

AMENDMENTS TO THE BYLAWS, RULES AND REGULATIONS OF THE UNIVERSITY OF IOWA HOSPITALS AND CLINICS AND ITS CLINICAL STAFF

The University of Iowa Hospitals and Clinics (“UIHC”) last revised the Bylaws, Rules & Regulations of the University of Iowa Hospitals and Clinics and its Clinical Staff (“Bylaws”) in December 2016. Current leadership desires to make structural changes to the Bylaws to:

- (1) optimize the collaboration between UIHC and its Clinical Staff to improve clinical operations;
- (2) more evenly balance and coordinate the functions of quality, safety, finance, and operations;
- and
- (3) more explicitly provide a voice for all clinical concerns to be heard in a single forum.

These recommendations include:

Section	Explanation/Rationale
1. Article II, Section 2(A)	Language added to reinforce the integrated structure of Carver College of Medicine (CCOM), University of Iowa Physicians (UIP), and University of Iowa Hospitals and Clinics (UIHC).

Article II, Section 2(A) is amended to read as follows:

Section 2: Administration

A. Organization

UIHC is a component of University of Iowa Health Care, which is comprised of UIHC, Carver College of Medicine, and the faculty practice plan referred to as University of Iowa Physicians. Consistent with the authority delegated by the Board of Regents as described in Article III, Section 1, the President of the University of Iowa delegates to the Vice President for Medical Affairs responsibility for the operations of University of Iowa Health Care. The Vice President for Medical Affairs delegates to the Chief Executive Officer of UIHC the responsibility for the operation of the hospitals and clinics. This is achieved through an organizational structure defined by the President of the University.

Section	Explanation/Rationale
2. Article II, Section 3(A)	Cardiothoracic surgery department was made a division of the Department of Surgery to facilitate collaboration among surgeons and facilitate coordinated leadership.

Article II, Section 3(A) is amended to read as follows:

Section 3: Clinical Services and Administration

A. Organization

The Clinical Staff of the UIHC shall be organized into Clinical Services coordinate with the departmental structure plus the Hospital Dentistry Clinical Service. Each Clinical Service shall have a Head who shall be responsible for the overall supervision of the clinical, teaching and research functions within his/her service. The Clinical Services shall be as follows:

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|---------------------------------|--------------------------------------|
| Anesthesia | Orthopaedics and Rehabilitation |
| Dermatology | Otolaryngology-Head and Neck Surgery |
| Emergency Medicine | Pathology |
| Family Medicine | Pediatrics |
| Hospital Dentistry | Psychiatry |
| Internal Medicine | Radiation Oncology |
| Neurology | Radiology |
| Neurosurgery | Surgery |
| Obstetrics-Gynecology | Urology |
| Ophthalmology & Visual Sciences | |

Section	Explanation/Rationale
3. Article II, Section 3(C)	To preserve the five (5) person Nominating Committee size but accommodate both the new co-Chair of the Clinical Systems Committee being a member of the Nominating Committee, reduced the number of members of the Nominating Committee selected by the co-Chairs of the Clinical Systems Committee and Dean of CCOM from three (3) members to two (2).

Article II, Section 3(C) is amended to read as follows:

C. Chief of Staff

1. Appointment

- a. Nominating Committee: The co-Chairs of the Clinical Systems Committee and the Dean of the College of Medicine shall select two (2) members of the Clinical Systems Committee to serve with them as a nominating committee of five (5). The nominating committee shall select not more than

two (2) candidates for the position of Chief of Staff after seeking advice from the Clinical Staff.

Section	Explanation/Rationale
4. Article III, Section 1 (and globally throughout the document)	Changed the name of the committee formerly known as the Hospital Advisory Committee to better reflect the role of Carver College of Medicine, University of Iowa Physicians, and University of Iowa Hospitals and Clinics to jointly oversee clinical operations.

Article III, Section 1 (and globally throughout the document) is amended to read as follows:

ARTICLE III: CLINICAL SYSTEMS COMMITTEE AND ITS SUBCOMMITTEES

Section	Explanation/Rationale
5. Article III, Section 2	Addressed The Joint Commission (TJC) suggestions about elements that were implicitly in the Bylaws that TJC would recommend be made more explicit.

Article III, Section 2 is amended to read as follows:

Section 2: Purpose

The purpose of this body shall be:

- A. To cause all patients to be properly evaluated, admitted to the UIHC if appropriate, and/or treated in the clinics, receive proper diagnosis, treatment and care and to make recommendations to the Board of Regents on matters of clinical management and planning;
- B. To further the objectives of this health science center in education and research;
- C. To represent and act on behalf of the Clinical Staff between annual meetings of the Clinical Staff. This authority is delegated to the Clinical Systems Committee by approval of these Amended and Restated Bylaws, Rules and Regulations;
- D. To provide a means whereby problems of a clinical-administrative nature may be discussed between the Clinical Staff and the UIHC administration;
- E. To initiate and maintain policies, rules, and regulations relating to the coordinate operation of the Clinical Services at University of Iowa Hospitals and Clinics;
- F. To provide a forum for the review of operational problems, recommended action on medical administrative matters, and the formulation of policies and procedures;
- G. To provide a forum whereby the UIHC administration may discuss programs and proposals of an institution-wide nature with the Clinical Staff;

- H. To pass judgment on major proposals affecting the clinical-administrative operations of the institution;
- I. To designate subcommittees to conduct the business of UIHC and its Clinical Staff consistent with these Amended and Restated Bylaws, Rules and Regulations, and to receive and act upon subcommittee reports; and
- J. To provide a medium for dissemination of information to the Clinical Staff.

Section	Explanation/Rationale
6. Article III, Section 3	Changed Clinical Systems Committee membership. Removed ex officio membership for UIHC associate directors and explicit option to appoint members who have previously made extraordinary contributions to UIHC. Added Vice President of Medical Affairs-appointed members.

Article III, Section 3 is amended to read as follows:

Section 3: Membership

Membership of the Clinical Systems Committee shall consist of the following:

- A. The Heads of the respective Clinical Services.
- B. The Chief Executive Officer.
- C. The Chief of Staff.
- D. The Vice President of Medical Affairs.
- E. The Dean of the College of Medicine (if not the same individual as the Vice President for Medical Affairs).
- F. The Executive Director of University of Iowa Physicians.
- G. Executive Dean of the Carver College of Medicine.
- H. The Director of the Clinical Cancer Center.
- I. Five at-large members of the Clinical Staff. These members shall be elected by ballot with each Active Clinical Staff member, excluding those Clinical Staff members who are already members of the Clinical Systems Committee, allotted a single vote. No more than two of the at-large members shall have clinical privileges in the same Clinical Service. Elections shall be held every three (3) years on April 1. In the event that an at-large position becomes vacant more than six (6) months prior to a scheduled election, a special election shall be held. The term of the member(s) elected in the special election will run until the next regular election. A member-at-large shall remain a member of the Committee until resignation or until replaced by a subsequent at-large election. An at-large member may be elected to no more than two (2) consecutive terms. Notwithstanding the foregoing, an at-large member of the Clinical Staff elected to the Clinical Systems

Committee may resign at any time, in which instance an election shall be held. In addition, an at-large member of the Clinical Staff elected to the Clinical Systems Committee may be removed by Vice President for Medical Affairs or by the Clinical Systems Committee, by a two-thirds vote, for conduct detrimental to the interest of the UIHC or its Clinical Staff, or if the member is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office. Notwithstanding the foregoing, in the event removal is by the Clinical Systems Committee, a removal notice of the meeting at which such action shall be decided shall be given in writing to the at-large member of the Clinical Staff being considered for removal at least ten (10) days in advance of the meeting. The at-large member of the Clinical Staff shall be afforded the opportunity to speak prior to the taking of any vote on such removal by the Clinical Systems Committee.

J. Such individuals appointed by the Vice President for Medical Affairs.

Section	Explanation/Rationale
7. Article III, Section 4	Clarified that representatives attending Clinical Systems Committee meetings on behalf of a member may not vote.

Article III, Section 4 is amended to read as follows:

Section 4: Meetings

The Clinical Systems Committee shall meet at least quarterly. The co-Chairs may schedule additional meetings as deemed necessary. Special meetings may be called at the request of any three (3) members of the Committee. An agenda shall be prepared by the co-Chairs and forwarded to Committee members prior to each meeting. Any member of the Clinical Staff may request that specific topics be included on the agenda. Any member of the Clinical Systems Committee who is unable to attend a meeting may designate a person to represent the member at the meeting. The representative may not cast the vote of the member and does not count for purposes of meeting quorum as further described in Article III, Section 5. If a member or the member's designee is not present or represented at two (2) consecutive regularly scheduled meetings without cause acceptable to the Committee, the member shall be notified by the co-Chairs that a third consecutive absence from a regularly scheduled meeting will lead to the designation of an alternate. Upon the third consecutive unexcused failure to be present or represented, the co-Chairs, after consultation with the member and with the approval of the Committee, shall designate an alternate to serve when the member is unable to attend. In the case of an at-large member, the member shall cease to be a member, a special election shall be held to replace the member and the designated alternate shall serve as the member until the special election is completed.

Section	Explanation/Rationale
8. Article III, Section 5	Clarified for Clinical Systems Committee: a) what constitutes a quorum and what is required for an action at a meeting; b) the ability to participate in meetings by telephone and electronic participation in meetings; and c) the ability to take an action by unanimous written consent without a meeting.

Article III, Section 5 is amended to read as follows:

Section 5: Quorum/Action at Meetings/Telephonic and Electronic Participation/Written Consents.

- A. Quorum. Fifty (50) percent of the total voting membership of the Committee shall constitute a quorum. Member-designated representatives shall not count toward a quorum. In the absence of a quorum at any meeting of the Clinical Systems Committee, a co-Chair or a majority of the Clinical Systems Committee present may adjourn the meeting to another date, time and place with notice to the members of the Clinical Systems Committee.
- B. Action at Meetings. A majority of a quorum at a meeting shall constitute an action of the Clinical Systems Committee.
- C. Telephone and Electronic Conference Meetings and Participation. The members of the Clinical Systems Committee may participate in a meeting by means of telephone or other communications equipment that enables all of the Clinical Systems Committee participating in the meeting to communicate with each other (including computer, video, or other electronic equipment). Such participation shall constitute presence in person at the meeting.
- D. Written Consents. Action may be taken by the Board without a meeting, if all Clinical Systems Committee consent to such action in writing, and the writing or writings are filed with the minutes of proceedings of the Clinical Systems Committee. Consents under this subsection may be given via electronic communication.

Section	Explanation/Rationale
9. Article III, Section 6	Created process for appointment, termination, resignation, and removal of non-ex officio co-chair of Clinical Systems Committee to be selected by the Vice President for Medical Affairs from amongst the members of the committee with Active Clinical Staff privileges.

Article III, Section 6 is amended to read as follows:

Section 6: Officers

- A. Co-Chairs. The Clinical Systems Committee shall have 2 co-Chairs: the Chief Executive Officer of the UIHC and a Clinical Systems Committee member with Active Clinical Staff privileges appointed by the Vice President for Medical Affairs.

- B. Vice Chair. The Chief of Staff shall be the Vice Chair of the Clinical Systems Committee. The Vice Chair, or in the absence of the Vice Chair one of the co-Chairs, shall preside at all meetings.
- C. Recorder. A member of the hospital administrative staff -- selected by the Chief Executive Officer -- shall be the Recorder. This function may be rotated at the Chief Executive Officer's discretion. The Recorder shall not be a member of the Committee and, thus, shall have no vote.
- D. Appointment. Appointment of the Chief Executive Officer co-Chair and Vice Chair shall be ex officio. Selection of the recorder will be as set forth in Article III, Section 4(C) above. Appointment of the other co-Chair shall be a member of the Clinical Systems Committee with Active Clinical Staff privileges as determined by the Vice President for Medical Affairs.
- E. Term of Appointment. The appointment of the co-Chair selected from amongst the members with Active Clinical Staff privileges shall be for a three (3) year term. An individual may be reappointed to no more than two (2) terms from the adoption of these Amended and Restated Bylaws, Rules and Regulations. A term will begin on January 1 and end on December 31.
1. Qualifications. The co-Chair selected from amongst the members with Active Clinical Staff privileges shall possess the background, experience and demonstrated competence to fulfill the duties of the position.
 2. Removal. The co-Chair selected from amongst the members with Active Clinical Staff privileges may be removed by Vice President for Medical Affairs or by the Clinical Systems Committee, by a two-thirds vote, for conduct detrimental to the interest of the UIHC or its Clinical Staff, or if the co-Chair is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office. Notwithstanding the foregoing, in the event removal is by the Clinical Systems Committee, a removal notice of the meeting at which such action shall be decided shall be given in writing to the co-Chair who was selected from amongst the members with Active Clinical Staff privileges at least ten (10) days in advance of the meeting. The co-Chair shall be afforded the opportunity to speak prior to the taking of any vote on such removal by the Clinical Systems Committee.

Section	Explanation/Rationale
10. Article III, Section 7(A)	<p>Established:</p> <p>1) Composition of subcommittees selected by Clinical Systems Committee co-chairs, except for Credentials Subcommittee and the chair of Clinical Staff Affairs Subcommittee, whose membership is described in the Bylaws;</p> <p>2) new two co-chair structure for subcommittees except Clinical Staff Affairs Subcommittee, with one chair selected by Chief Executive Officer and one chair selected by a majority vote of the members of the Clinical Systems Committee with Active Clinical Staff privileges; and</p> <p>3) Three (3) year terms for co-Chairs, renewable twice.</p>

Article III, Section 7(A) is amended to read as follows:

Section 7: Subcommittees

A. Structure

1. Membership. Subcommittees shall be either standing or ad hoc. Upon notice to the Clinical Systems Committee co-Chairs, subcommittees may create standing or ad hoc working groups, as appropriate, to fulfill their charge. Membership of a subcommittee may consist of Clinical Staff members, hospital administrative staff members, and other professional staff of the UIHC. Members of each subcommittee shall be designated by the co-Chairs of Clinical Systems Committee, except that the Credentials Subcommittee shall have the composition specified below in this subsection and the Chair of Clinical Staff Affairs Subcommittee shall be as set forth below in Article III, Section 7(A)(3).

If a subcommittee is empowered to adopt policies that apply to the Carver College of Medicine’s non-clinical operations as well as the University of Iowa Health Care clinical operations, Carver College of Medicine faculty and staff who are not members of the Clinical Staff may serve as members of the subcommittee.

The Credentials Subcommittee shall be composed of one Active Clinical Staff member for each Clinical Service, designated by the Head of the Clinical Service. Clinical Service Heads and members of the Clinical Systems Committee shall not be members. The members of the Credentials Subcommittee shall be divided into Medical and Surgical Credentials Panels as follows: Medical -- Dermatology, Emergency Medicine, Family Medicine, Internal Medicine, Neurology, Pathology, Pediatrics, Psychiatry, Radiation Oncology, and Radiology; and Surgical -- Anesthesia, Dentistry, Neurosurgery, Obstetrics-Gynecology, Ophthalmology and Visual Sciences, Orthopaedics and Rehabilitation, Otolaryngology—Head and Neck Surgery, Surgery and Urology. The Chairs of each Panel shall be selected from among the voting membership of the Panel by the co-Chairs of the Clinical

Systems Committee, in conjunction with the Vice Chair. Each Panel shall also include a member of the hospital administrative staff ex officio, without vote, appointed by the Chief Executive Officer.

Two subpanels, the physician assistant/advanced registered nurse practitioner (PA/ARNP) subpanel and the health care professional subpanel shall report jointly to the Medical and Surgical Credentials Panels. The subpanel shall be composed of four physician assistants, four advanced registered nurse practitioners, one physician supervising the practice of a PA, one physician with a collaborative agreement with an ARNP, and a chair selected by the Chair of the Clinical Staff Affairs Subcommittee. Members of the PA/ARNP subpanel shall be appointed by the Chair of the Clinical Staff Affairs Subcommittee, upon recommendations from the Clinical Services Heads in which physician assistants and advanced nurse practitioners practice. The PA/ARNP subpanel will be representative of the Clinical Services in which physician assistants and advanced registered nurse practitioners practice.

The health care professional subpanel shall be composed of four health care professionals, representative of the Clinical Services in which health care professionals practice, two physicians, and a chair selected by the Chair of the Clinical Staff Affairs Subcommittee. Members of the health care professional subpanel will be selected by the Chair of the Clinical Staff Affairs Subcommittee, upon recommendations from the Clinical Service Heads in which health care professionals practice. Subpanel membership will be representative of these Clinical Services.

Each subpanel shall also include a member of the hospital administrative staff ex officio, without vote, appointed by the Chief Executive Officer.

2. Terms. Subcommittee members shall be appointed to three (3) year renewable terms if the positions they occupy are not assigned by the head of the Clinical Service, associated with a specific administrative, management or supervisory position or other UIHC sponsored positions. To effectuate appropriately staggered terms, at the time of adoption of these Amended and Restated Bylaws, Rules and Regulations, one-third of members of each subcommittee will be given a one (1) year renewable term, one-third of members of each subcommittee will be given a two (2) year renewable term, and one-third of members of each subcommittee will be given a three (3) year renewable term
3. Subcommittee co-Chairs. Except as set forth in Article III, Section (7)(A)(1) and (3), each subcommittee shall have two co-chairs. One co-chair will be appointed by the Chief Executive Officer of UIHC. One co-chair will be appointed by a majority vote of the members of the Clinical Systems Committee with Active Clinical Staff privileges. Subcommittee chairs shall be appointed to a three (3) year term that may be renewed for one (1) additional three (3) year term. In the event that a subcommittee co-chair's appointment is associated with a specific office or leadership position they hold within the UIHC, a subcommittee co-chair shall remain co-chair as long as the associated administrative office or leadership

position is held (“Ex Officio Term”). If an existing subcommittee member is appointed a subcommittee co-chair, the term of their original membership will immediately cease, and a three (3) year term or Ex Officio Term as subcommittee co-chair will begin immediately. At the conclusion of a subcommittee co-chair’s term, that individual may be reappointed as a member of that subcommittee. If a former subcommittee co-chair is reappointed as a member of that subcommittee, the term of such subcommittee membership shall begin as a new three (3) year term, subject to the paragraph above. Except as expressly set forth to the contrary herein, a subcommittee co-chair may not simultaneously hold another chair or co-chair position on the Clinical Systems Committee or on a subcommittee or working group thereof.

The Vice Chair of the Clinical Systems Committee shall be the Chair of the Clinical Staff Affairs Subcommittee.

Section	Explanation/Rationale
11. Article III, Section 7(C)	Clarified for subcommittees: a) what constitutes a quorum and what is required for an action at a meeting; b) the ability to participate in meetings by telephone and electronic participation in meetings; and c) the ability to take an action by unanimous written consent without a meeting.

Article III, Section 7(C) is amended to read as follows:

A. Quorum/Action at Meetings/Telephonic and Electronic Participation/Written Consents.

1. Quorum. Fifty (50) percent of the total voting membership of the subcommittee shall constitute a quorum. In the absence of a quorum at any Clinical Systems Subcommittee, a co-chair or a majority of the Clinical Systems Subcommittee members present may adjourn the meeting to another date, time and place with notice to the members of the Clinical Systems Subcommittee.
2. Action at Meetings. A majority of a quorum at a meeting shall constitute an action of the Clinical Systems Subcommittee.
3. Telephone and Electronic Conference Meetings and Participation. The members of Clinical Systems Subcommittee may participate in a meeting by means of telephone or other communications equipment that enables all of the Clinical Systems Subcommittee members participating in the meeting to communicate with each other (including computer, video, or other electronic equipment). Such participation shall constitute presence in person at the meeting.
4. Written Consents. Action may be taken by the subcommittee without a meeting, if all members of the subcommittee consent to such action in writing, and the writing or writings are filed with the minutes of proceedings Clinical Systems Subcommittee meeting. Consents under this subsection may be given via electronic communication.

Section	Explanation/Rationale
12. Article III, Section 7(D)	<p>Established new subcommittee and working groups of subcommittees structure.</p> <p>Ongoing subcommittees: Compliance, Credentials, Clinical Staff Affairs (formerly known as Professional Practice and Well-Being), Quality and Safety Oversight, Surgical Services.</p> <p>New subcommittees: Clinical Operations, Finance and Revenue Cycle.</p> <p>Subcommittees transitioned to working groups (subcommittee providing oversight in parentheses): Critical Care (Clinical Staff Affairs), Diagnostic Services (Clinical Staff Affairs), Emergency Management (Clinical Staff Affairs), Environment of Care (Clinical Staff Affairs), Ethics (Quality and Safety), Graduate Medical Education (Clinical Staff Affairs), Health Information Management Systems (Clinical Staff Affairs), Infection Control (Quality and Safety), Pharmacy and Therapeutics (Clinical Staff Affairs), Product Lien Oversight and Analysis (transitioned to management committee function), Protection of Persons (Quality and Safety), Transfusion (Quality and Safety), Utilization Management (Clinical Staff Affairs).</p>

Article III, Section 7(D) is amended to read as follows:

D. Standing Subcommittee Charges

Standing subcommittees and their respective charges are as follows:

1. Clinical Operations Subcommittee

To collaboratively review the operations of specific clinical services at UIHC. As a form for collaboration between Clinical Staff leaders, patient care service leaders, support service leaders, and UIHC administration. A service line specific working group assisting this Subcommittee may be established or modified at any time by the Clinical Systems Committee. In fulfilling this charge, the Clinical Services Subcommittee will:

- a. Review operational performance, including:
 - i. Patient access and patient throughput performance;
 - ii. Operational efficiency and cost management performance;
 - iii. Provider satisfaction and efficiency;
 - iv. Staff engagement and efficiency;
 - v. Facilities and support services;

- vi. Service specific revenue cycle issues; and
- vii. Other operational issues as brought up by Clinical Staff and UIHC personnel.

Clinical Systems Committee may supplement or amend these duties with subcommittee specific duties at any time.

2. Clinical Staff Affairs Subcommittee

To cause patient care delivered at the UIHC to be consistent with professionally recognized standards of care and adjudicate conflicts regarding professional practice, care for the well-being of health care providers so that they are in the best position to care for patients. In fulfilling this charge, the Clinical Staff Affairs Subcommittee will:

- a. Adjudication.
 - i. Hear and adjudicate problems of a professional and ethical nature involving the clinical practice of either house staff or Clinical Staff members.
 - ii. Review interdisciplinary or inter-clinical department conflicts with the corollary responsibility for recommending to the Clinical Systems Committee policy statements or protocols to remedy such occurrences and otherwise foster harmonious interdepartmental relationships aimed at ensuring quality patient care.
- b. Critical Care. Through oversight of a standing Critical Care Working Group, formulate cross-departmental policies, procedures and programs, identify and seek solutions to current challenges, develop plans for future operations and to enhance the overall utilization and operating efficiency of all UIHC intensive care units, intermediate care units, and emergency treatment centers so that standards of patient care may be maintained at the highest level. The working group will also oversee the hospital-wide system for management of acute cardiopulmonary resuscitation emergencies and advise the Director of the Respiratory Care Department on policy formulation, establishment of patient care and didactic instruction programs, and on the provision of effective and efficient respiratory care services.
- c. Diagnostic Services. Through oversight of the standing Diagnostic Services Advisory Working Group, provide the Clinical Staff and UIHC's administration with information and advice concerning the quality, availability, and proper use of clinical laboratory and imaging services. In fulfilling this charge, the Diagnostic Services Advisory Working Group will:

- i. Assist in formulating operational policies designed to assure the most expeditious performance of diagnostic services for patients in all clinical departments in accord with available resources.
 - ii. Advise and make recommendations regarding optimal provision and utilization of clinical laboratory and imaging services for patients coordinate with cost considerations and market forces extant within the health care industry and in accord with the patient care, educational and research missions of UIHC.
 - iii. In accord with these recommendations and other pertinent factors including regulatory provisions and accreditation standards, review and provide recommendations on additions to and deletions from UIHC publications and documents on diagnostic services such as the Pathology Department, Laboratory Services Handbook.
- d. Emergency Management. Through oversight of the standing Emergency Management Working Group, organize, conduct and update an all hazards emergency management program to assure that the UIHC is prepared to deal effectively with all disaster situations and the treatment of mass casualties which may result therefrom. In fulfilling this charge, the Emergency Management Working Group will:
- i. Conduct a Hazard Vulnerability Analysis (HVA) on an annual basis.
 - ii. Maintain a written Emergency Operations Plan which features a Hospital Incident Command System (HICS) for organizing the UIHC's response to all hazards and standard operating procedures to address the hazards identified.
 - iii. Arrange at least twice yearly exercises of the Emergency Operations Plan.
 - iv. Provide continuity of operations plans to guide the UIHC's maintenance and restoration of essential services.
 - v. Provide that all staff with HICS assignments and other staff designated for responding to disasters and major emergencies receive training in accord with UIHC requirements and regulatory guidelines and understand their role(s) and responsibilities for responding to various disasters and emergencies.
 - vi. Maintain relationships and participates in County, State and Federal programs related to emergency management.
 - vii. Assure that UIHC meets the Emergency Management Standards of the Joint Commission and CMS Conditions of Participation in Medicare and Medicaid programs and follows the National Incident

Management System (NIMS) and HICS as standardized organizational and operational structures for meeting the demands of major emergencies and disasters.

- e. Environment of Care. Through oversight of the standing Environment of Care Working Group, establish, implement and maintain the UIHC Environment of Care Program, in accordance with the requirements of The Joint Commission and applicable state and federal laws. The Subcommittee develops and/or approves recommendations and interventions to protect the well-being of patients, visitors and staff in the areas of fire protection, safety, hazardous materials and waste, medical equipment, utilities and security.
- f. Graduate Medical Education. Through the oversight of the standing Graduate Medical Education Working Group, advise on all matters pertaining to the house staff training programs at UIHC, including, but not limited to the following: assist in the recruitment, orientation, and scheduling of house staff physicians and dentists; conduct periodic reviews of all UIHC residency programs in accordance with Accreditation Council for Graduate Medical Education guidelines; and provide a forum for house staff issues to provide a forum for house staff problems as expressed by the house staff representatives on the Working Group or by other house staff.
- g. Health Information Management Systems. Through the oversight of the standing Health Information Management Systems Working Group, maintain broad responsibility for the ongoing management and development of the medical records and other health information systems management at the UIHC to facilitate their efficiency and effectiveness. In fulfilling this charge, the Health Information Management Systems Working Group will:
 - i. Review, analyze and evaluate the quality of systems and processes to enable complete, accurate medical record documentation in the UIHC in compliance with applicable regulations of governmental agencies, accrediting bodies, and payers, and make recommendations for improvement where appropriate.
 - ii. Oversee all medical record forms including documents created during clinical information systems downtime and make appropriate recommendations for their improvement.
 - iii. Review procedures for safeguarding medical records against loss, defacement, tampering, or use by unauthorized persons, and make appropriate recommendations for their improvement. Review strategic planning for application system development.
 - iv. Evaluate the appropriateness of security and backup procedures for health care data in all settings, including the exchange of data with

other computers. Review for consistency the strategic plans of UIHC projects which have incremental computing equipment implications and/or an impact on patient and management data maintained on the health care information system.

- v. Review the use of computers in UIHC administrative and patient care settings with particular regard to appropriateness of application, security of patient information, and system maintenance.
- vi. Monitor system processes to ensure compliance with regulatory guidelines for safeguarding patient data security.
- vii. Following review of project and equipment requests, the Subcommittee will forward recommendations to UIHC administration.
- h. Pharmacy and Therapeutics. Through the oversight of the standing Pharmacy and Therapeutics Working Group, promote evidence-based, best practice standards in the formulary decision-making process to assure clinical efficacy, patient safety and cost-effective prescribing within UIHC. In fulfilling this charge, the Pharmacy and Therapeutics Working Group will:
 - i. Review policies and procedures related to proper medication administration to assure medications are administered safely and appropriately.
 - ii. Facilitate education of healthcare providers and students regarding medication-related issues.
 - iii. Assure that medications are prescribed appropriately, safely and effectively through medication use evaluation processes.
 - iv. Assure compliance with The Joint Commission, FDA and other regulatory and accreditation guidelines related to medication use.
 - v. Review and support investigational medication studies to ensure patient safety and adherence to UIHC policies.
 - vi. Evaluate and assess point-of-care and other technology systems and processes to effectuate safe, prompt and efficient prescribing in both the inpatient and ambulatory care settings.
- i. Provider Well-Being. Through oversight of the standing Provider Well-Being Working Group, care for the well-being of health care providers so that they are in the best position to care for patients, including review licensed independent provider satisfaction survey data and develop recommendations for improvement.
- j. Supervision of Non-Privileged Providers. Through oversight of the standing Supervision of Non-Privileged Providers Working Group, manage supervision of other providers whose services may be independently

billable but require appropriate Clinical Staff member medical direction and oversight to supervise clinically appropriate and compliant practice of non-privileged providers.

- k. Utilization Management. Through oversight of the standing Utilization Management Working Group: 1) promote the efficient use of facilities (including coordination of admission and continued stay reviews); and 2) formulate, maintain and review a utilization review plan appropriate for the UIHC and consistent with applicable federal requirements. In fulfilling this charge, the Utilization Management Working Group will:
 - i. Describe UIHC activities to cause services to be provided to patients that are medically necessary and at the appropriate level of care;
 - ii. Monitor utilization activities and outcomes;
 - iii. Minimize reimbursement penalties and physician sanctions through screening and appropriate documentation; and
 - iv. Centralize communication with external review agencies, including the quality improvement organization.

3. Compliance Subcommittee

To provide oversight and guidance for the regulatory audit and compliance activities of UIHC. Enable the organization to adopt and implement policies and procedures that will meet the intent and comply with all applicable laws, rules, regulations and policies. In fulfilling this charge, the Compliance Subcommittee will:

- a. Review and address the activities of the Joint Office for Compliance as it relates to the elements of the Federal Compliance Program Guidance including: Designation of a Compliance Officer; Development of Compliance Policies and Procedures; Developing Open Lines of Communication; Provision of Appropriate Training and Education; Internal Regulatory Monitoring and Auditing; Response to Detected Deficiencies; and Enforcement of Disciplinary Standards.
- b. Annually review the “Code of Ethical Behavior, a Guide for Staff” to assure it addresses all applicable federal, state and local laws, regulations and other compliance requirements.
- c. Oversee the enterprise risk assessment with the goal to align risk and strategy; enhance risk response decisions; increase operational predictability; identify and manage multiple and cross-enterprise risks; proactively manage and minimize risks while achieving strategic objectives; and align deployment of resources with risk mitigation strategy.

4. Credentials Subcommittee

To review the credentials of all members or other practitioners applying for initial or increased clinical privileges; to review proposals for decreased privileges either as part of the biennial review and reaffirmation or as part of a corrective action as described in these Amended and Restated Bylaws, Rules and Regulations; to make a recommendation to the Clinical Systems Committee on each application, reaffirmation, or corrective action described in this paragraph; and to report problems related to clinical practice or professional policy through the Clinical Staff Affairs Subcommittee to the Clinical Systems Committee.

5. Finance and Revenue Cycle Subcommittee

To cause proper oversight of financial systems and process of payment to be handled accurately and completely in accordance with applicable laws, regulations, and payer contractual obligations.

- a. Oversee proper financial systems management and reporting.
- b. Facilitate timely, accurate, and complete documentation of medically necessary services rendered.
- c. Enable timely, accurate, and complete submission of invoices for payment for medically necessary services rendered.
- d. Provide coding and documentation accuracy oversight.
- e. Oversee third party payor contracting efforts.
- f. Collaborate with other UI Health Care groups further payment for quality initiatives.
- g. Oversee payment processes including but not limited to prior authorization, eligibility and benefits verification, payment posting, denials management and appeals processing, and payment process reporting.
- h. Collaborate with other UI Health Care groups to develop revenue cycle- and finance-related provider and staff education.

6. Quality and Safety Oversight Subcommittee

To cause patient care delivered by the Clinical Staff of the UIHC to be provided in a safe, manner that is consistent with professionally recognized standards of care. In fulfilling this charge, the Quality and Safety Oversight Subcommittee will:

- a. Coordinate the quality and performance improvement activities of the UIHC.

- b. Ethics. Through oversight of the standing Ethics Working Group:
 - i. Develop and carry out educational programs that will enhance awareness and understanding of biomedical ethical issues for clinical and UIHC staff, undergraduate and graduate trainees, patients and their families, and propose policies and guidelines regarding the ethical aspects of medical, surgical and dental practice.
 - ii. Provide consultation on ethical issues to members of the UIHC Clinical Staff, House Staff and Professional Staff.
- c. Infection Control. Through oversight of the standing Infection Control Working Group, review infection data, policies, procedures and processes, and revise policies and procedures, and recommend changes in procedures and practices as necessary so that appropriate interventions to prevent infections in the UIHC and its associated clinics are made.
- d. Performance Improvement. Through the standing Performance Improvement Working Group, review, analyze and evaluate on a continuing basis the performance of the Clinical Service quality and Performance Improvement Program in formulating standards of care; measuring outcomes of care; and taking constructive intradepartmental action on the evaluation results, as specified in the UIHC Performance Improvement Program.
- e. Protection of Persons. Through oversight of the standing Protection of Persons Working Group, facilitate the protection of persons, including minors and dependent adults, to identify, treat, and as permitted or required by law, report cases of suspected child or dependent adult abuse or domestic violence.
- f. Transfusions Working Group. Through oversight of the standing Transfusion Working Group, review the records of transfusions of blood and blood components so as to assess transfusion reactions, to evaluate blood utilization, and to make recommendations regarding specific improvements in the transfusion service program.

7. Surgical Services Subcommittee

To review, deliberate, resolve, and, where indicated, formulate recommendations relative to all appropriate operational elements of the several surgical services with special emphasis upon the operating room suite.

E. Ad Hoc Subcommittees

Ad hoc subcommittees shall be appointed by the co-Chairs to study particular problems in response to the recommendations of the Clinical Systems Committee. Subcommittee membership shall be constituted in relationship to the particular problem to be addressed.

Section	Explanation/Rationale
13. Article IV, Sections 4(C), 4(D), and 4(E)	Removed language regarding fees that was not required to include in the Bylaws and is better memorialized in University of Iowa Physicians documentation.

Article IV, Sections 4(C), 4(D) and 4(E) are amended to read as follows:

Section 4: Clinical Privileges

Members of the Clinical Staff and other practitioners, as described in Article IV 4(F), are eligible to apply for clinical privileges.

C. Clinical Privileges of Physicians and Dentists

All clinical privileges granted by the Clinical Systems Committee are contingent on the person receiving and continuing to possess an appointment to the faculty of either the College of Medicine or the College of Dentistry. Clinical privileges shall be suspended automatically during any period when the faculty member is on administrative leave from his or her respective College. Privileges shall be re-instated automatically at the end of the administrative leave unless the faculty appointment terminates or corrective action is taken pursuant to Article IV, Section 6.

1. Clinical Privileges of Active Clinical Staff (Physicians/Dentists)

Physicians and dentists who are members of the Active Clinical Staff (or applicants for appointments which would qualify them for Active Clinical Staff membership whose appointments have been recommended to the Dean by the Head of the Clinical Service in which privileges are sought) may apply for clinical privileges according to the procedure in Article IV, Section 5.

Physicians with fellow-associate appointments shall serve as House Staff members in performing services other than those for which they are granted clinical privileges on the Active Clinical Staff.

Members of the Active Clinical Staff who are licensed physicians and licensed dentists and have clinical privileges may admit patients.

2. Clinical Privileges of Courtesy Teaching Staff

Members of the Courtesy Teaching Staff (and applicants for appointments which would qualify them for Courtesy Teaching Staff membership whose appointments have been recommended to the Dean by the Head of the Clinical Service in which privileges are sought) whose teaching responsibilities require them to be involved in patient treatment may apply for clinical privileges according to the procedure in Article IV, Section 5. Clinical privileges granted to members of the Courtesy Teaching Staff shall not exceed those necessary to effectively fulfill the member's

teaching responsibilities, and can only be exercised under the supervision of a member of the Active Clinical Staff who has clinical privileges to perform the procedures and who finds the Courtesy Teaching Staff Member qualified to participate. Members of the Courtesy Teaching Staff shall not admit patients.

The Clinical Systems Committee may adopt findings that the needs of the UIHC, in fulfilling its tripartite mission, require that opportunities be given to members of the Courtesy Teaching Staff to practice without supervision. Following the adoption of such findings, the Clinical Systems Committee may, upon request of the Clinical Service Head, authorize a Courtesy Teaching Staff member, who has been granted privileges according to the procedure in Article IV, Section 5, to practice without supervision, and to admit patients.

3. Clinical Privileges of Temporary Staff

A co-Chair of the Clinical Systems Committee, or his/her designee, may grant temporary clinical privileges to a Temporary Staff member, upon recommendation of the Clinical Service Head, who is responsible for verifying the required qualifications of the Temporary Staff member (Article IV, Section 3(C)(4) and Article IV, Section 4(B)). The Clinical Service Head shall then assign the temporary member to a member of the Active Clinical Staff for supervision. Temporary clinical privileges, unless otherwise limited, shall permit the Temporary Staff member to perform any procedures which the assigned Active Clinical Staff member has clinical privileges to perform and authorizes the Temporary Staff member to perform. The Clinical Systems Committee may, in its discretion, authorize a Temporary Staff Member to practice without supervision by approving temporary clinical privileges upon the recommendation of the applicable Credentials Panel. Temporary clinical privileges shall cease in accord with the written invitation to the Temporary Staff or when the Clinical Service head or a co-Chair of the Clinical Systems Committee, or his/her designee, in his/her sole discretion, ends the temporary clinical privileges.

Members of the Temporary Staff shall not admit patients and shall not, without the prior approval of the Clinical Systems Committee, practice without supervision. Temporary privileges may not exceed one hundred and twenty (120) days.

A Temporary Member of the Clinical Staff appointed pursuant to this subsection shall be assigned by the Vice Chair of the Clinical Systems Committee or the applicable Clinical Service Head to a member of the Active Clinical Staff for supervision. Temporary clinical privileges, unless otherwise limited, shall permit the Temporary Staff member to perform any procedures which the assigned Active Clinical Staff member has clinical privileges to perform and authorizes the Temporary Staff member to perform. The Temporary Member shall wear an identification badge identifying him or her as a Temporary Member of the Clinical Staff.

The credentials of a Temporary Member of the Clinical Staff appointed pursuant to this subsection shall be verified in the same manner as the credentials of any other

Temporary Member, except that the process may occur retrospectively. The process for verifying credentials shall begin as soon as the immediate situation that resulted in the declaration of a “full-scale disaster” is under control.

4. Clinical Privileges of House Staff

It is the responsibility of a supervising member of the Active Clinical Staff, or the Emeritus Staff to authorize each House Staff member, including temporary members, to perform only those services which the House Staff member is competent to perform under supervision.

D. Clinical Privileges of Emeritus Staff

Members of the Emeritus Staff, who have assigned Clinical Service responsibilities by the Colleges of Medicine or Dentistry, may apply for clinical privileges according to the procedure in Article IV, Section 5.

Members of the Emeritus Staff who have clinical privileges may admit patients.

E. Clinical Privileges of Other Members of the Active Clinical Staff

All clinical privileges granted by the Clinical Systems Committee are contingent on the health care professional (as defined in Article IV, Section 3(B)(1)) receiving and continuing to possess a faculty appointment to a clinical department in the College of Medicine. Health care professionals who are members of the Active Clinical Staff (or applicants for appointments which would qualify them for Active Clinical Staff membership whose appointments have been recommended to the Dean by the Head of the Clinical Service in which privileges are sought) may apply for clinical privileges limited to the clinical duties and responsibilities intrinsic to his/her professional discipline (Article IV, Section 3(C)(1)(c) according to the procedure in Article IV, Section 5. Health care professionals with clinical privileges may not admit patients.

Section	Explanation/Rationale
14. Article VIII, Section 1	Removed no longer applicable language regarding physical and occupational therapy.

Article VIII, Section 1 is amended to read as follows:

ARTICLE VIII: PATIENT CARE RULES AND REGULATIONS

Section 1:

All patients admitted to the UIHC as inpatients or housed outpatients shall be assigned to the Service of their attending physician or dentist who pledges to provide or arrange for continuous care for his or her patients. Except in an emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been made. In cases of emergency, the provisional diagnosis shall be stated as soon after admission as possible.