileges

Credentialing Policy
to treat patients is necessary because there is a compelling patient care, treatment or service needed for the care of a specific patient and/or to perform a specific procedure, with such appointment typically not being for more than ninety (90) days.

(b) If this case is initiated by the Chief Executive Officer or designee or designated Administrator on call, the Emergency Privileging Authority (Chief Executive Officer, Medical Staff President, or Vice President of Medical Staff Affairs) may grant emergency privileges to non-Medical Staff licensed independent practitioners (NLIP) after consultation with the Department Head.

(c) In an emergency, a currently appointed Medical Staff physician (LIP) may be permitted by the Downtown Campus to exercise clinical privileges to the extent permitted by his or her license, regardless of that individual’s department status or specific grant of clinical privileges.

(d) For the purpose of this section, “emergency clinical privileges” if granted, to an LIP or NLIP only after the Emergency Privileging Authority or designee has verified at least two of the following:

1) Current picture ID card from a health care organization that clearly identifies professional designation (i.e., hospital photo ID card);

2) Current medical license to practice;

3) Primary source verification of medical licensure;

4) Presentation by a current Downtown Campus or medical staff member who can vouch for the LIP’s or NLIP’s identity and current competence to practice medicine; or

5) Drivers license or government issued ID.

(e) Once the Volunteer Practitioner’s identity has been verified (in accordance with the above), the Volunteer Practitioner should be directed to the Medical Director or physician designee on the unit.

(f) The Volunteer Practitioner shall be assigned to a department of the Medical Staff, and an appointee of the Active Staff designated to whom the Volunteer Practitioner shall report for assignment for the treatment of patients. The Active Staff appointee will provide direct observation of the Volunteer Practitioner’s performance and will review records of patients seen by the Volunteer Practitioner (once circumstances permit). This review will be documented on an Emergency Privilege Application Form.

(g) Volunteer Practitioners will be readily identified by an approved identification badge.

(h) Once the immediate emergency situation is under control, the Medical Staff Office will begin to verify a Volunteer Practitioners credentials in accordance with the Section 2.G. Procedure for Temporary Clinical Privileges.

Primary source verification of licensure begins as soon as the immediate emergency situation is under control, and is completed within 72 hours from the time the Volunteer Practitioner presents to the Downtown Campus. If a primary source verification is not possible within 72 hours, the reason will be documented, evidence of demonstrated ability will be noted on the Volunteer Practitioner Review Form, and an attempt to perform the primary source verification will be done as soon as possible.

(i) Emergency privileges will be immediately terminated in the event that any information received
through the verification process and/or through the Emergency Privilege Application Form indicates any adverse information or suggests the person is not capable of rendering services.

(j) Emergency privileges shall be granted only for the duration of 90 days.

(k) Volunteer LIPs shall not carry out any clinical activities for which they do not already hold privileges at another institution.

(l) If any problems are uncovered during a full credentials verification of a Volunteer Practitioner, the Volunteer Practitioner may have his/her emergency privileges immediately terminated. Such termination shall not trigger any hearing or appeal rights for the Volunteer Practitioner under the Bylaws.

(m) After the Emergency is under control, patients shall be assigned (by the President of the Medical Staff) to an appointee with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of a physician.

ARTICLE 3

ACTIONS AFFECTING MEDICAL STAFF APPOINTEES

A: PROCEDURE FOR REAPPOINTMENT

3.A.1. Application:

All terms, conditions, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment. If required by the appointee’s certifying board, recertification must be completed at the required intervals. Reappointments to the Medical Staff shall not exceed a period of two (2) years.

3.A.2. Factors to be Considered:

Each recommendation concerning reappointment of an individual currently appointed to the Medical Staff shall be based upon such appointee’s:

(a) ethical behavior, clinical competence, and clinical judgment in the treatment of patients;

(b) compliance with the bylaws, policies, and rules and regulations of the Medical Staff and the Downtown Campus;

(c) behavior at the Downtown Campus, including cooperation with Medical Staff and Downtown Campus personnel as it relates to patient care, the orderly operation of this Downtown Campus, and general attitude toward patients, the Downtown Campus and its personnel;

(d) use of the Downtown Campus’s facilities for patients, taking into consideration the individual’s comparative utilization patterns;

(e) current physical, mental, and emotional health status;

(f) capacity to satisfactorily treat patients as indicated by the results of the Downtown Campus’s quality improvement activities or other reasonable indicators of continuing
qualifications;

(g) satisfactory completion of such continuing education requirements as may be imposed by law, this Downtown Campus, or applicable accreditation agencies;

(h) current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments, and settlements;

(i) current licensure, including currently pending challenges to any license or registration (state or district, Drug Enforcement Administration) or voluntary relinquishment of such license or registration;

(j) voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another Downtown Campus;

(k) relevant findings from the Downtown Campus’s quality improvement activities; and

(l) the reasonable indicators of continuing qualifications.

To be eligible to apply for renewal of clinical privileges, an individual must have performed sufficient procedures, treatments, or therapies in the previous appointment term to enable the Department Head and the Credentials Committee to assess the applicant’s current clinical competence for the privileges requested.

Ongoing professional practice evaluation for all appointees of the Medical Staff will be conducted under the direction of the Credentials Committee. In conducting ongoing professional practice evaluations, the Credentials Committee is engaged in peer review activities and is functioning as a peer review committee. Information used in this evaluation may be acquired through, but not limited to, periodic chart review, direct observation, monitoring of techniques and procedures, and discussion with other individuals involved in the care of shared patients.

With input from the clinical department, the Credentials Committee shall set evaluation criteria and triggers requiring further investigation. The Credentials Committee shall direct collection of pertinent information. Each Department Head will review the collected information and report to the Credentials Committee periodically. Each department member’s report shall consist of either confirmation of the performance indicators or of performance indicator concerns.

Should there be uncertainty about a practitioner’s professional performance, the Credentials Committee shall direct a focused review of that performance, or of one or more privileges, as in 2.C.4 €.

3.A.3. Duties of Reappointees:

(a) Reappointment to the Medical Staff shall require that each reappointee assume such reasonable duties and responsibilities as the Clinical Systems Committee or the Medical Staff shall require.

(b) A reappointee must demonstrate all of the qualifications, may exercise all of the prerogatives, and must fulfill all of the obligations attendant to his or her staff category.

(c) Each reappointee must arrange, or cooperate in the arrangement of the required numbers and types of cases to be reviewed/observed by the Department Head and/or designated proctors.
(d) Failure of the reappointee to admit, treat, or attend to the number of patients established by the Credentials Committee (sufficient to permit observation and assessment), or failure of the reappointee to fulfill all requirements of appointment relating to completion of medical records, and/or cooperation with monitoring or proctoring conditions, may render the reappointee ineligible to apply for reappointment. In that event, at the expiration of previous appointment, all clinical privileges shall terminate. The reappointee may be permitted to reapply for initial appointment in accordance with this Policy, if the individual evidences a greater interest in or intention to use the Downtown Campus in the future. This provision may be waived, at the discretion of the Credentials Committee and the Clinical Systems Committee, for reappointees in specialties that do not require use of Downtown Campus facilities or treatment of hospitalized patients.

3.A.4. Clinical Privileges:

(a) Medical Staff reappointment as such shall not confer any clinical privileges or right to practice at the Downtown Campus.

(b) Each individual who has been reappointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Clinical Systems Committee.

(c) The grant of clinical privileges shall carry with it acceptance of the obligations of such privileges, including emergency service and other rotational obligations established to fulfill the Downtown Campus’s responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.

(d) Clinical privileges shall be voluntarily relinquished only in the manner that provides for the orderly transfer of such obligations.

(e) The clinical privileges recommended to the Clinical Systems Committee shall be based upon consideration of the following:

1) the reappointee’s education, training, experience, demonstrated current competence and judgment, utilization patterns, and health status;

2) the applicant’s ability to meet all current criteria for the requested clinical privileges;

3) availability of qualified physicians or other appropriate appointees to provide medical coverage for the applicant in case of the applicant’s illness or unavailability;

4) adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;

5) the Downtown Campus’s available resources and personnel;

6) any previously successful or currently pending challenges to any licensure or registration, or the voluntary relinquishment of such licensure or registration;

7) any information concerning professional review actions, voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;
8) Other relevant information, including a written report and findings by the Department Heads of each of the clinical departments in which such privileges are sought.

(f) The applicant shall have the burden of establishing qualifications for and competence to exercise the clinical privileges requested.

1) appointees* requesting procedural sedation privileges must provide proof of their ability to manage airways via the following method:

   (i) providing documentation of current ACLS, ATLS, PALS or NRP certification and complete Downtown Campus’s approved Moderate Sedation Online Course or such other course as designated by Downtown Campus. Documentation of successful completion must be provided with Hospital Moderate Sedation Privilege requests.

   (* exemption: anesthesiologists, Iowa Board of Dental Examiners General Anesthesia Permit or American Board of Emergency Medicine certified Emergency Medicine physicians.)

(g) The reports of the Department Head of each of the clinical departments in which privileges are sought shall be forwarded to the Credentials Committee and processed as a part of the application for staff reappointment in accordance with this Policy.

3.A.5. Department Head Procedure:

(a) No later than three (3) months prior to the end of the current appointment period, the Chief Executive Officer or designee shall send to the Department Head of each department a current list of all appointees who have clinical privileges in that department, together with a description of the clinical privileges each holds, accompanied by copies of their applications.

(b) The Department Head shall provide the Credentials Committee with a written report concerning each individual seeking reappointment. The Department Head shall include in each written report, when applicable, the reasons for any changes recommended in staff category, in clinical privileges, or for non-reappointment. The Department Head concerned shall be available to the Credentials Committee to answer any questions that may be raised with respect to any such report.

3.A.6. Credentials Committee Procedure:

(a) The Credentials Committee, after receiving the reports from each Department Head, shall review all pertinent information available, including all information provided from other committees of the Medical Staff and from Downtown Campus management, for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing appointment period.

(b) As part of the process of making its recommendation, to the extent and in the manner permitted by law, the Credentials Committee may require that an individual currently seeking reappointment to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee either as part of the reapplication process or at anytime during the appointment period to aid it in determining whether clinical privileges should be granted or continued. The results of such examination shall be available for the Credentials Committee’s consideration. Failure of an individual
seeking reappointment to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary relinquishment of all clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

(c) The Credentials Committee shall have the right to require the appointee to meet with the committee to discuss any aspect of the individual’s reappointment application, qualifications, or clinical privileges requested.

(d) The Credentials Committee may use the expertise of the Department Head, or any member of the department, or an outside consultant, if additional information is required regarding the appointee’s qualifications for reappointment.

3.A.7. Credentials Committee Recommendation:

(a) Except as set forth herein, not later than 60 days from the date the application is deemed complete the Credentials Committee shall make a written report and recommendation on the applicant to the Clinical Systems Committee, through the President and Chief Executive Officer, providing a copy of the recommendation to the Medical Executive Committee for its information and recommendation.

(b) If the recommendation of the Credentials Committee is delayed longer than 60 days after the application is deemed complete the Chairperson of the Credentials Committee shall send a letter to the applicant, with copies to the Clinical Systems Committee through the President and Chief Executive Officer and to the Medical Executive Committee explaining the delay.

3.A.8. Procedure Thereafter:

(a) The Medical Executive Committee shall receive the Credentials Committee’s recommendation in sufficient time for the Medical Executive Committee to comment on that recommendation, as it may deem appropriate, to the Clinical Systems Committee prior to Clinical Systems Committee action on the recommendation. If the Medical Executive Committee disagrees with the Credentials Committee’s recommendation, it shall specify to the Clinical Systems Committee in writing the reasons for that disagreement.

(b) If the recommendation of the Credentials Committee is favorable, it shall transmit the completed application along with its recommendations through the Chief Executive Officer to the Clinical Systems Committee, including the findings and comments of the Medical Executive Committee. All recommendations to reappointment must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.

(c) Any recommendations by the Credentials Committee that would entitle the affected individual to the procedural rights provided in this Policy shall be forwarded to the Chief Executive Officer or designee who shall promptly notify the affected individual by certified mail, return receipt requested. The Chief Executive Officer or designee shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing as provided in this Policy, after which time, the Chief Executive Officer or designee shall forward the recommendation of the Credentials Committee, together with all supporting documents to the Clinical Systems Committee. The chairperson of the Credentials Committee shall be available to the Clinical Systems Committee to answer any questions that may be raised with respect to the recommendation.
Upon receipt of a favorable recommendation from the Credentials Committee that the applicant be granted appointment and the requested clinical privileges, the Clinical Systems Committee (or its designated committee) may:

1) appoint the applicant and grant clinical privileges as recommended; or

2) refer the matter back to the Credentials Committee or to another source inside or outside the Downtown Campus for additional research or information; or

3) reject the recommendation. If the Clinical Systems Committee determines to reject the favorable recommendation, it should first discuss the matter with the chairperson of the Credentials Committee and the President of the Medical Staff. If the Clinical Systems Committee’s determination remains unfavorable to the applicant, that determination and the reasons in support thereof, shall be sent to the Chief Executive Officer or designee, who shall promptly notify the applicant in writing, certified mail, return receipt requested. The Clinical Systems Committee shall make no final decision until the applicant has exercised or waived the right to a hearing and appeal as outlined in this Policy.

3.A.9. Meeting with Affected Individuals:

If, during the processing of an individual’s reappointment, it becomes apparent to the Credentials Committee or its chairperson that the committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the chairperson of the Credentials Committee may notify the individual of the general tenor of the possible recommendation and ask if the individual desires to meet with the Credentials Committee prior to any final recommendation by such committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated, and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in this Policy with respect to hearings shall apply.

Minutes of the discussion in the meeting shall not be kept. However, the Credentials Committee shall indicate as part of its report to the Medical Executive Committee and the Clinical Systems Committee whether such a meeting occurred, and shall include a summary of the meeting.

3.B. CLINICAL PRIVILEGES

3.B.1. Application for Additional Clinical Privileges:

Whenever, during the term of appointment, additional clinical privileges are desired, the appointee requesting increased privileges shall apply in writing to the Chief Executive Officer on a form approved by the Clinical Systems Committee. The application shall state in detail the specific additional clinical privileges desired and the appointee’s relevant recent training and experience which justify the additional privileges. This application shall be transmitted by the Chief Executive Officer to the appropriate Department Head. Thereafter, it shall be processed in the same manner as an application for initial clinical privileges.

3.B.2. Factors to be Considered:

1. Recommendations for additional clinical privileges shall be based upon:

   1) relevant recent training;

   2) observation of patient care provided;
3) review of the records of patients treated in this or other hospitals;

4) results of the Downtown Campus’s quality improvement activities;

5) applicant’s ability to meet the qualifications and criteria for the clinical privileges requested; and

6) other reasonable indicators of the individual’s continuing qualifications for the privileges in question.

2. The recommendation for such increased privileges may carry with it such requirements for supervision or consultation or other conditions, for such periods of time as are thought necessary.

3.B.3. Ongoing Professional Practice Evaluation (OPPE)

1. OPPE is a means of continually evaluating the performance and competence of the appointees of the Medical Staff.

2. The Credentials Committee has set the following policy of OPPE review, approved by the Medical Executive Committee and the Clinical Systems Committee:

3. Each department and specialty practice shall determine which privileges and other criteria are to be reviewed for each member of that department. These may coincide with general department indicators selected for their impact on quality of care and patient safety.

4. The department may also select criteria from the physician profiles, national safety goals and from directives of the Quality Improvement Committee of the Downtown Campus and Medical Staff.

5. The Credentials Committee will ask that a member-specific evaluation using a scorecard be prepared for each appointee of the Medical Staff.

6. Each Department Head will review the OPPE scorecard report with the aid of the Quality Department and Clinical Information Services.

7. The Department Head will submit completed review, at agreed upon intervals, to the Credentials Committee for its review. A recommendation will be included.

8. The Credentials Committee will review all evaluations. The Credentials Committee may delegate some initial review to its individual members or outside reviewers. Though evaluation plan details may vary, even within a specialty, the Credentials Committee will ensure that all practitioners are evaluated using consistent criteria.

9. The Credentials Committee as a whole will arrive at a recommendation which may include:

   a) No action;

   b) A letter to the Medical Staff appointee;

   c) A review by the Department Head in three or six months;

   d) A Focused Professional Practice Evaluation; or
e) Modification or suspension of one or more privileges.

10. Recommendations of the Credentials Committee shall be transmitted to the Medical Staff appointee and appropriate Department Head.

11. The review will be ongoing, with a report submitted annually to the Credentials Committee.

3.C: PROCEDURES FOR OTHER QUESTIONS INVOLVING MEDICAL STAFF APPOINTEES

3.C.1. Initial Procedure:

(a) Whenever a concern or question has been raised regarding:

1) the clinical competence or clinical practice of any Medical Staff appointee;

2) the care or treatment of a patient or patients or management of a case by any Medical Staff appointee;

3) the known or suspected violation by any Medical Staff appointee of applicable ethical standards or the bylaws, policies, rules or regulations of the Downtown Campus or the Medical Staff, including, but not limited to the Downtown Campus’s quality assessment, risk management, and utilization review programs; and/or

4) behavior or conduct on the part of any Medical Staff appointee that is considered lower than the standards of the Downtown Campus or disruptive to the orderly operation of the Downtown Campus or its Medical Staff, including the inability of the appointee to work harmoniously with others; the President of the Medical Staff, Department Head, chairperson of the Credentials Committee, chairperson of the Quality Improvement Committee, or Chief Executive Officer (or designee) shall make sufficient inquiry to satisfy themselves that the concern or question raised is credible, after which it shall be either (i) dealt with in accordance with the Medical Staff Code of Conduct Policy to the extent applicable and appropriate; or (ii) submitted in writing to the Credentials Committee. If any of the inquiring individuals set forth in this provision believe it to be in the best interest of the Downtown Campus and the appointee concerned, they may, but are not required to, discuss the matter with the affected appointee as part of the inquiry process.

3.C.2. Initiation of Investigation:

(a) When a concern or question involving clinical competence or behavior/conduct has been referred to the Credentials Committee, that committee shall determine whether to initially discuss the matter with the appointee involved, or to begin an investigation.

(b) If a decision is made to initially discuss the matter with the appointee involved, the discussion shall not be an investigation but shall be based on the results of the inquiry made under 3.C.1. The discussion shall be at a regular or special meeting of the Credentials Committee. If the Credentials Committee determines it to be appropriate under the reported circumstances, then the matter may be dealt with informally without additional investigation or formal recommendation. Under any such informal resolution, the Credentials Committee may not impose any requirements or conditions upon the appointee, but the appointee may offer to voluntarily resolve the concern(s) reported. In the event an informal resolution is not offered by the appointee or not deemed by the Credentials Committee sufficient under the circumstances,
or in the event an informal resolution is initially reached but, in the opinion of the Credentials Committee, is not sufficiently fulfilled by the appointee, then the Credentials Committee shall proceed with the investigation and/or recommendation process.

(e) An investigation and/or recommendation process shall begin only after a formal resolution of the Credentials Committee to that effect.

(d) The Credentials Committee may, by formal resolution, initiate an investigation on its own motion without there having been an inquiry under 3.C.1. If the Clinical Systems Committee wishes to initiate an investigation, it shall also formally resolve to do so, but may delegate the actual investigation to the Credentials Committee or other investigatory body as it may determine.

(e) The chairperson of the Credentials Committee shall promptly notify the Chief Executive Officer in writing of all requests for investigation, and shall keep the Chief Executive Officer reasonably informed of all actions taken in connection therewith.

3.C.3. Investigative Procedure:

Upon resolving to initiate an investigation, the Credentials Committee shall meet as promptly as reasonably possible:

(a) If the concern as initially reported contains sufficient information to warrant a recommendation, the Credentials Committee, at its discretion, may make such a recommendation, without further investigation and without a personal interview with the appointee involved.

(b) If the concern as initially reported does not contain sufficient information to warrant a recommendation, the Credentials Committee shall promptly investigate the matter, appoint a subcommittee to do so, or appoint an ad hoc investigating committee consisting of up to three (3) persons, who may or may not hold appointments to the Medical Staff. This investigating committee shall not include partners, associates, or relatives of the individual being investigated.

(c) The Credentials Committee, its subcommittee, or the ad hoc investigating committee shall have available to it the full resources of the Medical Staff and the Downtown Campus, as well as the authority to use outside consultants, if needed. To the extent and in the manner permitted by law, the committee may also require a physical and mental examination of the individual being investigated by a physician or physicians satisfactory to the committee, and shall require that the results of such examination be made available for the committee’s consideration.

(d) The individual being investigated shall have an opportunity to meet with the investigating committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the individual shall be informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in this Policy with respect to hearings shall apply. A summary of such interview shall be made by the investigating committee and included with its report to the Credentials Committee.

(e) If a subcommittee or ad hoc investigating committee is used, the Credentials Committee may accept, modify, or reject any recommended action that is contained in the report it receives from such committee.
3.C.4. Procedure Thereafter:

(a) In acting after the investigation, the Credentials Committee may:

1) determine that no action is justified;
2) reach a voluntary resolution with the individual, subject to possible further Credentials Committee action;
3) recommend that a written warning be issued;
4) recommend that a letter of reprimand be issued;
5) recommend that a term of probation be imposed;
6) recommend a Focused Professional Practice Evaluation (“FPPE”) be imposed;
7) recommend reduction of clinical privileges;
8) recommend suspension of clinical privileges for a period of time;
9) recommend revocation of Medical Staff appointment; or
10) make such other recommendations as it deems necessary or appropriate.

(b) The Credentials Committee shall forward its recommendation to the Medical Executive Committee. The chairperson of the Credentials Committee shall be available to the Medical Executive Committee to answer any questions that may be raised with respect to the recommendation.

(c) The Medical Executive Committee shall then forward its comments and recommendations, along with those of the Credentials Committee, to the Clinical Systems Committee.

(d) Any recommendation by the Credentials Committee that would entitle the individual being investigated to the procedural rights provided in this Policy shall be forwarded to the Chief Executive Officer or designee who shall promptly notify the affected individual by certified mail, return receipt requested. The Chief Executive Officer or designee shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing.

(e) If the action of the Credentials Committee does not entitle the individual to a hearing, the action shall take effect immediately without action of the Clinical Systems Committee and without the right of appeal to the Clinical Systems Committee. A report of the action taken and reasons therefore shall be made to the Clinical Systems Committee through the Chief Executive Officer or designee, and the action shall stand unless modified by the Clinical Systems Committee.

(f) In the event the Clinical Systems Committee determines to consider modification of the action of the Credentials Committee and such modification would entitle the individual to a hearing in accordance with this Policy, it shall so notify the affected individual, through the Chief Executive Officer or designee, and shall take no final action thereon until the individual has had an opportunity to exercise the right to a hearing and appeal as provided in this Policy.

3.D: PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES

3.D.1. Grounds for Precautionary Suspension:
The President of the Medical Staff, the Department Head, or the chairperson of the Credentials Committee, together with either the Chief Executive Officer (or designee), or the co-chair of the Clinical Systems Committee, shall have the authority to suspend all or any portion of the clinical privileges of a Medical Staff appointee or other individual whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual or to the orderly operations of the Downtown Campus. Such precautionary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended individual but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.

Such precautionary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer or designee, the President of the Medical Staff, and the chairperson of the Credentials Committee, and shall remain in effect unless or until modified by the Chief Executive Officer (or designee) or the Clinical Systems Committee.

3.D.2. Credentials Committee Procedure:

(a) Any individuals who exercise authority under Section 3.D.1 to suspend clinical privileges as a precaution shall immediately report this action to the Credentials Committee to take further action in a manner that is consistent with this Policy.

(b) A review of the matter resulting in precautionary suspension shall be completed within a reasonable time period not to exceed thirty (30) days or reasons for the delay shall be transmitted to the Clinical Systems Committee so that the Clinical Systems Committee may consider whether the suspension should be lifted. In any event, the Credentials Committee shall take such further action as is required in a manner that is consistent with this Policy.

3.D.3. Care of Suspended Individual’s Patients:

(a) Immediately upon the imposition of a precautionary suspension, the appropriate Department Head or, if unavailable, the President of the Medical Staff, shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual’s patients still in the Downtown Campus. The assignment shall be effective until such time as the patients are discharged. The wishes of the patient shall be considered in the selection of the assigned appointee.

(b) It shall be the duty of all Medical Staff appointees to cooperate with the President of the Medical Staff, the Department Head concerned, the Credentials Committee, and the Chief Executive Officer in enforcing all suspensions.

3.E: OTHER ACTIONS

3.E.1 Reserved:

Reserved.

3.E.2. Failure to Complete Medical Records:

The elective and emergency admitting and clinical privileges of any individual shall be deemed to be voluntarily relinquished for failure to complete medical records in accordance with applicable regulations governing the same, after notification by the medical records department of such delinquency. Such relinquishment shall continue until all the records of the individual’s patients are no longer delinquent. Failure to complete the medical records that caused
relinquishment of clinical privileges within sixty (60) days from the relinquishment of such privileges shall constitute a voluntary relinquishment of all clinical privileges and resignation from the Medical Staff.

3.E.3. Action by State Licensing Agency:

Action by the appropriate state licensing board or agency revoking or suspending an individual’s professional license, or loss or lapse of state license to practice for any reason, shall result in voluntary relinquishment of all Downtown Campus clinical privileges as of that date, until the matter is resolved, and an application for reinstatement of privileges has been approved by the Medical Executive Committee and the Clinical Systems Committee. In the event the individual’s license is only partially restricted, the clinical privileges that would be affected by the license restriction shall be similarly restricted; provided, however, if the Credentials Committee and Clinical Systems Committee determine such partial restrictions materially affect the individual’s performance of core privileges, all of the individual’s clinical privileges at the Downtown Campus shall be deemed voluntarily relinquished until the matter is resolved.

3.E.4. Failure to be Adequately Insured:

If at any time an appointee’s professional liability insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect (in whole or in part), the appointee’s clinical privileges that would be affected shall be voluntarily relinquished or restricted as applicable as of that date until the matter is resolved and adequate professional liability insurance coverage is restored.

3.E.5. Failure to Satisfy Continuing Education Requirements:

(a) Any appointee who is ineligible for reappointment for failure to or to satisfy continuing education requirements shall be entitled to meet with a committee to be designated by the Clinical Systems Committee before final action is taken. This meeting with the Clinical Systems Committee shall not be conducted under the procedural rules provided in this Policy.

(b) If reappointment is refused by the Clinical Systems Committee, the individual shall be eligible to reapply for staff appointment, and the application shall be processed in the same manner as if it were an initial application.

3.E.6. Failure to Provide Requested Information:

If, at any time, an appointee fails to provide required information pursuant to a formal request by the Department Head, the Credentials Committee, the Medical Executive Committee, or the Chief Executive Officer, the appointee’s clinical privileges shall be deemed to be voluntarily relinquished until the required information is provided to the satisfaction of the requesting party. For purposes of this section “required information” includes, but is not limited to: (1) if permitted by applicable law, undergo a physical or mental examinations as specified elsewhere in this Policy, or (2) information necessary to explain an investigation, professional review action, or resignation from another facility or agency.

3.E.7. Procedure for Leave of Absence:

(a) Individuals appointed to the Medical Staff may, for good cause, be granted leaves of absence by the Clinical Systems Committee for a definitely stated period of time not to exceed one (1) year. Absence for longer than one (1) year shall constitute voluntary resignation of Medical Staff appointment and clinical privileges, unless an exception is made by the Clinical Systems Committee.
(b) Requests for leaves of absence shall be made to the President of the Medical Staff, and shall state the beginning and ending dates of the requested leave. The President of the Medical Staff shall transmit the request together with a recommendation to the Chief Executive Officer or designee for action by the Clinical Systems Committee.

(c) At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement with the Chief Executive Officer or designee summarizing the professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the Downtown Campus at that time. All information shall be considered by the Credentials Committee in arriving at a recommendation regarding reinstatement.

(d) If the leave of absence was for medical reasons, then the appointee must submit a report from his or her attending physician indicating that the appointee is physically and/or mentally capable of resuming a practice at the Downtown Campus and exercising the clinical privileges requested. The appointee shall also provide such other information as may be requested by the Downtown Campus at that time. After considering all relevant information, the Credentials Committee shall then make a recommendation to the Clinical Systems Committee for final action.

(e) In acting upon the request for reinstatement, the Clinical Systems Committee may approve reinstatement either to the same or a different Medical Staff category and may limit or modify the clinical privileges to be extended to the individual upon reinstatement.

3.F: INFORMAL PROCEEDINGS

Nothing in this Policy or the Medical Staff Bylaws shall preclude collegial or informal efforts to address questions or concerns relating to an individual’s practice and conduct at the Downtown Campus, and this Policy specifically encourages voluntary structuring of clinical privileges to achieve a clinical practice mutually acceptable to the individual, the Credentials Committee, Medical Executive Committee, and the Clinical Systems Committee.

3.G: CONFIDENTIALITY AND REPORTING

(a) Actions taken and recommendations made pursuant to this Policy shall be treated as confidential in accordance with applicable legal requirements and such policies regarding confidentiality as may be adopted by the Medical Staff and the Clinical Systems Committee. In addition, reports of actions taken pursuant to this policy shall be made by the Chief Executive Officer or to such governmental agencies as may be required by law.

(b) All records and other information generated in connection with and/or as a result of professional review activities shall be confidential, and each individual or committee member participating in such review activities shall agree to make no disclosures of any such information except as authorized, in writing, by the Chief Executive Officer (or designee) or by legal counsel to the Downtown Campus. Any breach of confidentiality by an individual or committee member may result in a professional review action, and/or may result in appropriate legal action to ensure that confidentiality is preserved, including application to a court of law for injunctive or other relief.

3.H: PEER REVIEW PROTECTION

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this Policy are deemed to be covered by the provisions of the Iowa Peer Review Protection Act, and the Health Care Quality Improvement Act of 1986, or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the
committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this Policy shall be considered to be acting on behalf of the Downtown Campus and the Downtown Campus’s governing body—the Clinical Systems Committee—when engaged in such professional review activities and thus shall be deemed to be “professional review bodies” as that term is defined by the Iowa Peer Review Act and the Health Care Quality Improvement Act of 1986.

ARTICLE 4

HEARING AND APPEAL PROCEDURES

4.A: INITIATION OF HEARING

4.A.1. Grounds for Hearing:

(a) An applicant or an individual holding a Medical Staff appointment shall be entitled to request a hearing whenever an unfavorable recommendation has been made by the Credentials Committee or the Clinical Systems Committee regarding the following:

1) denial of initial Medical Staff appointment;
2) denial of Medical Staff reappointment;
3) revocation of Medical Staff appointment;
4) denial of requested initial clinical privileges;
5) denial of requested additional clinical privileges;
6) decrease of clinical privileges;
7) suspension of clinical privileges for more than thirty (30) days (other than precautionary suspension);
8) imposition of mandatory Focused Professional Practice Evaluation (“FPPE”) (i.e., not only must the individual obtain a consult but must also reach agreement with the consult as to the course of treatment before that treatment can be pursued);
9) the issue of a letter of warning, a letter of admonition, or a letter of reprimand;
10) the imposition of terms of probation, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not reach agreement with the consult before the treatment is pursued); or
11) the imposition of a requirement for additional training or continuing education.

(b) No other recommendations except those enumerated in (a) of this section shall entitle the individual to request a hearing.

(c) The affected individual shall also be entitled to request a hearing before the Clinical Systems Committee enters a final decision, in the event the Clinical Systems Committee should determine without a similar recommendation from the Credentials Committee, to take any action set forth above.
4.A.2. Actions Not Grounds for Hearing:

None of the actions identified in Section 3.E shall constitute grounds for a hearing, but shall take effect without hearing or appeal.

4.B. THE HEARING

4.B.1. Notice of Recommendation:

When a recommendation is made which, according to this Policy entitles an individual to a hearing prior to a final decision of the Clinical Systems Committee, the affected individual shall promptly be given notice by the Chief Executive Officer or designee, in writing, certified mail, return receipt requested. The Chief Executive Officer or designee shall provide this notice to the individual within ten (10) business days from the date the recommendation was made. This notice shall contain:

(a) a statement of the recommendation made and the general reasons for it;

(b) notice that the individual has the right to request a hearing on the recommendation within thirty (30) days of receipt of this notice; and

(c) a copy of this Article outlining the rights in the hearing as provided for in this Policy.

4.B.2. Request for Hearing:

An individual shall have thirty (30) days following the date of the receipt of such notice within which to request the hearing. The request shall be in writing to the Chief Executive Officer or designee. In the event the individual does not request a hearing within the time and in the manner required by this Policy, the individual shall be deemed to have waived the right to the hearing and to have accepted the action involved. That action shall become effective immediately upon final Clinical Systems Committee action.

4.B.3. Notice of Hearing and Statement of Reasons:

(a) The Chief Executive Officer or designee shall schedule the hearing and shall give written notice, certified mail, return receipt requested, to the person who requested the hearing. The Chief Executive Officer or designee shall provide this notice to the individual within twenty (20) business days from the date the individual’s request for a hearing is received. The notice shall include:

1) the time, place, and date of the hearing;

2) a proposed list of witnesses, as known at that time, but which may be modified, who will give testimony or present evidence at the hearing in support of the Credentials Committee or the Clinical Systems Committee;

3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

4) a statement of the specific reasons for the recommendation, as well as the list of patient records and information supporting the recommendation. This statement, and the list of supporting patient record numbers and other supporting information, may be revised or amended at any time, even during the hearing, so long as the additional material is
relevant to the continued appointment or clinical privileges of the individual requesting the hearing. The individual and counsel, if the individual is represented by counsel, shall have sufficient time, up to thirty (30) days, to study this additional information and rebut it.

(b) The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

4.B.4. Witness List:

(a) Within ten (10) days after receiving notice of the hearing, the individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or present evidence on his or her behalf.

(b) The affected individual’s witness list, as well as the witness list of the Credentials Committee or the Clinical Systems Committee, shall include a brief summary of the nature of the anticipated testimony. Both lists shall be finalized at the time of the pre-hearing conference. However, the witness list of either party may, thereafter, in the discretion of the Presiding Officer or Hearing Panel Chairperson, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The Presiding Officer shall have the authority to limit the number of witnesses, especially character witnesses or witnesses whose testimony is merely cumulative, as set forth in Section 4.B.5.

4.B.5. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

1) When a hearing is requested, the Chief Executive Officer or designee, acting for the Clinical Systems Committee and after considering the recommendations of the President of the Medical Staff (and that of the other co-chair of the Clinical Systems Committee, if the hearing is occasioned by a Clinical Systems Committee determination) shall appoint a Hearing Panel which shall be composed of not less than three (3) members. The Hearing Panel shall be composed of Medical Staff appointees who shall not have actively participated in the consideration of the matter involved at any previous level or of physicians or lay persons not connected with the Downtown Campus, or any combination of such persons. At least a majority of Panel members will be physicians.

2) The Hearing Panel shall not include any individual who is in direct economic competition with the affected person or any such individual who is professionally associated with or related to the affected individual. Such appointment shall include designation of a Chairperson or a Presiding Officer. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.

(b) Presiding Officer:

1) In lieu of a Hearing Panel Chairperson, the Chief Executive Officer or designee may appoint an attorney at law as Presiding Officer. Such Presiding Officer must not act as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

2) If no Presiding Officer has been appointed, a Chairperson of the Hearing Panel shall be
appointed by the Chief Executive Officer or designee to serve as the Presiding Officer, and shall be entitled to one (1) vote.

3) The Presiding Officer (or Hearing Panel Chairperson) shall:

(i) act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

(ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, abusive, or that causes undue delay;

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure throughout the hearing;

(v) have the authority and discretion, in accordance with this Policy, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;

(vi) act in such a way that all information relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the Hearing Panel in formulating its recommendations; and

(vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the panel wishes to be present.

4) The Presiding Officer may be advised by legal counsel to the Downtown Campus.

(c) Hearing Officer:

1) As an alternative to the Hearing Panel described in paragraph (a) of this Section, the Chief Executive Officer or designee, after consulting with the President of the Medical Staff (and the other co-chair of the Clinical Systems Committee if the hearing was occasioned by a Clinical Systems Committee determination) may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Panel. The Hearing Officer may be appointed in lieu of a Hearing Panel only when it is acceptable to the physician who has requested the hearing.

2) The Hearing Officer may not be in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the “Hearing Panel” or “Presiding Officer” shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

4.C: HEARING PROCEDURE

4.C.1. Discovery:

(a) There is no right to discovery in connection with the hearing. However, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation
signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

1) copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at the individual’s expense;

2) reports of experts relied upon by the Credentials Committee or the Clinical Systems Committee;

3) copies of relevant portions of relevant committee or department minutes (such provision does not constitute a waiver of the state peer review protection statute); and

(b) Prior to the hearing, on dates set by the Presiding Officer or agreed upon by counsel for both sides, each party shall provide the other party with a list of proposed exhibits. All objections to documents or witnesses to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(c) Neither party, nor their attorney, nor any other person acting on their behalf, shall contact Downtown Campus employees appearing on the other party’s witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

4.C.2. Pre-Hearing Conference:

The Presiding Officer shall require counsel for the individual and for the Credentials Committee or the Clinical Systems Committee to participate in a pre-hearing conference for purposes of resolving all procedural questions in advance of the hearing. The Presiding Officer shall specifically require that:

(a) all documentary evidence to be submitted by the parties be presented to each other prior to this conference and that any objections regarding the documents be made at this conference and resolved by the Presiding Officer;

(b) evidence unrelated to the reasons for the unfavorable recommendation or unrelated to the individual’s qualifications for appointment or the relevant clinical privileges be excluded;

(c) the names of all witnesses and a brief statement of their anticipated testimony be submitted prior to this conference and that any objections regarding witnesses be made at this conference and resolved by the Presiding Officer;

(d) the time granted to each witness’ testimony and cross-examination be agreed upon, or determined by the Presiding Officer, in advance; and

(e) witnesses and documentation not provided and agreed upon in advance of the hearing may be excluded from the hearing.

4.C.3. Failure to Appear:

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the pending recommendations or actions, which shall then be forwarded to the Clinical Systems Committee for final action.
4.C.4. Record of Hearing:

The Hearing Panel shall maintain a record of the hearing by a stenographic reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Downtown Campus, but copies of the transcript shall be provided to the individual requesting the hearing at that individual’s expense. Oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

4.C.5. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer or Hearing Panel Chairperson:

1) to call and examine witnesses to the extent available;

2) to introduce exhibits;

3) to cross-examine any witness on any matter relevant to the issues and to rebut any evidence;

4) representation by counsel who may call, examine, and cross-examine witnesses and present the case. Both sides shall notify the other of the name of that counsel at least ten (10) days prior to the date of the hearing; and

5) to submit a written statement at the close of the hearing.

(b) Any individual requesting a hearing whom does not testify in his or her own behalf may be called and examined as if under cross-examination.

(c) The Hearing Panel may question the witnesses, call additional witnesses, and/or request documentary evidence.

4.C.6. Admissibility of Evidence:

The hearing process articulated here is intended to be a professional review process and should be conducted as such. That means that the rules that relate to how a case is tried in court do not apply. The hearing shall not be conducted according to rules of evidence.

Hearsay evidence shall not be excluded merely because it constitutes hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

4.C.7. Post-Hearing Memorandum:

Each party shall have the right to submit a memorandum outlining any law or authority in support of his or her position, and Hearing Panel may request such a memorandum to be filed following the close of the hearing.

4.C.8. Acknowledgment:

The Presiding Officer shall have the discretion to acknowledge any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially
noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be acknowledged or to refute the acknowledgment by written or oral presentation. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence acknowledged by the presiding officer.

4.C.9. Postponements and Extensions:

Postponements and extensions of time beyond any time limit set forth in this Policy may be requested by anyone but shall be permitted only by the Presiding Officer or the Chief Executive Officer on a showing of good cause.

4.D: HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

4.D.1. Order of Presentation:

The Credentials Committee or the Clinical Systems Committee, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

4.D.2. Basis of Decision:

(a) The Hearing Panel shall recommend in favor of the Credentials Committee or the Clinical Systems Committee unless it finds that the individual who requested the hearing has proved that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial evidence.

(b) The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

1) oral testimony of witnesses;

2) memorandum of points and authorities presented in connection with the hearing;

3) any information regarding the individual who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;

4) any and all applications, references, and accompanying documents;

5) other documented evidence, including medical records; and

6) any other evidence that has been admitted.

4.D.3. Adjournment and Conclusion:

The Presiding Officer may, without special notice, adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and/or questions by the Hearing Panel, the hearing shall be closed.


Within twenty (20) days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript), the Hearing Panel shall conduct its
deliberations outside the presence of any other person except the Presiding Officer, and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for the Panel’s decision.


The Hearing Panel shall deliver its report and recommendation to the Chief Executive Officer or designee who shall forward it, along with all supporting documentation, to the Clinical Systems Committee for further action. The Chief Executive Officer or designee shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the Credentials Committee for information and comment.

4.E: APPEAL PROCEDURE

4.E.1. Time for Appeal:

Within ten (10) days after notice of the Hearing Panel’s recommendation, either party may request an appellate review. The request shall be in writing, and shall be delivered to the Chief Executive Officer or designee either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) days as provided herein, both parties shall be deemed to have waived appellate review, and the Hearing Panel’s report shall be forwarded to the Clinical Systems Committee for final action.

4.E.2. Grounds for Appeal:

The grounds for appeal shall be that:

(a) there was substantial failure to comply with this Policy, and/or the Downtown Campus or Medical Staff bylaws during or prior to the hearing, so as to deny due process or a fair hearing; or

(b) the recommendations of the Hearing Panel were made arbitrarily, capriciously, or with prejudice; or

(c) the recommendations of the Hearing Panel were not supported by substantial evidence.

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

Whenever an appeal is requested as set forth in the preceding sections, the co-chairs of the Clinical Systems Committee shall, within ten (10) days after receipt of such request, schedule and arrange for an appellate review. The affected individual shall be given notice of the time, place, and date of the appellate review. The date of appellate review shall be not less than ten (10) days, nor more than (30) days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from an appointee who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made. The time for appellate review may be extended by the co-chairs of the Clinical Systems Committee for good cause.

4.E.4. Nature of Appellate Review:

(a) The co-chairs of the Clinical Systems Committee shall appoint a Review Panel composed of not less than three (3) persons, either members of the Clinical Systems Committee or others, including but not limited to reputable persons outside the Downtown Campus, to consider the
record upon which the recommendation before it was made, or the Clinical Systems Committee may hear the appeal as a whole body.

(b) The Review Panel may in its discretion accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was denied.

(c) Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes. The Review Panel shall recommend final action to the Clinical Systems Committee.

(d) The Clinical Systems Committee may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Clinical Systems Committee’s ultimate legal responsibility to grant appointment and clinical privileges. In the event the Clinical Systems Committee determines to modify or reverse the recommendation of the Review Panel and such action would entitle the affected individual to a hearing in accordance with this Policy, it shall so notify the affected individual through the Chief Executive Officer, and shall take no final action thereon until the individual has exercised or has waived the procedural rights provided in this Policy.

4.E.5. Final Decision of the Clinical Systems Committee:

Within thirty (30) days after receipt of the Review Panel’s recommendation, the Clinical Systems Committee shall render a final decision in writing, including specific reasons, and shall deliver copies thereof to the affected individual and to the chairperson of the Credentials Committee, in person or by certified mail, return receipt requested.

4.E.6. Further Review:

Except where the matter is referred for further action and recommendation in accordance with Section 4.E.4, the final decision of the Clinical Systems Committee following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred pursuant to Section 4.E.4. for further action and recommendation, such recommendation shall be promptly made to the Clinical Systems Committee in accordance with the instructions given by the Clinical Systems Committee. This further review process and the report back to the Clinical Systems Committee shall in no event exceed thirty (30) days except as the parties may otherwise stipulate.

4.E.7. Right to One Hearing and One Appeal Only:

No applicant or Medical Staff appointee shall be entitled to more than one (1) hearing and one (1) appellate review on any matter which may be the subject of an appeal. If the Clinical Systems Committee determines to deny initial Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current appointee, that individual may not apply for staff appointment or for those clinical privileges at this Downtown Campus for a period of five (5) years unless the Clinical Systems Committee provides otherwise.

ARTICLE 5

AMENDMENTS
This Policy is part of the Downtown Campus’s Medical Staff Bylaws and may be amended in accordance with Article 8 of the Medical Staff Bylaws.

ARTICLE 6

ADOPTION OF CREDENTIALS POLICY

This Policy is part of the Downtown Campus’s Medical Staff Bylaws and shall be adopted in accordance with Article 9 of the Medical Staff Bylaws.

APPROVED BY THE CLINICAL SYSTEMS COMMITTEE:

APPROVED BY THE PRESIDENT OF THE UNIVERSITY OF IOWA:

APPROVED BY THE BOARD OF REGENTS:
POLICY ON CREDENTIALING

ADVANCED PRACTICE PROVIDERS

UNIVERSITY OF IOWA HOSPITALS AND CLINICS d/b/a
UNIVERSITY OF IOWA HEALTH CARE MEDICAL CENTER DOWNTOWN

500 E. Market Street, Iowa City, Iowa 52245

January 31, 2024
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POLICY ON CREDENTIALING

ADVANCED PRACTICE PROVIDERS

1. SCOPE AND OVERVIEW OF POLICY

This Policy on Credentialing Advanced Practice Providers (the “Policy”) addresses those practitioners other than Physicians, Dentists, and Podiatrists who may function at University of Iowa Health Care Medical Center Downtown (the “Downtown Campus”). When the Clinical Systems Committee determines that it is consistent with the Downtown Campus’ mission and otherwise in the best interest of the Downtown Campus to grant privileges to permit a practitioner other than Physicians, Dentists, or Podiatrists, the Clinical Systems Committee shall adopt a policy that establishes the minimum qualifications that must be demonstrated by such practitioners, as well as the authorized clinical privileges or scope of practice for these practitioners at the Downtown Campus. Once this has been accomplished, the remainder of this Policy shall become applicable.

This Policy contains the credentialing processes for Advanced Practice Providers (“APPs”). APPs are those practitioners, other than Physicians, Dentists, and Podiatrists who are privileged to function within the Downtown Campus. Such practitioners may include physician assistants, advanced practice registered nurses, or surgical assistants.

With respect to these practitioners, the supervising and/or employing Medical Staff appointee (or appointees) remains fully responsible for the actions of the APPs at the Downtown Campus.

This Policy may be supplemented by separate Downtown Campus policies that address each specific category of practitioner. In the event of any conflict between this Policy and any supplemental policies, this Policy shall control. The separate policies for each category of practitioner shall articulate: (1) the required qualifications and/or training beyond those set forth in this Policy, (2) a detailed description of authorized clinical privileges and/or scope of practice, (3) any specific conditions that apply to functioning within the Downtown Campus.

The definitions in Article 1 “Definitions” of the Medical Staff Bylaws shall apply to terms used in this Policy.

2. ADVANCED PRACTICE PROVIDERS

2.1 Qualifications for Scope of Practice – Hospital Based

(a) Classes of APPs other than Physicians, Dentists and Podiatrists who (1) are approved by the Clinical Systems Committee, and (2) desire to provide services only under the direct supervision of (or as employees of) a Medical Staff appointee are eligible to apply for Advanced Practice Provider Staff status at the Downtown Campus.

(b) In order to be granted a scope of practice as an APP Staff, individuals must satisfy the following qualifications:

(1) are currently licensed or certified to practice their profession in Iowa (if applicable);
(2) are located close enough to the Downtown Campus to provide timely and continuous care for their patients in the Downtown Campus;

(3) possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Downtown Campus; and

(4) are able to document their:

(i) background, relevant training, experience, and current clinical competence;

(ii) adherence to the ethics of their profession;

(iii) good reputation and character;

(iv) health status, including physical health and mental and emotional stability;

(v) ability to work harmoniously with others sufficiently to convince the Downtown Campus that all patients treated by them will receive quality care and that the Downtown Campus will be able to operate in an orderly manner; and

(vii) satisfaction of all continuing education requirements relating to re-certification and licensure.

2.2 Qualifications for Scope of Practice – Telemedicine

(a) Classes of Telemedicine APPs other than Physicians, Dentists and Podiatrists who (1) are approved by the Clinical Systems Committee, and (2) desire to provide services only under the direct supervision of (or as employees of) a Medical Staff appointee are eligible to apply for Advanced Practice Provider Staff status at the Downtown Campus.

(b) The Telemedicine APPs shall consist of APPs who will be providing patient care, treatment and services only through an electronic communication link and have been granted privileges by the medical staff and governing body of another Medicare participating hospital or Telemedicine entity (a “Distant-Site Hospital” or “Telemedicine Entity,” respectively) with which the Downtown Campus has a written telemedicine services agreement that meets applicable regulatory requirements and provides for delegated credentialing. For all Distant-Site Hospital or Telemedicine Entity APPs that will provide telemedicine services under the agreement, the Distant-Site Hospital or Telemedicine Entity’s medical staff and governing body will be responsible for: (i) conducting an evaluation of each APPs licensure and qualifications pursuant to the provision of the Distant Site Hospital or Telemedicine Entity’s medical staff and hospital bylaws, rules and regulations, and granting membership and clinical privileges at the Distant-Site Hospital or Telemedicine Entity in accordance with those provisions; (ii) providing the Downtown Campus with a list of those APPs covered by the agreement that includes the licensure information and clinical privileges that have been granted to each APP; and (iii) providing the Downtown Campus with an updated list of APPs and, if applicable, physicians, covered by the agreement when necessary to reflect
additions, deletions, and changes. Upon receipt from the Distant-Site Hospital or Telemedicine Entity of the information required by this Section 2.2(b) each APP may be admitted as a member of the Telemedicine APP Consulting Staff and granted clinical privileges. An APP who has privileges limited or terminated at the Distant-Site Hospital or Telemedicine Entity will have his/her privileges similarly limited or terminated at the Downtown Campus without a right of hearing or appeal under these Bylaws.

(c) In order to be granted a scope of practice as a Telemedicine APP Consulting Staff, individuals must satisfy the following qualifications:

(1) are currently licensed or certified to practice their profession in Iowa (if applicable);

(2) possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the hospital; and

(3) are able to document their:

   (i) background, relevant training, experience, and current clinical competence;

   (ii) adherence to the ethics of their profession;

   (iii) good reputation and character;

   (iv) health status, including physical health and mental and emotional stability;

   (v) ability to work harmoniously with others sufficiently to convince the Downtown Campus that all patients treated by them will receive quality care and that the Downtown Campus will be able to operate in an orderly manner; and

   (vii) satisfaction of all continuing education requirements relating to re-certification and licensure.

(d) Telemedicine APP Privileges. The Downtown Campus shall determine which patient care, treatment and services may be provided through an electronic communication link. The clinical services offered must be consistent with commonly accepted quality standards. APPs providing care, treatment and services to patients via telemedicine link are subject to the Downtown Campus’s credentialing and privileging process and must apply for, and be granted privileges to provide telemedicine services to patients at the Downtown Campus. If the Downtown Campus has arranged for telemedicine services to be provided by a Distant-Site Hospital or Telemedicine Entity, upon the Clinical Systems Committee’s approval, the Downtown Campus may rely on the credentialing and privileging decisions of the Distant-Site Hospital or Telemedicine Entity with respect to a telemedicine APP if the Downtown Campus has a written agreement with the Distant-Site Hospital or Telemedicine Entity which requires it to: (a) determine in accordance with Iowa law which categories of APPs are eligible candidates for privileges; (b) grant APP privileges after considering the
recommendations of the existing members of its medical staff; (c) ensure its medical staff has bylaws; (d) approve its medical staff bylaws and other medical and APP staff rules and regulations; (e) ensure the APP staff is accountable to the hospital’s governing body for the quality of care provided to patients; (f) ensure its criteria for granting APP privileges includes the individual’s character, competence, training, experience and judgement; (g) ensure under no circumstances its APP privileges are dependent solely upon certification, fellowship or membership in a specialty body or society; (h) participate in the Medicare program; and (i) ensure all APPs providing telemedicine services are appropriately licensed. The Downtown Campus’ reliance on the credentialing and privileging decision of the Distant-Site Hospital or Telemedicine Entity will be appropriately documented in the individual’s Medical Staff file at the Downtown Campus. An individual’s telemedicine privileges at the Downtown Campus will change automatically with any change in the privileges at the Distant-Site Hospital or Telemedicine Entity and will terminate without the right to any hearing or appeal upon (i) the termination of the services agreement or delegated credentialing agreement between the Downtown Campus and Distant-Site Hospital or Telemedicine Entity or (ii) termination of board certification

2.3 No Entitlement to Medical Staff Appointment

(a) Individuals applying to practice as APPs are not eligible for appointment to the Medical Staff of the Downtown Campus, or entitled to the rights, privileges, and/or prerogatives attendant Medical Staff appointment.

(b) Advanced Practice Providers practice at the Downtown Campus at the discretion of the Clinical Systems Committee and as such may be denied access and/or terminated at will by the Clinical Systems Committee.

2.4 Application to Practice as an Advanced Practice Provider

(a) A Letter of Intent on behalf of an applicant shall be submitted to the President of the Medical Staff and the Chief Executive Officer or designee by the supervising physician and APP.

(b) An application to practice as an APP shall be submitted by the applicant to the Medical Staff Office and shall contain a request for the particular scope of practice desired by the applicant. The applicant must identify a supervising physician who is an appointee to the Active Staff or Associate Staff categories of the Medical Staff and willing to serve as the supervising physician during the applicant’s service at the Downtown Campus.

The completed application shall include a current copy of the applicant’s license/certificate to practice (if applicable), Drug Enforcement Administration Certification (if applicable), and certificates from all graduate, post-graduate training program completion and the supervising physician/Collaboration portion of the statewide application for non-physician applicants.

(c) The application shall require information about the applicant’s professional qualifications, including:
(1) the names and addresses of at least three (3) practitioners who have had recent experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant’s current professional competence and character;

(2) the names and addresses of the department heads, if any, and all hospitals or other institutions at which the applicant has practiced or trained;

(3) information as to whether the applicant’s right to practice has ever been relinquished, denied, revoked, suspended, reduced, or not renewed at any other hospital or health care facility;

(4) information as to whether the applicant has ever withdrawn his or her application to practice or resigned such practice before a final decision by the hospital’s or health care facility’s governing board;

(5) information as to whether the applicant’s (a) membership in any local, state, or national professional society, (b) license to practice any profession in any state (if applicable), or (c) Drug Enforcement Administration certificate (if applicable) is, or has ever been, suspended, modified, terminated, restricted, or is currently being challenged;

(6) information as to the applicant’s professional liability insurance coverage, the name of the insurance company, the amount and classification of such coverage, whether said insurance policy covers the scope of practice the applicant seeks to exercise at the Downtown Campus, and a consent to the release of information from present and past professional liability insurance carriers;

(7) information concerning the applicant’s malpractice litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the applicant may deem appropriate;

(8) information concerning the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid, or any other government sponsored program or any private or public medical insurance program;

(9) current information regarding the applicant’s physical and mental health status;

(10) information as to whether the applicant has ever been a defendant in a criminal action or convicted of a crime, with details about any such instance;

(11) information on citizenship and/or visa status of the applicant;
(12) the applicant’s written or electronic signature; and

(13) such other information as the Downtown Campus may require.

2.5 Burden of Providing Information

(a) The applicant shall have the burden of producing information deemed adequate by the Downtown Campus for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.

(b) The applicant shall have the burden of proving that all the statements made and information given on the application are true and correct.

2.6 Release and Immunity

By applying for privileges at the Downtown Campus as an APP, the applicant expressly accepts and agrees to the following conditions (whether or not the requested privileges are granted):

(a) The applicant specifically authorizes the Downtown Campus and its authorized representatives to consult with any third party who may have information bearing on the applicant’s professional qualification, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the applicant’s qualification for a scope of practice as an Advanced Practice Provider. This authorization includes the right to inspect or obtain any and all communications, reports, records, and documents from said third parties. The applicant also specifically authorizes said third parties to release said information to the Downtown Campus and its authorized representatives upon request.

(b) To the fullest extent permitted by law, the applicant releases from any and all liability, extends absolute immunity to, and agrees not to sue the Downtown Campus, its authorized representatives, and any third parties with respect to any acts, communications or documents, recommendations, or disclosures involving the applicant.

2.7 Submission of Application

A completed application to practice as an Advanced Practice Provider shall be submitted to the Medical Staff Office and must be accompanied by the designated processing fee (if applicable).

An application shall be deemed to be completed when all questions on the application have been answered, all supporting documentation has been supplied, and all information verified. Under no circumstances may curriculum vitae be used in place of a formal application. An application that continues to be incomplete ninety (90) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate response from references. An incomplete application will not be processed.
After reviewing the application to determine that all questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with the primary sources, the Medical Staff Office shall transmit the completed application along with all supporting materials to the appropriate Department Head.

2.8 Credentialing Procedure

(a) The appropriate Department Head shall evaluate the applicant’s education, training, and experience and provide the Credentials Committee with a written report concerning the applicant’s qualification for the requested privileges. The recommendation shall be made part of the application. The Department Head may meet with the applicant to discuss any aspect of the application.

(b) The Credentials Committee shall examine the application and all supporting information and documentation and make a recommendation regarding the applicant’s qualification for the requested privileges as an APP. In evaluating the application, the Credentials Committee may meet with the applicant and/or the supervising/employing appointee.

(c) The Credentials Committee must specifically recommend the privileges requested by the APP. If the Credentials Committee’s recommendation is favorable to the applicant, it shall be forwarded to the Clinical Systems Committee.

(d) If the Credentials Committee’s recommendation is adverse to the applicant, the applicant and the supervising/employing appointee shall have a right, pursuant to Section 2.11 of this Policy, to appear personally before the Credentials Committee to discuss the Credentials Committee’s recommendation before the committee prepares its final recommendation. This meeting shall be informal and shall not be considered a hearing. Following this meeting, the Credentials Committee shall forward its recommendation to the Clinical Systems Committee.

(e) If following a favorable recommendation by the Credentials Committee, final Clinical Systems Committee action is adverse to the applicant, then the procedure described in Section 2.11 shall be before the Clinical Systems Committee rather than the Credentials Committee.

2.9 Expedited Process

(a) If recommended by the applicable Department Head, applications for initial credentialing may be processed as set forth in this section in a timeframe of no less than one week or more than 90 days, unless another time frame is approved by the Vice President of Medical Staff Affairs, so long as they meet the following conditions:

(1) the applicant has successfully completed appropriate education for which privileges are requested with no disciplinary actions or conditions imposed during training;

(2) the applicant has not changed practice locations more than three times in the past 10 years;
all reference evaluations are completed and received within a reasonable time of the initial request;

all references contain only favorable evaluations, including unqualified recommendations for appointment and clinical privileges;

the applicant’s claims activity (including past malpractice claims and settlements) is reasonable in light of his or her profession and there have been no adverse malpractice judgments;

there are no current or previously successful challenges to licensure, registration or certification;

there has been no involuntary termination, limitation, restriction, reduction, denial or loss of the applicant’s staff credentials or privileges at any hospital or other entity;

there has been no investigation into and no disciplinary action taken relating to the applicant’s staff credentials or privileges at any hospital or other entity; and

there have been no questions raised about the applicant’s qualifications.

An applicant for privileges is ineligible for the expedited process if either of the following has occurred:

(i) the applicant submits an incomplete application; or

(ii) the Medical Executive Committee makes a final recommendation that is adverse or has limitations.

The following circumstances will be evaluated on a case-by-case basis and may result in ineligibility of the expedited process.

(i) The Downtown Campus determines that there has been an unusual pattern of, or an excessive number of, professional liability actions resulting in one or more final judgments against the applicant.

(b) The chairperson of the Credentials Committee, acting on behalf of the committee, shall review the report from each Department Head and all relevant information and prepare a report containing a recommendation on credentials and privileges. This report shall be forwarded to the President of the Medical Staff.

c) The President of the Medical Staff, acting on behalf of the Medical Executive Committee, shall review the report and recommendation made by the chairperson of the Credentials Committee. If the President of the Medical Staff concurs with the recommendation, the recommendation shall be forwarded to the Chief Executive Officer or designee.

d) If the Department Head, the chairperson of the Credentials Committee, the President of the Medical Staff, or the Chief Executive Officer (or designee) has
any questions about the applicant, the questions shall be noted and the matter shall be referred to the full Credentials Committee for further action.

(e) The Chief Executive Officer or designee may grant the applicant interim credentials and privileges for a period not to exceed 120 days.

A report regarding all APP applicants who are granted interim credentials and privileges shall be forwarded to the Credentials Committee for its information, the Medical Executive Committee for review and comment, and to the Clinical Systems Committee for final action.

2.10 Conditions of Practice Applicable to Advanced Practice Providers

(a) Any activities permitted by the Clinical Systems Committee to be done at the Downtown Campus by an APP shall be done only under the direct supervision of the Medical Staff appointee who is supervising/employing that individual. Except as provided by law or Downtown Campus policy, “direct supervision” shall not require the actual physical presence of the supervising/employing Medical Staff appointee.

(b) Should the Medical Staff appointment or clinical privileges of the appointee supervising/employing the APP be revoked or terminated, the privileges of the APP shall automatically be terminated. In addition, the APP may function in the Downtown Campus only so long as he/she remains an employee of or is supervised by a Medical Staff appointee.

(c) Should any Downtown Campus employee who is licensed or certified by the state have any question regarding the clinical competence or authority of the APP either to act or to issue instructions outside the physical presence of the supervising/employing medical staff appointee in a particular instance, such Downtown Campus employee has the right to require that the APP’s supervising/employing Medical Staff appointee validate, either at the time or later, the instructions of the APP. Any act or instruction of the APPs shall be delayed until such time as the Downtown Campus employee can be certain that the act is clearly within the APP’s privileges as granted by the Clinical Systems Committee. At all times the supervising/employing Medical Staff appointee will remain responsible for all acts of the APP while at the Downtown Campus. The supervising physician retains ultimate responsibility for directing and the specific patient’s course of medical treatment.

(d) The number of APPs acting under the supervision of (and/or as employees of) one Medical Staff appointee, as well as the acts they may undertake, shall be consistent with the applicable state statutes and regulations, the rules and regulations of the Medical Staff, and the policies of the Clinical Systems Committee.

(e) For APPs with privileges at the Downtown Campus who are not Downtown Campus employees, it shall be the responsibility of the APP’s employer to provide professional liability insurance for the APP in amounts required by the Clinical Systems Committee that covers any activities of the APP at the Downtown Campus, and to furnish evidence of such to the Downtown Campus. The APP shall act at the Downtown Campus only while such coverage is in effect.
2.11 Application for Renewed Scope of Practice

(a) An APP’s privileges shall be granted for a period not to exceed two (2) years. In seeking renewed privileges, APP shall be required to complete an appropriate reapplication form.

(b) These applications shall be evaluated in the same manner and shall follow the same procedures as initial applications for privileges.

2.12 Procedural Rights for Advanced Practice Providers

APPs are not entitled to the hearing and appeals procedures set forth in the Downtown Campus’s Credentialing Policy (Article 10 of the Medical Staff Bylaws). However, in the event an APP is not granted the requested privileges, or has his/her privileges terminated, the APP and his or her supervising/employing Medical Staff appointee shall have the right to appear personally before the Credentials Committee to discuss the recommendation or action. The APP must request such a meeting with the Credentials Committee in writing. Should the APP request a meeting in a timely manner, he/she shall be informed of the general nature of the evidence supporting the recommendation/action at least ten (10) days prior to the meeting. At the meeting, the APP shall be invited to discuss, explain, or refute the recommendation or action, but such meeting shall not constitute a hearing and none of the procedural rules set forth in the Downtown Campus’s Credentialing Policy with respect to hearings and appeals shall apply. However, minutes of the discussion in the meeting shall be kept and shall be attached to the Credentials Committee’s recommendation that is sent to the Clinical Systems Committee.

3. DOWNTOWN CAMPUS EMPLOYEES

With the prior written authorization of the Chief Executive Officer or his/her designee, a Downtown Campus employee with an appropriate license and qualifications, and when consistent with his/her assigned Downtown Campus functions, may be credentialed as an APP under this Policy. Being credentialed and privileged may be a requirement for certain employment positions. Notwithstanding the foregoing, a credentialed Downtown Campus employee shall remain subject to and limited by i) the job description and employment policies made specifically applicable to such employee; and ii) the Downtown Campus’ policies, procedures and manuals generally applicable to all employees, as each may be established from time to time by the Downtown Campus’s Chief Executive Officer or designees. The Credentials Committee will have general oversight responsibility for determining the specific set of Downtown Campus privileges that will be available for APPs to request. Being credentialed and having privileges as an Advanced Practice Provider shall not be construed as satisfactory job performance nor shall it change an employee’s “at will” employment status.

4. AMENDMENTS

This Policy is part of the Downtown Campus’s Medical Staff Bylaws and may be amended in accordance with Article 8 of the Medical Staff Bylaws.

5. ADOPTION

This Policy is part of the Downtown Campus’s Medical Staff Bylaws and shall be adopted in accordance with Article 9 of the Medical Staff Bylaws.
APPROVED BY THE CLINICAL SYSTEMS COMMITTEE:

APPROVED BY THE PRESIDENT OF THE UNIVERSITY OF IOWA:

APPROVED BY THE BOARD OF REGENTS: