



Mercy Medical Center

MEDICAL STAFF BYLAWS

Part I: Governance

Board Approval Date: March 28th, 2025

Table of Contents

Section 1.	Medical Staff Purpose and Authority	1
Section 2.	Medical Staff Membership	3
Section 3.	Categories of the Medical Staff	7
Section 4.	Officers of the Medical Staff	9
Section 5.	Medical Staff Organization	12
Section 6.	Committees	15
Section 7.	Medical Staff Meetings	17
Section 8.	Conflict Resolution	19
Section 9.	Review, Revision, Adoption, and Amendment	20

Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this Medical Staff is to organize the activities of physicians and other clinical providers who practice at Mercy Medical Center in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the hospital Board of Trustees.

1.2 Authority

Subject to the authority and approval of the Board of Trustees the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and associated rules, regulations, and policies and under the corporate bylaws of the Mercy Medical Center.

1.3 Definitions

“Advanced Practice Professional” or “APP” means those individuals eligible for privileges but not staff Members who are qualified by academic education and clinical experience or training to provide medical care.. APPs to include physician assistants (PAs) and advance registered nurse practitioners (ARNPs) along with specialist ARNPs such as certified registered nurse anesthetists (CRNAs) are supervised in accordance with hospital policy.

“Allied Health Professional” or “AHP” means those individuals eligible for privileges who are not staff Members who are qualified by academic education and clinical experience or other training to provide patient care services in a clinical or supportive role such as a clinical psychologist and radiology assistant. AHPs provide services only under supervision of a Member of the Medical Staff.

“Appointee” means any medical or osteopathic physician, dentist, oral and maxillofacial surgeon, or podiatrist holding a current license to practice within the scope of his or her license who is a Member of the Medical Staff.

“Chief Executive Officer” or “CEO” is the individual appointed by the Board of Trustees to serve as the representative in the overall administration of the Hospital. The CEO may, consistent with his or her authority granted by the Hospital Bylaws, appoint a representative to perform certain administrative duties identified in these Bylaws.

“Chief Medical Officer” or “CMO” is the individual appointed by the CEO to serve as a liaison between the Medical Staff and Administration (this position may also be known as a Vice President of Medical Affairs or Executive Medical Director, but the term “CMO” will be used in these Bylaws).

“Clinical Privileges” or “Privileges” mean the permission granted to a Provider to render specific diagnostic, therapeutic, medical, dental or surgical services with the Hospital.

“Dentist” means an individual who has received a Doctor of Dental Medicine or Doctor of Dental Surgery degree and is currently licensed to practice dentistry in Iowa.

“Good Standing” means having no adverse actions, limitations, or restriction on privileges or Medical Staff membership at the time of inquiry based on a reason of competence or conduct.

“Governing Body” or “Board” means the Board of Trustees of Mercy Medical Center.

“Hospital” means Mercy Medical Center.

“Medical Executive Committee” and “MEC” shall mean the Executive Committee of the Medical Staff.

“Medical Staff or “Staff” means the organization of those professionals granted membership under these Bylaws of the Medical Staff of Mercy Medical Center of Cedar Rapids, Iowa.

“Medical Staff Bylaws” or “Bylaws” means these Bylaws covering the operations of the Medical Staff of Mercy Medical Center.

“Medical Staff Rules and Regulations” means the rules and regulations adopted by the Medical Executive Committee and approved by the Board of Trustees.

“Member” is a physician, dentist, oral and maxillofacial surgeon, or podiatrist who has been granted Membership status by the Board of Trustees.

“Oral and Maxillofacial Surgeon” means a licensed dentist with advanced training qualifying him for board certification by the American Board of Oral and Maxillofacial Surgery.

“Physician” means an individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is currently fully licensed to practice medicine in the State of Iowa.

“Podiatrist” means an individual who has received a Doctor of Podiatric Medicine degree and is currently licensed to practice podiatry in Iowa.

“Practitioner” means an appropriately licensed medical physician, osteopathic physician, oral and maxillofacial surgeon, podiatrist who has been granted clinical privileges but is not eligible for membership.

“Prerogative” means the right to participate, by virtue of Staff category or otherwise, granted to a practitioner, and subject to the ultimate authority of the Board of Trustees and the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.

“President” or “President of the Medical Staff” means the primary elected officer of the Medical Staff and is the Medical Staff’s advocate and representative in its relationships to the Board and the administration of the hospital.

“Provider” means a medical professional who is eligible for clinical privileges at the hospital as defined in these Bylaws.

“Special Appearance” - means the required attendance and participation of any member or privileges holder at a conference of a Medical Staff committee or department, or with the chair of a Medical Staff committee or department, whenever possible deviation from Medical Staff standards of clinical practice or Medical Staff rules and regulations or policy is identified.

“Special Notice” means written notice sent by U.S. mail, registered with return receipt requested.

“Written” means documented through entry in an electronic format or on paper.

Section 2. Medical Staff Membership

2.1 Nature of Medical Staff Membership

Membership on the Medical Staff of the hospital is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated rules, regulations, policies, and procedures of the Medical Staff and the hospital.

2.2 Qualifications for Membership

The qualifications for Medical Staff membership are delineated in Part III of these Bylaws (Credentials Procedures Manual).

2.3 Nondiscrimination

The hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, color, sex, sexual orientation, gender identification, religion, age, marital status, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.4 Economic Credentialing

Economic credentialing is not used in Medical Staff membership or privileging decisions. Medical Staff membership, participation in Medical Staff activities, clinical privileges, and access to resources or patients will not be restricted or terminated or denied because the member's financial or professional interests or plans compete with those of the hospital or system.

2.5 Conditions and Duration of Appointment

The Board of Trustees shall make initial appointment and reappointment to the Medical Staff. The Board of Trustees shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC) except for temporary, emergency and disaster privileges. Appointment and reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months.

2.6 Medical Staff Membership and Clinical Privileges

Requests for Medical Staff membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the Board of Trustees. Membership and/or privileges will be granted and administered as delineated in Part III (Credentials Procedures Manual) of these Bylaws.

2.7 Responsibilities

2.7.1 Each provider with privileges must provide appropriate, timely, and continuous care of his/her patients, at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances.

2.7.2 Each provider shall promote and maintain a culture of safety.

2.7.3 Each staff member must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions (including service on appropriate Medical Staff committees) as may be required.

2.7.4 Each staff member, consistent with his/her granted clinical privileges, must participate in the on-call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the Board of Trustees and documented in the rules and regulations, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.

2.7.5 Each provider with privileges must submit to any pertinent type of health evaluation as requested by any of the Officers of the Medical Staff, Hospital CEO, and/or their Department Chair when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or Credentials Committee as part of an evaluation of the provider's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and hospital policies addressing health or impairment.

2.7.6 Each provider with privileges must abide by the Medical Staff Bylaws and any other rules, regulations, policies, procedures, and standards of the Medical Staff and Hospital.

2.7.7 Each provider with privileges must provide evidence of professional liability coverage of a type and in an amount sufficient to cover the clinical privileges granted or an amount established by the Board of Trustees, whichever is higher. In addition, providers shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each provider with privileges shall notify the CEO or designee immediately of all malpractice claims filed in any court of law against the provider.

2.7.8 Each applicant for privileges or provider with privileges agrees to release from any liability, to the fullest extent permitted by law, all persons acting in good faith and without malice for their conduct in connection with investigating and/or evaluating the quality of care or professional conduct provided by the provider and his/ her credentials.

2.7.9 Each provider with privileges shall prepare, maintain, and complete in timely fashion, according to Medical Staff and hospital policies, the medical and other required records for all patients to whom the provider provides care in the hospital, or within its facilities, clinical services, or departments. Practitioners granted History & Physical privileges shall comply with the following:

- a. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (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, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.
- b. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (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, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.
- c. The content of complete and focused history and physical examinations is delineated in the rules and regulations and in hospital policy.

2.7.10 Each provider with privileges will access, use, and disclose confidential information only as necessary for treatment, payment, or healthcare operations in accordance with Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), and state and federal laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and the hospital's business information designated as confidential by the hospital or its representatives prior to disclosure. Peer review confidentiality and protection is further defined in the Rules & Regulations.

2.7.11 Each provider with privileges must participate in any type of competency evaluation when determined necessary by the MEC and/or Board of Trustees in order to properly delineate that member's clinical privileges.

2.7.12 Each provider with privileges must abide by the Code of Ethics of their profession.

2.7.13 Each Medical Staff leader and any provider identified shall disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or hospital. All reported and/or identified conflicts will be managed as defined in the Rules & Regulations.

2.7.14 Each medical staff member has an ongoing duty to immediately report (within fourteen (14) days) to the Chief Medical Officer relevant facts and documents: regarding the institution of disciplinary proceedings or taking of action by any health facility (including HMOs), professional society or licensing authority; including but not limited to a fine, limitation, suspension, revocation or resignation of clinical privileges at any health facility; censure, reprimand, suspension, restriction, probation or limitation of professional licensure; or censure of any kind by any professional organization; or debarment, exclusion or sanction from any state or federal program (e.g., Medicare or Medicaid). Failure to inform the Chief Medical Officer shall result in an immediate administrative suspension pending further review, and corrective action for the failure to report.

2.7.15 Each medical staff member shall report to the Chief Medical Officer a lapse in board certification for any reason. Unless a waiver is requested and granted by the department chair and affirmed by the MEC, corrective action must be taken by the medical staff member prior to their subsequent reappointment.

2.8 Medical Staff Member Rights

Each staff member in the Active category has the right to:

2.8.1 A meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with his/her Department Chair or other appropriate Medical Staff leader(s), that practitioner may, upon written notice to the President of the Medical Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

2.8.2 Initiate a recall election of a Medical Staff officer by following the procedure outlined in Section 4.7 of these Bylaws, regarding removal and resignation from office.

2.8.3 Initiate a call for a general staff meeting, to be held within thirty (30) days, to discuss a matter relevant to the Medical Staff by presenting a petition signed by twenty percent (20%) of the members of the Active category. Upon presentation of such a petition, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

2.8.4 Challenge any rule, regulation, or policy established by the MEC. If a rule, regulation, or policy is thought to be inappropriate, any Medical Staff member may submit a petition signed by twenty percent (20%) of the members of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Section 9 will be followed.

2.8.5 Call for a Department meeting by presenting a petition signed by twenty percent (20%) of the Active members of the Department, not less than two (2) Active members. Upon presentation of such a petition the Department Chair will schedule a Department meeting.

2.8.6 Any practitioner eligible for Medical Staff appointment has a right to a hearing/appeal pursuant to the conditions and procedures described in the Medical Staff's hearing and appeal plan (Part II of these Bylaws).

2.9 Member Dues

2.9.1 Annual Medical Staff dues, if any, shall be determined by the MEC.

2.9.2 The MEC may pass policies that allow for exemption under certain circumstances.

2.9.3 If a member fails to pay dues as required, the member will not be deemed to meet the minimum criteria at the time of reappointment and membership and clinical privileges will be considered automatically relinquished.

2.10 Indemnification

2.10.1 Members of the Medical Staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the hospital and Medical Staff.

2.10.2 Subject to applicable law, the hospital shall indemnify against reasonable and necessary expenses, costs, and liabilities incurred by a Medical Staff member in connection with the defense of any pending or threatened action, suit, or proceeding to which he is made a party by reason of his having acted in an official capacity in good faith on behalf of the hospital or Medical Staff. However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

Section 3. Categories of the Medical Staff

3.1 The Active (voting) Category

3.1.1 Qualifications

Members of this category must:

- Conduct at least twenty-four (24), on average, patient contacts per year (i.e., a patient contact is defined as an inpatient admission, consultation, an inpatient or outpatient surgical procedure, shifts performed by an emergency department practitioner, hospitalist, pathologist, radiologist, anesthesiologist, or practitioner in a provider-based clinic),

OR

- Attend at least six (6) meetings per year. These meetings can either be six (6) meetings of a Medical Staff or hospital committee OR six (6) general staff and department meetings.

In the event that a member of the Active category does not meet the qualifications for reappointment to the Active category, and if the member is otherwise abiding by all Bylaws, rules, regulations, and policies of the Medical Staff and hospital, the member may be appointed to the Affiliate Category if s/he meets the eligibility requirements for such category.

3.1.2 Prerogatives

Members of this category may:

- a. Attend Medical Staff and Department meetings of which s/he is a member and any Medical Staff or hospital education programs;
- b. Vote on all matters presented by the Medical Staff, Department and committee(s) to which the member is assigned; and
- c. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws or Medical Staff policies.

3.1.3 Responsibilities

Members of this category shall:

- a. Contribute to the organizational and administrative affairs of the Medical Staff;
- b. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk, and utilization management, medical records completion and in the discharge of other staff functions as may be required; and
- c. Fulfill or comply with any applicable Medical Staff or hospital policies or procedures.

3.2 The Affiliate (non-voting) Category

3.2.1 Qualifications

The Affiliate category is reserved for Medical Staff members who do not meet the eligibility requirements for the Active category.

3.2.2 Prerogatives

Members of this category may:

- a. Attend Medical Staff and Department meetings of which s/he is a member and any Medical Staff or hospital education programs;
- b. Not vote on matters presented by the entire Medical Staff or be an officer of the Medical Staff; and
- c. Serve on Medical Staff committees, other than the MEC, and may vote on matters that come before such committees.
- d. May vote on matters that come before their Department that do not require a ballot.

3.2.3 Responsibilities

Members of this category shall have the same responsibilities as Active Category Members.

3.3 Honorary Recognition

Honorary Recognition is restricted to those individuals recommended by the MEC and approved by the Board of Trustees. This recognition is entirely discretionary and may be rescinded at any time. Practitioners granted Honorary Recognition shall be those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend Medical Staff meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote.

Section 4. Officers of the Medical Staff

4.1 Officers of the Medical Staff

- 4.1.1 President of the Medical Staff
- 4.1.2 Vice President of the Medical Staff
- 4.1.3 Secretary/Treasurer

4.2 Qualifications of Officers

4.2.1 Officers must be members in good standing of the Active category and be actively involved in patient care in the hospital, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, be board certified or board eligible, in compliance with the professional conduct policies of the hospital, and have excellent administrative and communication skills. The Medical Staff Nominating Committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

4.2.2 Officers and other MEC members may not hold a leadership position (MEC or Board of Trustees) on an unaffiliated hospital or health system competing with the Hospital. Noncompliance with this requirement will result in the officer being automatically removed from office.

4.3 Election of Officers

4.3.1 The Nominating Committee shall consist of the three (3) most recent available Past-Presidents with the third Past President as the chair.

4.3.2 The Nominating Committee shall nominate at least one candidate for each of the positions of Vice President of the Medical Staff and Secretary/Treasurer. The Vice President shall automatically assume the position of President. The names of the nominees will be announced at least sixty (60) days prior to the election.

4.3.3 Any Active Member may submit their name or the name of another Active Member and must be supported in writing by two active Medical Staff members. The Medical Staff must submit additional nominations to the Medical Staff Office at least thirty (30) days prior to the election for the nominee(s) to be placed on the ballot. The Medical Staff Office must determine if the candidate meets the qualifications defined in these Bylaws before he/she can be placed on the ballot.

4.3.4 Voting will occur electronically during even-numbered years. Ballots will be sent out to the members of the Medical Staff eligible to vote thirty (30) days before the final meeting of the year. The nominee(s) who receives the most votes will be elected.

4.4 Term of Office

All officers serve a term of two (2) years. They shall take office on January 1st, in odd years, following their election.

4.5 Removal and Resignation from Office

4.5.1 **Removal by Vote:** Removal of an officer shall be for just cause. Just cause may include but is not limited to:

- a) Failure to meet the responsibilities and duties of office assigned within these Bylaws,
- b) Failure to comply with policies and procedures of the Medical Staff,
- c) Conduct or statements that damage the hospital, its goals, or programs, or a culture of safety.

The Medical Staff may initiate the removal of any officer if at least twenty percent (20%) of the Active members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two-thirds (2/3) supermajority of those Active staff members casting ballot votes, when a quorum is met.

4.5.2 **Automatic Removal:** Automatic removal shall be for failure to meet or maintain any of the qualifications for being an Officer, as noted in these Bylaws.

4.5.3 **Resignation:** Any elected officer may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

4.6 Vacancies of Office

If there is a vacancy in the office of the President of the Medical Staff, the Vice President of the Medical Staff shall serve the remainder of the term. If there is a vacancy in the office of the Vice President of the Medical Staff, the Secretary/Treasurer shall serve the remainder of the term. If there is a vacancy in the office of the Secretary/Treasurer, the MEC will appoint an acting Secretary/Treasurer to serve the remainder of the term.

4.7 Duties of Officers

4.7.1 **President of the Medical Staff:** The President of the Medical Staff (“President”) shall represent the interests of the Medical Staff to the MEC and the Board of Trustees. The President is the primary elected officer of the Medical Staff and is the Medical Staff’s advocate and representative in its relationships to the Board of Trustees and the administration of the hospital. The President, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in the Medical Staff Bylaws, rules, regulations, and policies. Specific responsibilities and authority are to:

- a) Representing the interests of the Medical Staff in their role of service on the Board of Trustees, and in their activities where they interact with the CEO and Board of Trustees.
- b) Calling, presiding, and being responsible for the agenda of all general meetings of the Medical Staff.
- c) Serving as chairperson of the MEC. The President casts the tie-breaking vote in those instances where a tie vote exists.
- d) Serving on the Board of Trustees as a voting member.
- e) Serving as ex-officio, non-voting member of all other Medical Staff committees unless otherwise stated in these Bylaws.
- f) Responsibility for the enforcement of Medical Staff bylaws, rules and regulations, and policies for implementation of sanctions where these are indicated, and for the Medical Staff’s compliance with procedural safeguards in all instances where corrective action has been requested against a member or provider.

- g) Appointing committee members to all standing, special, and interdisciplinary Medical Staff committees except the MEC.
- h) Representing the views, policies, needs, and grievances of the Medical Staff to the Board of Trustees and to the CEO.
- i) Reporting to the Board of Trustees on the quality of medical care provided by members of the Medical Staff as the individual responsible for the Medical Staff, with whom the Board of Trustees shall directly consult on all matters related to the quality of medical care provided to patients at the Hospital, and other matters of mutual concern.
- j) Assisting with the general educational activities of the Medical Staff.
- k) Serving as the spokesperson for the Medical Staff in its external professional and public relations.
- l) Assisting in the development and periodic review of Medical Staff policies, rules and regulations.
- m) Providing appropriate physician input regarding patient care policies and procedures.

4.7.2 Vice President of the Medical Staff: In the absence of the President, the Vice President of the Medical Staff shall assume all the duties and have the authority of the President. The Vice President shall serve as a member of the MEC and the Credentials Committee and shall perform such further duties to assist the President as requested.

4.7.3 Secretary/Treasurer: This officer will be responsible for producing accurate and complete minutes of all Medical Staff meetings, calling Medical Staff meetings on order of the President, attending to all necessary correspondence, and performing other duties as ordinarily pertain to the office. S/he shall serve as a member of the MEC and Credentials Committee. S/he shall perform such further duties to assist the President as requested.

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

5.1.1 The Medical Staff shall be organized into departments. The Medical Staff may create Specialty Section(s) within a department to facilitate Medical Staff activities, which will be defined in the Rules & Regulations. The departments organized by the Medical Staff and formally recognized by the MEC include:

- Anesthesia
- Cardiovascular Medicine
- Dental
- Emergency Medicine
- Family Medicine
- Internal Medicine
- Obstetrics-Gynecology
- Ophthalmology
- Orthopedics
- Pathology
- Pediatrics
- Podiatry
- Psychiatry
- Radiology
- Surgery
- Urology

The MEC, with approval of the Board of Trustees, may designate new Medical Staff departments or Specialty Section or dissolve current departments or Specialty Sections as it determines will best promote the Medical Staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

5.2 Qualifications of Department and Assistant Department Chairs

5.2.1 All Department and Assistant Department Chairs must be Members of the Active Medical Staff, be in good standing at the time of election and throughout the term, have demonstrated executive and medico-administrative abilities, be certified or eligible for certification by an appropriate specialty board, and be willing and able to perform the functions of the position.

5.2.2 Department and Assistant Department Chairs may not hold a leadership position (MEC or Board of Trustees) on an unaffiliated hospital's or Health System's medical staff competing with the hospital. Noncompliance with this requirement will result in the officer being automatically removed from office.

5.3 Election of Department & Assistant Department Chairs

The Department and Assistant Department Chairs shall be elected by the Active Members of their departments:

5.3.1 On even years the following departments will vote for Department and Assistant Department Chairs: dental, emergency medicine, obstetrics-gynecology, ophthalmology, orthopedics, pathology, podiatry, radiology, and urology.

5.3.2 On odd years the following departments will vote for Department and Assistant Department Chairs: anesthesia, internal medicine, cardiovascular medicine, family medicine, pediatrics, psychiatry, and surgery.

5.4 Term of Department and Assistant Department Chairs

Department and Assistant Department Chairs shall have a term of two (2) years starting on January 1st and may serve an unlimited number of terms.

5.5 Removal of Department Chairs

5.5.1 **Automatic Removal:** Automatic removal shall be for failure to meet or maintain any of the qualifications for being a Department or Assistant Department Chair as noted in these Bylaws.

5.5.2 **Removal by Vote:** Removal of a Department or Assistant Department Chair shall be for just cause. Just cause may include but is not limited to:

- a. Failure to meet the responsibilities and duties of office assigned within these Bylaws,
- b. Failure to comply with policies and procedures of the Medical Staff,
- c. Conduct or statements that damage the hospital, its goals, or programs, or a culture of safety.

Initiation for the removal by vote may be done by the MEC, Board of Trustees, or the Active members of that Department. The Active Members of a Department may initiate the removal of any officer if at least twenty percent (20%) of the Active members of that Department, but not less than two (2) Active members, sign a petition advocating for such action. An affirmative vote by a two-thirds (2/3) supermajority of those Active staff members of the Department casting votes is required for removal. Removal shall not be effective until it has been ratified by the MEC.

5.5.3 **Resignation:** Any elected Department or Assistant Department Chair may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt.

5.6 Vacancies of Department Chairs Office

5.6.1 A vacancy in a Department Chairman position is filled by the Assistant Department Chair who will complete the vacated term of the Department Chair. The department shall hold a meeting to select an Assistant Department Chair to complete the vacated term. Any election or other selection process required by this Section is to be conducted as an expeditiously as possible.

5.6.2 A vacancy in an Assistant Department Chair position is filled by election of the department.

5.7 Responsibilities of Department Chairs

- a. Manage the Department through cooperation and coordination with the nursing and other patient care services and Hospital management on all clinically related and administrative activities of the department and all matters affecting patient care.
- b. Participate in planning with respect to the Department's personnel, equipment, facilities, services and budget, including recommending sufficient numbers of qualified and competent staff, determining staff qualifications and competence, recommending off-site services, integrating these services into

the hospital's primary functions, and recommending space and other resources needed by the department.

- c. Communicate and implement within the Department actions taken by the Executive Committee, the Hospital Board of Trustees, and other relevant authorities.
- d. Serve on the Executive Committee if the Medical Staff Bylaws so provide, give guidance on the overall medical policies of the Hospital, and make specific recommendations and suggestions regarding the Department to the Executive Committee and the Hospital Board of Trustees, including credentialing criteria.
- e. Assist in developing, implementing and supervising relevant Medical Staff components of the continuous improvement program as required by these Bylaws.
- f. Maintain continuing review of patient care and the professional performance of practitioners and allied health professionals with clinical privileges or specified services in the Department and present regular written reports to the Executive Committee and other Staff committees when appropriate or required.
- g. Prepare and transmit to the appropriate authorities as required by the Medical Staff Bylaws recommendations concerning Medical Staff membership, delineation of clinical privileges, and corrective action with respect to practitioners in the Department.
- h. Enforce the Medical Staff Bylaws, rules, policies, procedures, and regulations within the Department, including initiating corrective action and investigation of clinical performance and ordering consultations to be provided or sought when necessary.
- i. Assign individual Department members and/or appoint Department committees and designate a chairman and secretary of each such committee, as appropriate to perform the functions of the Department.
- j. Perform such other duties commensurate with the office as are set forth in the Medical Staff Bylaws and, where applicable, in a contract with the Hospital and as may from time to time be reasonably requested by the President of the Staff or the Executive Committee.
- k. Serve as a member of the MEC, participate in the development and implementation of policies and procedures affecting the provision of care, treatment and services in the hospital.

5.8 Assignment to Department

The MEC will, after considering the recommendations of the Chief of the appropriate Department, recommend Department assignments for all members in accordance with their qualifications. Each member will be assigned to one primary Department. Clinical privileges are independent of Department assignment.

Section 6. Committees

6.1 Designation and Substitution

There shall be a Medical Executive Committee (MEC), and such other standing and ad hoc committees as established by the MEC and enumerated in the Organization and Functions Manual which is part of the Rules and Regulations. Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the Medical Staff may be discharged by Medical Staff representation on such hospital committees as are established to perform such functions. The President of the Medical Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 Medical Executive Committee (MEC)

6.2.1 Committee Membership:

- a. Composition: The MEC shall be a standing committee consisting of the following voting members: the Officers of the Medical Staff, the Department Chairs or Assistant Department Chairs in the Chair's absence, and the immediate Past-President of the Medical Staff.
 - i. The non-voting attendee(s) to the MEC are the CEO, CMO, Nursing Executive, and designees.
 - ii. The chair will be the President of the Medical Staff.
- b. Removal from MEC: A Medical Staff Officer or Department Chair who is removed from his/her position in accordance with these Bylaws will no longer qualify to be a member on the MEC and will automatically lose his/her membership on the MEC.

6.2.2 The duties of the MEC, as delegated by the Medical Staff, shall be to:

- a. Represent and act on behalf of the Medical Staff, including between Medical Staff meetings, subject to such limitations as may be imposed by these bylaws.
- b. Review, as necessary, the activities and general policies of the clinical departments.
- c. Receive and act on committee reports and recommendations of clinical departments and other assigned responsibilities.
- d. Review, approve and implement policies of the Medical Staff applicable across clinical departments that impact patient care and safety.
- e. Act as a liaison between Medical Staff, the CEO, and the Board of Trustees.
- f. Recommend action to the CEO on matters of a medico-administrative nature including advising the CEO and Board of Trustees on the selection of administrative staff who may influence the quality of care being provided by the practitioners and members at the hospital.
- g. Review the credentials of all applicants and make recommendations to the Board of Trustees for staff membership, departmental assignments, and delineation of clinical privileges.
- h. Periodically review all available data regarding the performance and clinical competence of providers with clinical privileges.
- i. Make recommendations to the Board of Trustees for appointments to, or renewal or membership on the Medical Staff.
- j. Make recommendations to the Board of Trustees for granting, restricting, or denying clinical privileges.
- k. Make recommendations to the Board of Trustees regarding the Medical Staff structure/organization, function, Medical Staff membership and approval of clinical privileges.
- l. Fulfill the Medical Staff's accountability to the Board of Trustees.
- m. Receive and disseminate information from accrediting bodies to the Medical Staff.

- n. Support medical education programs, and provide oversight as required.
- o. Participate in peer review activities, and Medical Staff correction or accountability measures when warranted.
- p. Report to the Medical Staff at each general staff meeting regarding Medical Staff activities.
- q. Review and act on department recommendations for improving patient safety and patient satisfaction.
- r. Evaluate resource allocation on an interdepartmental basis and recommend changes in staffing, space and other hospital resources as needed to support privileges for which criteria have been approved by the MEC.
- s. Advise the Board of Trustees on the quality of patient care.
- t. Provide input to the Board of Trustees on existing and proposed agreements between Mercy Medical Center and its Medical Staff members, or other providers exercising clinical privileges, or any entity where these agreements can affect the quality of patient care; and
- u. Maintain a permanent record of its proceedings and actions.
- v. Department Chair orientation shall be held at the December General Medical Staff meeting and at the January meeting of the Medical Executive Committee. All new members of the Medical Executive Committee and new Assistant Department Chairs are required to attend one of the two orientation sessions. New Department Chairs and Assistant Department Chairs shall not be seated until they have attended one of the two orientation sessions. All current members of the Medical Executive Committee are invited to attend orientation to provide additional guidance and support.

6.2.3 MEC Meetings:

- a. The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions.
- b. For decision making, a quorum must be present, and is met whenever at least 50% of all eligible MEC voting members are present (virtually or in person).

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

7.1.1 An annual meeting of the Medical Staff shall be held in the last quarter of the year. Notice of the meeting shall be given to all Medical Staff members via appropriate media and posted conspicuously.

7.1.2 The action of a majority of the Active members present and voting at a meeting of the Medical Staff is the action of the group, except as otherwise specified in these Bylaws. Action may be taken without a meeting of the Medical Staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or virtual meeting, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.

7.1.3 Special Meetings of the Medical Staff

- a. The President of the Medical Staff may call a special meeting of the Medical Staff at any time. The President of the Medical Staff must call a special meeting if so directed by resolution of the MEC. The President of the Medical Staff must call a special meeting if so directed by the Medical Staff with a petition signed by thirty percent (30%) of the Active members. Such request or resolution shall state the purpose of the meeting. The MEC shall designate the time and place of any special meeting.
- b. Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff, along with an agenda for the meeting, at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.2 Regular Meetings of Medical Staff Committees and Departments

7.2.1 Committees and Departments may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

7.2.2 Departments should meet at least two (2) times per year; committees shall meet as needed, unless otherwise stipulated in these Bylaws.

7.2.3 There shall be periodic meetings to review and analyze medical records of patients for adequacy and quality of care. This will be incorporated in the Peer Review Committee processes.

7.3 Special Meetings of Committees and Departments

A special meeting of any committee or Department, may be called by the committee chair or Chair or of the Department thereof or by the President of the Medical Staff.

7.4 Quorum for Voting

7.4.1 Medical Staff and Departmental Meetings: Those eligible Medical Staff members present and voting on an issue.

7.5 Attendance Requirements

7.5.1 The Medical Staff attendance requirements are as follows:

- a. Members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Membership category attendance expectations are noted in Part I, Section 3 of these Bylaws.

- b. MEC meetings: Department Chairs are expected to attend at least fifty percent (50%) of the regularly scheduled meetings. If a Department Chair is unable to attend a regularly scheduled meeting, the Assistant Chair is encouraged to attend to represent the Department.
- c. Participation in meetings through electronic means: virtual attendance is permitted; however, the Chair has the discretion to require in-person attendance for certain matters and to notify members accordingly.

7.6 Participation by the CEO

The CEO or his/her designee may attend any general, committee, or Department meetings of the Medical Staff as an ex-officio member without vote.

7.7 Executive Session

At the request of any committee member, or at the request of its chair, the committee will excuse all non-Medical Staff committee members for closed discussion by the Medical Staff on the committee.

7.8 Robert's Rules of Order

Medical Staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest abridged edition of Robert's Rules of Order shall determine procedure.

7.9 Notice of Meetings

Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the Department or committee not less than twenty-four (24) hours before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.10 Action of Committee or Department

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or Department. Such recommendation will then be forwarded to the MEC for action.

7.11 Rights of Ex Officio Members

Except as otherwise provided in these Bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members, except that they shall not vote, be able to make motions, or be counted in determining the existence of a quorum.

7.12 Minutes

Minutes of each regular and special meetings of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding committee chair or Department Chair shall authenticate the minutes. A permanent file of the minutes of each meeting shall be maintained.

Section 8. Conflict Resolution

8.1 Conflict Resolution

- 8.1.1 In the event the Board of Trustees acts in a manner contrary to a recommendation by the MEC, the matter may (at the request of the MEC) be submitted to a Joint Conference Committee for review and recommendation to the full the Board of Trustees. The recommendations of the Joint Conference Committee shall be submitted for review and recommendation by the MEC at its next meeting or within thirty (30) days, whichever is sooner, and at such MEC meeting the MEC shall review and provide a recommendation to the Governing Body for final action.
- 8.1.2 To promote timely and effective communication and to foster collaboration between the Board of Trustees, management, and Medical Staff, the chair of the Board of Trustees, CEO, or the President of the Medical Staff may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.
- 8.1.3 Any conflict between the Medical Staff and the Medical Executive Committee will be resolved using the mechanisms noted in Sections 2 of Part I of these Bylaws.

Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

- 9.1.1 The Medical Staff shall have the responsibility to formulate, review at least triennially, and recommend to the Board of Trustees any Medical Staff Bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the Bylaws and Rules & Regulations shall be effective when approved by the Board of Trustees. The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.
- 9.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This also applies to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these Bylaws.

9.2 Methods of Adoption and Amendment to these Bylaws

- 9.2.1 **Initiation by MEC:** Proposed amendments to these Bylaws may be originated by Medical Staff leadership. All proposed amendments will be reviewed by the Bylaws Committee and forward to the MEC. Once approved by the MEC, the amendment will be sent to the Medical Staff for review and then for vote.
- 9.2.2 **Initiation by the Medical Staff:** Proposed amendments to these Bylaws may be originated by a petition signed by twenty percent (20%) of the Members of the Active category.
- 9.2.3 **Approval Process.**
- a. Each Active member of the Medical Staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All active members of the Medical Staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by the Medical Staff if the Medical Staff receives an affirmative vote by two-thirds (2/3rds) of the votes received.
 - b. Amendments so adopted shall be effective when approved by the Board of Trustees.

9.3 Methods of Adoption and Amendment to any Medical Staff Rules, Regulations, and Policies

- 9.3.1 The Medical Staff may adopt additional rules, regulations, and policies as necessary to carry out its functions and meet its responsibilities under these Bylaws. A Rules and Regulations and/or Policies Manual may be used to organize these additional documents.
- 9.3.2 When a new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized Medical Staff) will communicate the proposal to the other party prior to vote.
- 9.3.3 After thirty (30) day notice to the Medical Staff, the MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, rules and regulations may be adopted, amended, or repealed, and such changes shall be effective when approved by the Board of Trustees. Policies and procedures will become effective upon approval of the MEC.
- 9.3.4 In addition to the process described in 9.3.3 above, the organized Medical Staff itself may recommend directly to the Board of Trustees an amendment(s) to any rule, regulation, or policy by submitting a petition signed by twenty percent (20%) of the members of the Active category. Upon presentation of such petition, the adoption process outlined in 9.2 above will be followed.
- 9.3.5 In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board of Trustees may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the MEC immediately informs the Medical Staff.

- 9.3.6 The MEC may adopt such amendments to these Bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or legal modifications, or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression and shall be effective when approved by the Board of Trustees.
- 9.3.7 Neither the organized Medical Staff nor the Board of Trustees may unilaterally amend the Medical Staff Bylaws or rules and regulations.



Mercy Medical Center

MEDICAL STAFF BYLAWS

**Part II: Investigations, Corrective Actions, Hearing and
Appeal Plan**

Board Approval Date: March 28th, 2025

Table of Contents

Section 1.	Collegial, Educational, and/or Informal Proceedings	1
Section 2.	Investigations	2
Section 3.	Corrective Action	4
Section 4.	Initiation and Notice of Hearing	8
Section 5.	Hearing Review Panel and Presiding Officer or Hearing Officer	11
Section 6.	Pre-Hearing and Hearing Procedure	13
Section 7.	Appeal to the Hospital Board of Trustees	16

Section 1. Collegial, Educational, and/or Informal Proceedings

1.0 Criteria for Initiation

These Bylaws encourage Medical Staff leaders and hospital management to use progressive steps, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that have been raised. All collegial intervention efforts by Medical Staff leaders and hospital management shall be considered confidential and part of the hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and hospital management. When any observations arise suggesting opportunities for a provider to improve his/her clinical skills or professional behavior, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the Medical Staff and hospital. Collegial intervention efforts may include but are not limited to the following:

- a. Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
- b. Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and
- c. Sharing summary comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms.

Following collegial intervention efforts, if it appears that the provider's performance places patients in danger or compromises the quality of care, or in cases where it appears that patients may be placed in harm's way while collegial interventions are undertaken, the MEC will consider whether it should be recommended to the Board of Trustees to restrict or revoke the provider's membership and/or privileges. Before issuing such a recommendation the MEC may authorize an investigation for the purpose of gathering and evaluating any evidence and its sufficiency.

Section 2. Investigations

2.1 Initiation

A request for an investigation must be submitted in writing by a Medical Staff officer, Medical Staff committee chair, Department Chair, CEO, CMO, or Hospital Board of Trustees chair to the MEC. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC itself initiates an investigation, it shall appropriately document its reasons and notify the practitioner.

2.2 Investigation

If the MEC decides that an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution. In the event the Board of Trustees believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the Medical Staff.

If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and either the CEO or CMO. The investigating body may also require, with the approval of the President of the Medical Staff and either the CEO or CMO, the provider under review to undergo a physical and/or mental examination and may access the results of such exams.

The investigating body shall notify the provider in question of the allegations that are the basis for the investigation and provide to the practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a “hearing” as that term is used in the hearing and appeals sections of these Bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the Medical Staff to engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process; or other action.

2.2.1 An external peer review consultant should be considered when:

- a. Litigation seems likely.
- b. The hospital is faced with ambiguous or conflicting recommendations from Medical Staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances, consideration may be given by the MEC or the Board of Trustees to retain an objective external reviewer.
- c. There is no one on the Medical Staff with expertise in the subject under review, or when the only physicians on the Medical Staff with appropriate expertise are direct competitors, partners, or associates of the practitioner under review.

2.3 MEC Action

As soon as feasible after the conclusion of the investigation the MEC shall take action that may include:

- a. Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the practitioner's file.
- b. Deferring action for a reasonable time when circumstances warrant.
- c. Issuing letters of education, admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee chairs or Department Chairs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner's file.
- d. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring.
- e. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges.
- f. Recommending reductions of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care.
- g. Recommending suspension, revocation, or probation of Medical Staff membership.
- h. Taking other actions deemed appropriate under the circumstances.

2.4 Subsequent Action

If the MEC recommends any termination or restriction of the practitioner's membership or privileges, the practitioner shall be entitled to the procedural rights afforded in this hearing and appeal plan. The Board of Trustees shall act on the MEC's recommendation unless the member requests a hearing, in which case the final decision shall be determined as set forth in this Hearing and Appeal plan.

Section 3. Corrective Action

3.1 Automatic Relinquishment/Voluntary Resignation

In the following triggering circumstances, the provider's privileges and/or membership will be considered relinquished, or limited as described, and the action shall be final without a right to hearing. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. The President of the Medical Staff with the approval of the CMO or CEO may reinstate the provider's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within sixty (60) days, the practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these Bylaws whenever any of the following actions occur:

3.1.1 Licensure

- a. **Revocation and suspension:** Whenever a provider's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, Medical Staff membership and clinical privileges shall be automatically relinquished by the provider as of the date such action becomes effective.
- b. **Restriction:** Whenever a provider's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the provider has been granted at this hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- c. **Probation:** Whenever a provider is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

3.1.2 **Medicare, Medicaid, Tricare :** Whenever a provider is sanctioned or barred from Medicare, Medicaid, Tricare, or other state or federal programs, Medical Staff membership and clinical privileges shall be considered immediately and automatically relinquished as of the date such action becomes effective. Exclusion lists may include, but are not limited to the Office of the Inspector General's List of Excluded Individuals/Entities, state Medicaid Fraud Control Unit lists, and the General Services Administration System for Award Management.

3.1.3 Controlled Substances

- a. **DEA Certificate:** Whenever a practitioner's United States Drug Enforcement Administration (DEA) certificate is revoked, limited, or suspended, the provider will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
- b. **Probation:** Whenever a provider's DEA certificate is subject to probation, the provider's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

- 3.1.4 **Medical Record Completion Requirements:** A provider will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever s/he fails to complete medical records within time frames established by the MEC. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.
- 3.1.5 **Professional Liability Insurance:** Failure of a provider to maintain professional liability insurance in the amount required by state regulations and Medical Staff and Board of Trustees policies and sufficient to cover the clinical privileges granted shall result in immediate automatic relinquishment of a provider's clinical privileges. If within 60 calendar days of the relinquishment the provider does not provide evidence of required professional liability insurance (including prior acts or "nose" coverage for any period during which insurance was not maintained), the provider shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical Staff. The provider must notify the Medical Staff Office immediately of any change in professional liability insurance carrier or coverage.
- 3.1.6 **Medical Staff Dues/Special Assessments:** If a member fails to pay dues or special assessments as required, the member will not be deemed to meet the minimum criteria at the time of reappointment and membership and clinical privileges will be considered automatically relinquished.
- 3.1.7 **Felony Conviction:** A provider who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a felony relating to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, violence, abuse (physical, sexual, child, or elder) in any jurisdiction shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board of Trustees or through corrective action, if necessary. This does not preclude the MEC from taking action on charges or indictments of the above or other offenses.
- 3.1.8 **Failure to Satisfy the Special Appearance Requirement:** A provider who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these Bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored when the provider complies with the special appearance requirement. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.
- 3.1.9 **Failure to Participate in Required Testing:** A provider who fails to participate in required testing, as noted in Part I, and authorizes release of this information to the MEC, shall be considered to have automatically relinquished all privileges. These privileges will be restored when the practitioner complies with the requirement for an evaluation. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the Medical Staff.
- 3.1.10 **Failure to become board certified:** Unless granted a waiver by the department chair and affirmed by the MEC, a provider shall become board certified within the eligibility period of their specialty's licensing board. If a waiver is not granted, the provider will be deemed to have voluntarily relinquished his or her Medical Staff appointment and clinical privileges, becoming effective at the next reappointment date.

- 3.1.11 **Loss of Supervising/Collaborating Physician for Advanced Practice Professionals:** If an APP loses their relationship with a supervising/collaborating physician on staff at this Hospital, then the APP is automatically suspended until the APP develops a new supervision/collaboration relationship with another Member of the Medical Staff. If another supervising/collaborating relationship is not developed within sixty (60) days, then the APP automatically relinquished their privileges.
- 3.1.12 **Suspension at any Mercy Health System Hospital:** A provider who is suspended at another any Mercy Health System Hospital, with the exception of suspensions due to medical records violations or the payment of dues, shall be considered to have all privileges at this Hospital automatically suspended. If the suspension is terminated at the other any Mercy Health System Hospital, the suspension will be automatically rescinded at this Hospital.
- 3.1.13 **Involuntary Termination at any Mercy Health System Hospital:** A provider who is involuntarily terminated at any Mercy Health System Hospital shall result in automatic termination at this Hospital.
- 3.1.14 **Failure to Execute Release and/or Provide Documents:** A provider who fails to execute a general or specific release of information and/or provide documents when requested by the President of the Medical Staff or designee to evaluate the competency and credentialing/privileging qualifications of the provider shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within thirty (30) calendar days of notice of the automatic relinquishment, the provider may be reinstated. After thirty (30) calendar days, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.
- 3.1.15 **MEC Deliberation:** As soon as feasible after action is taken or warranted as described above, the MEC shall convene to review and consider the facts and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in these Bylaws.

3.2 Summary Restriction or Suspension

- 3.2.1 **Criteria for Initiation:** A summary restriction or suspension may be imposed when a good faith belief exists that immediate action must be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when Medical Staff leaders and/or the CEO determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to adversely affect patient or employee safety or the effective operation of the institution. Under such circumstances one (1) Medical Staff leader (such as a Medical Staff Officer, Department Chair, or Section Chief) in conjunction with one (1) administrator (such as CEO, CMO, or administrator on call) restrict or suspend the Medical Staff membership or clinical privileges of such practitioner as a precaution. A suspension of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a summary suspension of all or any of the practitioner's clinical privileges at this hospital.

Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the practitioner, the MEC, the CEO, and the Board of Trustees. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The summary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.

Unless otherwise indicated by the terms of the summary restriction or suspension, the practitioner's patients shall be promptly assigned to another Medical Staff member by the President of the Medical Staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

- 3.2.2 **MEC Action:** As soon as feasible and within fourteen (14) calendar days after such summary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the summary restriction or suspension, but in any event, it shall furnish the practitioner with notice of its decision.
- 3.2.3 **Procedural Rights:** Unless the MEC promptly terminates the summary restriction or suspension prior to or immediately after reviewing the results of any investigation described above, the member or other physician or dentist with privileges without membership (or applicant for the above) shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days.

Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any practitioner eligible for Medical Staff appointment or physicians eligible for privileges without membership shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board of Trustees. Hearings will be triggered only by the following “adverse actions” when the basis for such action is related to clinical competence or professional conduct:

- a. Denial of Medical Staff appointment or reappointment.
- b. Revocation of Medical Staff appointment.
- c. Denial or restriction of requested clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member’s failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.
- d. Involuntary reduction or revocation of clinical privileges.
- e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual Medical Staff member and is imposed for more than fourteen (14) calendar days.
- f. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member’s failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

4.2 Hearings Will Not Be Triggered by the Following Actions:

- a. Issuance of a letter of guidance, warning, or reprimand.
- b. Imposition of a requirement for proctoring (i.e., observation of the practitioner’s performance by a peer in order to provide information to a Medical Staff peer review committee) with no restriction on privileges.
- c. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege.
- d. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee.
- e. Requirement to appear for a special meeting under the provisions of these Bylaws.
- f. Automatic relinquishment or voluntary resignation of appointment or privileges.
- g. Imposition of a summary suspension that does not exceed fourteen (14) calendar days.
- h. Denial of a request for leave of absence, or for an extension of a leave.
- i. Determination that an application is incomplete or untimely.
- j. Determination that an application will not be processed due to misstatement or omission.
- k. Decision not to expedite an application.
- l. Denial, termination, or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct.
- m. Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership.

- n. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a Medical Staff development plan or covered under an exclusive provider agreement.
- o. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted.
- p. Termination of any contract with or employment by hospital.
- q. Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any regulatory standards on focused professional practice evaluation.
- r. Any recommendation voluntarily accepted by the practitioner.
- s. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period.
- t. Change in assigned staff category.
- u. Refusal of the Credentials Committee or MEC to consider a request for appointment, reappointment, or privileges after a final adverse decision on membership or privileges at any healthcare facility.
- v. Removal or limitations of emergency department call obligations.
- w. Any requirement to complete an educational assessment.
- x. Retrospective chart review.
- y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these Bylaws.
- z. Grant of conditional appointment or appointment for a limited duration.
- aa. Appointment or reappointment for duration of less than 24 months.

4.3 Notice of Recommendation of Adverse Action

When a summary suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which, according to this plan entitles an individual to request a hearing prior to a final decision of the Board of Trustees, the affected individual shall promptly (but no longer than five (5) calendar days) be given written notice by the CEO or designee, delivered either in person or by certified mail, return receipt requested. This notice shall contain:

- a. A statement of the recommendation made and the general reasons for it (Statement of Reasons).
- b. Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation.
- c. Notice that the recommendation, if finally adopted by the Board of Trustees, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank.
- d. The individual shall receive a copy of Part II of these Bylaws outlining procedural rights with regard to the hearing.

4.4 Request for Hearing

A practitioner shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the CEO or designee. In the event the affected 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 such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final Board of Trustees action.

4.5 Notice of Hearing and Statement of Reasons

4.5.1 Upon receipt of the practitioner's timely request for a hearing, the CEO, Medical Staff President, or designee shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

- a. The time, place, and date of the hearing.
- b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the MEC, (or the Board of Trustees), at the hearing.
- c. The names of the Review Panel members and presiding officer or hearing officer, if known.
- d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to 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, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

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

4.6 Witness List

At least fifteen (15) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses intended to be called. Either party may request that the other party provide either a list of, or copies of, all documents that will be offered as pertinent information or relied upon by witnesses at the Hearing Review Panel and which are pertinent to the basis for which the disciplinary action was proposed. The witness list of either party may, in the discretion of the presiding officer, 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.

Section 5. Hearing Review Panel and Presiding Officer or Hearing Officer

5.1 Hearing Review Panel

5.1.1 **Selection of Review Panel:** When a hearing is requested, a hearing review panel (“Review Panel”) of not fewer than three individuals will be appointed. This Review Panel will be appointed by the Hospital CEO, in conjunction with the President of the Medical Staff.

- a. No individual appointed to the Review Panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the Review Panel.
- b. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the Review Panel. Review Panel members need not be members of the hospital Medical Staff.
- c. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.
- d. The Review Panel shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is in professional practice with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or the presiding officer.

5.1.2 **Notification of Review Panel Selection:** The CEO, President of the Medical Staff, or designee shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the Review Panel or to the hearing officer or presiding officer shall be made in writing to the CEO. The Hospital CEO and Medical Staff President shall determine whether a replacement panel member should be identified. Although the practitioner who is the subject of the hearing may object to a panel member, s/he is not entitled to veto that member’s participation. Final authority to appoint panel members will rest with the Hospital CEO.

5.2 Hearing Review Panel Chairperson or Presiding Officer

5.2.1 In lieu of a Review Panel chair, the CEO, acting for the Board of Trustees and after considering the recommendations of the President of the Medical Staff (or those of the chair of the Board of Trustees, if the hearing is occasioned by a Board of Trustees determination) may appoint an attorney at law or other individual experienced in legal proceedings as presiding officer. The presiding officer should have no previous conflicting relationship with either the hospital, organized Medical Staff, or the practitioner. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the Review Panel and may serve as a legal advisor to it but shall not be entitled to vote on its recommendation.

5.2.2 If no presiding officer has been appointed, a chair of the Review Panel shall be appointed by the CEO to serve as the presiding officer and shall be entitled to one vote.

5.2.3 The presiding officer (or Review Panel chair) shall do the following:

- a. Act to ensure 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.
- b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than fifteen (15) hours.
- c. Maintain decorum throughout the hearing.
- d. Determine the order of procedure throughout the hearing.
- e. Have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.
- f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the Review Panel in formulating its recommendations.
- g. Conduct argument by counsel on procedural points and may do so outside the presence of the Review Panel.
- h. Seek legal counsel when s/he feels it is appropriate. Legal counsel to the hospital may advise the presiding officer or panel chair.

5.3 Hearing Officer

5.3.1 As an alternative to the Review Panel described above, the CEO, acting for the Board of Trustees and in conjunction with the President of the Medical Staff (or those of the chair of the Board of Trustees, if the hearing is occasioned by a Board of Trustees determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the Review Panel. The hearing officer may be an attorney in non-clinical matters.

5.3.2 The hearing officer may not be any individual who is 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 Review Panel, all references to the "Review Panel" or "presiding officer" shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

- 6.1.1 There is no right to formal “discovery” in connection with the hearing. The presiding officer, Review Panel chair, or hearing officer shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. In general, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the individual’s counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:
- a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense.
 - b. Reports of experts relied upon by the MEC.
 - c. Copies of redacted relevant committee minutes.
 - d. Copies of any other documents relied upon by the MEC or the Board of Trustees.
 - e. No information regarding other practitioners shall be requested, provided, or considered.
 - f. Evidence unrelated to the reasons for the recommendation or to the individual’s qualifications for appointment or the relevant clinical privileges shall be excluded.
- 6.1.2 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 all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing prior to the hearing. The presiding officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- 6.1.3 There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the hospital’s witness list concerning the subject matter of the hearing; nor shall there be contact by the hospital with individuals appearing on the affected individual’s witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his/her counsel.

6.2 Pre-Hearing Conference

The presiding officer may require a representative for the individual and for the MEC (or the Board of Trustees) to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be allotted to each witness’s testimony and cross-examination. The appropriate role of attorneys will be decided at the pre-hearing conference.

6.3 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 a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Board of Trustees for final action. Good cause for failure to appear will be determined by the presiding officer, chair of the Review Panel, or hearing officer.

6.4 Record of Hearing

The Review Panel shall maintain a record of the hearing by a 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 hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The Review Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Iowa.

6.5 Rights of the Practitioner and the Hospital

6.5.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the presiding officer:

- a. To call and examine witnesses to the extent available.
- b. To introduce exhibits.
- c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence.
- d. To have representation by counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may argue the case for his/her client. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing.
- e. The practitioner may also opt to be represented by a member of the Medical Staff who is in good standing, or another person of the practitioner's choice instead of counsel.
- f. To submit a written statement at the close of the hearing.

6.5.2 Any individuals requesting a hearing who do not testify in their own behalf may be called and examined as if under cross-examination.

6.5.3 The Review Panel may question the witnesses, call additional witnesses, or request additional documentary evidence.

6.6 Admissibility of Evidence

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

6.7 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum, and the Review Panel may request such a memorandum to be filed with ten (10) business days, following the close of the hearing.

6.8 Official Notice

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. 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 officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

6.9 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 on a showing of good cause.

6.10 Persons to be Present

6.10.1 The hearing shall be restricted to those individuals involved in the proceeding.

6.10.2 Administrative personnel may be present as requested by the President of the Medical Staff or CEO.

6.10.3 The presiding officer may allow for virtual attendance for a Review Panel member or witness upon showing of good cause.

6.11 Order of Presentation

The Board of Trustees or the MEC, 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.

6.12 Basis of Recommendation

The Review Panel shall recommend in favor of either 1) the MEC, or 2) the Board of Trustees, depending on the body that recommended the action, or 3) the practitioner, if it finds that the practitioner who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

6.13 Adjournment and Conclusion

The presiding officer may recess 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 questions by the Review Panel, the hearing shall be closed.

6.14 Deliberations, Voting, and Recommendation of the Hearing Review Panel

6.14.1 Within thirty (30) calendar days after final adjournment of the hearing, the Review Panel shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation.

6.14.2 A simple majority of Review Panel members shall constitute a quorum. Action is taken by the affirmative vote of a simple majority of the Review Panel members present during a meeting or hearing. No member of a Review Panel may vote by proxy.

6.15 Disposition of Hearing Review Panel Report

The Review Panel shall deliver its report and recommendation to the CEO or President of the Medical Staff, who shall forward it, along with all supporting documentation, to the Board of Trustees for further action. A copy of the report and recommendation, shall be sent by certified mail, return receipt requested, to the individual who requested the hearing, and to the MEC for information and comment. If the Review Panel report confirms the original adverse recommendation, the practitioner shall have the right to appellate review as outlined below. If the Review Panel report differs from the original MEC or Board of Trustees recommendation, the MEC or Board of Trustees may uphold its original recommendation or modify or adjust its recommendation and submit its new recommendation in writing to the affected practitioner, including a statement of the basis for its recommendation.

Section 7. Appeal to the Hospital Board of Trustees

7.1 Time for Appeal

Within seven (7) calendar days after the Review Panel makes a recommendation, or after the MEC or Board of Trustees makes its final recommendation, either the practitioner subject to the hearing or the MEC may appeal an adverse recommendation. The request for appellate review shall be in writing and shall be delivered to the CEO or designee either in person or by certified mail and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within seven (7) calendar days, both parties shall be deemed to have accepted the recommendation involved, and the Review Panel's report and recommendation shall be forwarded to the Board of Trustees.

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

- a. There was substantial failure to comply with the Medical Staff Bylaws prior to or during the hearing so as to deny a fair hearing; or
- b. The recommendation of the Review Panel was made arbitrarily, capriciously, or with prejudice; or
- c. The recommendation of the Review Panel was not supported by substantial evidence based upon the hearing record.

7.3 Time, Place, and Notice

Whenever an appeal is requested as set forth in the preceding sections, the chair of the Board of Trustees shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected individual shall be given notice of the time, place, and date of the appellate review. The chair of the Board of Trustees may extend the time for appellate review for good cause.

7.4 Nature of Appellate Review

- a. The chair of the Board of Trustees shall appoint a review panel composed of at least three (3) members of the Board of Trustees to consider the information upon which the recommendation before the Board of Trustees was made. Members of this appellate review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.
- b. The appellate review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the Review Panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, the appellate review panel shall maintain a record of any oral arguments or statements by a reporter present to make a record of the review or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the review at that individual's expense. The appellate review panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Iowa.
- c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the appellate review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument.

- d. The appellate review panel shall recommend final action to the Board of Trustees.
- e. The Board of Trustees may affirm, modify, or reverse the recommendation of the appellate review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board of Trustees' ultimate legal responsibility to grant appointment and clinical privileges.

7.5 Final Decision of the Hospital Board of Trustees

Within thirty (30) calendar days after receiving the appellate review panel's recommendation, the Board of Trustees shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairs of the Credentials/Bylaws Committee and MEC, in person or by certified mail, return receipt requested.

7.6 Right to One Appeal Only

No applicant or Medical Staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board of Trustees ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current member or a practitioner with privileges without membership, that individual may never apply for Medical Staff appointment or for those clinical privileges at this hospital unless the Board of Trustees advises otherwise.

7.7 Fair Hearing and Appeal for Those Providers with Privileges Without Medical Staff Membership and Who are Not Practitioners

7.7.1 It is noted that if the action against an APP/AHP is to be reported to the NPDB, the provider must have the full fair hearing and appeal process as noted above, instead of the simplified version below.

7.7.2 Whenever the MEC or the Board of Trustees makes a recommendation or takes an action to deny an APP/AHP application, to terminate or summarily suspend clinical privileges, or to restrict any or all privileges for more than thirty (30) days, the CEO, or designee, provides special written notice of the recommendation or action, the reasons for it, and the time period within which the provider can request a meeting to discuss the matter.

7.7.3 If the APP/AHP fails to timely request a meeting, the right to a meeting shall be waived. The APP/AHP's right to a meeting may be forfeited for failure to appear at the scheduled meeting without good cause.

7.7.4 If the APP/AHP requests a meeting, the President of the Medical Staff and CMO appoint a committee comprised of at least three (3) unbiased Medical Staff members and/or providers with Clinical Privileges at the Hospital, to hear the provider's objections to the proposed action or recommendation.

7.7.5 The committee shall establish the rules for the meeting, in advance of the meeting, and shall communicate those rules to the provider. It is intended that the meeting will not be judicial in form but rather a forum for professional evaluation and discussion between members of the committee and the provider.

7.7.6 During the meeting, the provider shall have the right to receive an explanation of the recommendation or action upon which the meeting is based, and to submit any additional information to the committee that the provider and the committee deem relevant to the review of the recommendation or action.

7.7.7 After the meeting, the committee shall make a written recommendation, including an explanation of the basis for its recommendation, to the Board of Trustees for final action. The committee's written recommendation shall also be delivered to the provider.

7.7.8 The APP/AHP shall have the right to one appeal of the committee's recommendation to the Board of Trustees.

7.7.9 Final actions regarding APP/AHPs are reported to the National Practitioner Data Bank.



Mercy Medical Center

MEDICAL STAFF BYLAWS

Part III: Credentials Procedures Manual

Board Approval Date: March 28th, 2025

Table of Contents

Section 1. Qualifications for Membership and/or Privileges	1
Section 2. Initial Appointment Procedure	3
Section 3. Reappointment	9
Section 4. Clinical Privileges	11
Section 5. Quality Performance Monitoring	18
Section 6. Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies	19
Section 7. Leave of Absence	20

Section 1. Qualifications for Membership and/or Privileges

- 1.1. No provider shall be entitled to membership on the Medical Staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.
- 1.2. The following qualifications must be met and continuously maintained by all applicants for Medical Staff appointment, reappointment, or clinical privileges:
 - a. Currently licensed in the state of Iowa,
 - b. Graduate of medical, osteopathic, dental or podiatric medical schools accredited by the appropriate nationally recognized accrediting body or recognized by the National Committee on Foreign Medical Education and Accreditation,
 - c. Graduate of post graduate training programs accredited by the appropriate nationally recognized accrediting body, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada and other comparable accreditation bodies. Such consideration shall be based upon the program's standardized supervision, teaching and formal evaluation of the graduate; medical information content; didactic sessions and clinical experience provided,
 - d. Demonstrate proof of current malpractice liability insurance. This coverage must be provided by an insurer licensed or approved by the Iowa State Insurance Commission.
 - e. Board certified or board eligible in their specialty.
 - f. Have a record that is free from current Medicare/Medicaid sanctions and not be on any state or federal exclusion list, such as the OIG List of Excluded Individuals/Entities,
 - g. Have a record of no previous adverse decision regarding membership and/or privileges at any other healthcare facility, and
 - h. Have appropriate written and verbal communication skills.
 - i. In addition to privilege-specific criteria, the following qualifications must also be met and maintained by all applicants requesting clinical privileges:
 1. Demonstrate his/her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested,
 2. Possess a current, valid, and unrestricted Drug Enforcement Administration (DEA) and/or CSR number if applicable and required for privileges,
 3. Possess a valid NPI number,
 4. Upon request provide evidence of both physical and mental health that does not impair the fulfillment of his/her responsibilities of Medical Staff membership and/or the specific privileges requested by and granted to the applicant,
 5. Any practitioner granted privileges who may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care, including compliance with medical record documentation requirements to the satisfaction of the MEC and Board,
 6. Demonstrate recent clinical performance within the last twenty-four (24) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet.
 7. Applicants shall report any previous conviction or charge of a felony or misdemeanor (aside from misdemeanor traffic violations.)

1.3. Exceptions

1.3.1. Initial applicants applying to the Medical Staff after March 28th, 2025 shall be required to be board certified or eligible in their specialty. All providers who are current Medical Staff members and/or hold privileges as of March 28th, 2025 and who have met prior qualifications for membership and/or privileges shall be exempt from board certification requirements.

1.3.2. Only the Board of Trustees may create additional exceptions but only after consultation with the MEC and if there is documented evidence that a practitioner demonstrates an equivalent competence in the areas of the requested privileges.

Section 2. Initial Appointment Procedure

2.1. Completion of Application

All requests for applications for appointment to the Medical Staff and requests for clinical privileges will be forwarded to the Medical Staff office. Upon receipt of the request, the Medical Staff office will provide the applicant an application package, which will include a complete set or overview of the Medical Staff Bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for Medical Staff membership and/or privileges and a list of expectations of performance for individuals granted Medical Staff membership or privileges (if such expectations have been adopted by the Medical Staff).

2.1.1. A completed application includes, at a minimum:

- a. A completed, signed, dated application form,
- b. A completed privilege delineation form (as applicable),
- c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency,
- d. All applicable fees,
- e. A current picture ID card issued by a state or federal agency (e.g., driver's license or passport) or current picture hospital ID card,
- f. Receipt of at least two (2) peer references at a minimum, or more as determined by the Department Chair. References shall come from peers knowledgeable about the applicant's experience, ability, and current competence to perform the privileges being requested. At least one reference must be from someone in the same professional discipline.
- g. Relevant provider-specific data as compared to aggregate data (if available), and
- h. Morbidity and mortality data, when available.

2.1.2. An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed, and the applicant will not be entitled to a fair hearing. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated, and no further action taken.

2.1.3. The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the Medical Staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for Medical Staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the applicant. If the requested information is not returned to the Medical Staff office within forty-five (45) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

2.1.4. Upon receipt of a completed application the CMO or credentials chair, in collaboration with the Medical Staff office, will determine if the requirements of these Bylaws are met. In the event the requirements are not met, the potential applicant will be notified that s/he is ineligible to apply for membership or privileges on the Medical Staff, the application will not be processed, and the applicant will not be eligible for a fair hearing.

- 2.1.5. Individuals seeking appointment shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.
- 2.1.6. Upon receipt of a completed application, the Medical Staff office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the Medical Staff office will collect relevant additional information which may include:
- a. Verification of the applicant's past clinical work experience for at least the past five (5) years.
 - b. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the Medical Staff office will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration.
 - c. Information from the AMA or AOA Physician Profile, and state and federal exclusion lists, such as the OIG list of Excluded Individuals/Entities, and the Federation of State Medical Boards (FSMB).
 - d. Information from professional training programs including residency and fellowship programs.
 - e. Information regarding board certification status from the applicable board.
 - f. Information from the National Practitioner Data Bank (NPDB); in addition, each provider will be enrolled in continuous query. Any new NPDB reports will be reviewed when received by the Medical Staff Office and included for review in the file as part of the process for the renewal of privileges.
 - g. Other information about adverse credentialing and privileging decisions.
 - h. Peer recommendations who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism to perform requested privileges.
 - i. Information from a lifetime criminal background check for initial application only.
 - j. Information from any other sources relevant to the qualifications of the applicant to serve on the Medical Staff and/or hold privileges.
 - k. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available.
- 2.1.7. In the event there is undue delay in obtaining required information, the Medical Staff office will request assistance from the applicant. During this time, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after forty-five calendar days will be deemed a withdrawal of the application.

2.2. Application Evaluation

All initial applications for membership and/or privileges will be designated as Category 1 or Category 2 as defined below.

2.2.1. Category 1

A completed application that does not raise concerns as identified in the criteria for Category 2.

2.2.2. Category 2

If one or more of the following criteria are identified in the course of reviewing a completed and verified application, the application will be treated as Category 2. The Credentials Committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that s/he meets the criteria for membership on the Medical Staff and for the granting of requested privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

- a. The application is deemed to be incomplete.
- b. The applicant has a reported prior conviction or charge of a felony or misdemeanor (aside from misdemeanor traffic violations.)
- c. The final recommendation of the MEC is adverse or with limitation.
- d. The applicant is found to have experienced an involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration.
- e. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions.
- f. Applicant has had an unusual pattern of malpractice cases settled or had an adverse judgment within the past five (5) years.
- g. Applicant changed medical schools or residency programs or has gaps in training or practice.
- h. Applicant has changed practice affiliations more than three times in the past ten (10) years, excluding military service, telemedicine, and locum tenens providers.
- i. Applicant has practiced or been licensed in three (3) or more states post residency/fellowship, excluding telemedicine and locum tenens providers.
- j. Applicant has one or more reference responses that raise concerns or questions.
- k. Discrepancy is found between information received from the applicant and references or verified information,
- l. Applicant has an adverse National Practitioner Data Bank report unrelated to professional liability actions.
- m. The request for privileges is not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria.
- n. Applicant has been removed from a managed care panel for reasons of professional conduct or quality.
- o. Other reasons as determined by a Medical Staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism, or appropriateness of the applicant for membership or privileges.

2.2.3. Applicant Interview

- 2.2.3.1. All applicants for appointment to the Medical Staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the Department Chair, Credentials Committee, MEC, or Board. The interview may take place in person or by telephone at the discretion of the interviewer. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided.

- 2.2.3.2. Failure of the applicant to appear for a scheduled interview within forty-five (45) days of completion of his or her application will be deemed a withdrawal of the application.

2.2.4. Expedited Credentialing Process

- 2.2.4.1. **Category 1 – Clean Files.** A Category I application may be eligible for an expedited process of review and approval for the granting of initial privileges.
- a. Following review and approval of the file by the Department Chair and Credentials Committee, expedited privileges for a Category 1 file may be granted by the CEO or designee and the Medical Staff President or Vice President in the absence of the President.
 - b. Expedited privileges shall be granted for 90 days. They may be immediately terminated at any time by the President of the Medical Staff or the CEO. Termination of expedited privileges shall in no event give rise to the right to a fair hearing or appellate review.
 - c. An applicant, with a Category 1 file, which has been granted expedited privileges will continue to follow the standard process for final review and action for the granting of privileges and medical staff membership.
- 2.2.4.2. **Category 2 – Unclean files.** A Category 2 application will not be eligible for review and approval for the granting of expedited privileges and will follow the standard process for review and action as outlined in these bylaws.

2.2.5. Department Chair Action

- 2.2.5.1. All completed applications are presented to the Department Chair for review, and recommendation. The Department Chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Department Chair, in consultation with the Medical Staff office, determines whether the application is forwarded as a Category 1 or Category 2. The Department Chair may obtain input, if necessary, from an appropriate subject matter expert.
- 2.2.5.2. It is the responsibility of all members to report and identify any potential, actual, or perceived conflict of interest. If a Department Chair believes a conflict of interest exists that might preclude his/her ability to make an unbiased recommendation s/he will notify the credentials chair and forward the application without comment. The chair of the Credentials Committee and the President of the Medical Staff hold the right to reassign a credentials file review, if a Department Chair does not recognize a potential, actual, or perceived conflict of interest.
- 2.2.5.3. The Department Chair forwards the following recommendations to the Medical Staff Credentials Committee:
1. Whether the application should be acted on as Category 1 or Category 2.
 2. Whether to approve, approve and modify, or deny the applicant's request to membership and/or privileges.
 3. The circumstances and criteria which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
 4. Comments to support these recommendations.

2.2.6. Medical Staff Credentials Committee Action

- 2.2.6.1. The Credentials Committee shall examine the evidence of the character, professional competence, qualifications, current health status, and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including a written appraisal from the chair of the clinical department in which privileges are sought, whether the applicant has established that he/she meets all of the necessary qualifications for the category of Medical Staff membership and the clinical privileges requested. At the discretion of the Credentials Committee, the applicant, in addition to the information submitted, may be requested to personally appear and be given an opportunity to be heard before the Credentials Committee or be interviewed by telephone by a committee member.
- 2.2.6.2. The Credentials Committee will make a formal report and recommendation to the MEC:
- a. To approve, approve but modify, or deny the applicant's request for membership and/or privileges.
 - b. To define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
 - c. Comments to support these recommendations.

2.2.7. MEC Action

- 2.2.7.1. The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following recommendations to the Board:
- a. Approve, approve but modify, or deny the applicant's request for membership and/or privileges.
 - b. Define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
 - c. Comments to support these recommendations.
- 2.2.7.2. Whenever the MEC makes an adverse recommendation to the Board, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

2.2.8. Board of Trustees Action:

The Board of Trustees reviews the application and votes for one of the following actions:

- a. If the Board of Trustees agrees with the recommendations of the MEC, the application is approved, and the requested membership and/or privileges are granted for a period not to exceed twenty-four (24) months.
- b. The Board of Trustees may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made.
- c. If the Board of Trustees action is adverse to the applicant, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan); or

- d. The Board of Trustees shall take final action in the matter as provided in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

2.2.9. Notice of Final Decision:

Notice of the Board of Trustees final decision shall be given, through the CEO to the MEC and to the Chair of each Department concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the Department to which s/he is assigned, the clinical privileges s/he may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

2.2.10. Time Periods for Processing:

All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days.

These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.

Section 3. Reappointment

3.1. Criteria for Reappointment

- 3.1.1. It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in Section 2. The MEC must also determine that the practitioner provides effective care that is consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program. The practitioner must provide the information enumerated in 3.2.3 below.
- 3.1.2. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months.
- 3.1.3. The granting of new clinical privileges to existing Medical Staff members or other practitioners with privileges will follow the same initial appointment process, including the requirements for initial quality performance monitoring.
- 3.1.4. The Assistant Department Chair or President of the Medical staff, in the absence of an Assistant Chair, shall substitute for the Department Chair in the evaluation of current competency of the Department Chair and recommend appropriate action to the Credentials Committee.

3.2. Information Collection and Verification

- 3.2.1. From appointee: On or before three (3) months prior to the date of expiration of a Medical Staff appointment or grant of privileges, a representative from the Medical Staff office notifies the practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least two (2) months prior to this date the provider must return the following to the Medical Staff Office:
 - a. A completed reapplication form, which includes complete information to update his/her file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees or dues;
 - b. Information concerning continuing training and education internal and external to the hospital during the preceding period; and
 - c. By signing the reapplication form the appointee agrees to the same terms as initial appointment.
- 3.2.2. From internal and/or external sources: The Medical Staff Office collects and verifies information regarding each provider's professional and collegial activities to include those items listed in the application and these Bylaws.
- 3.2.3. The following information is also collected and verified:
 - a. A summary of clinical activity at this hospital for each provider due for reappointment.
 - b. Performance and conduct in this hospital and other healthcare organizations in which the provider has provided substantial clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice.
 - c. Documentation of any required hours of continuing medical education activity.
 - d. Service on Medical Staff, Department, and hospital committees.
 - e. Timely and accurate completion of medical records.

- f. Compliance with all applicable Bylaws, policies, rules, regulations, and procedures of the hospital and Medical Staff.
- g. Any significant gaps in employment or practice since the previous appointment or reappointment.
- h. Verification of current licensure.
- i. National Practitioner Data Bank query, information from the OIG List of Excluded Individuals/Entities or SAM (System for Award Management) and FSMB (Federation of State Medical Boards).
- j. When sufficient peer review data is not available to evaluate competency, one or more peer recommendations chosen from provider(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges; and
- k. Malpractice history for the past two (2) years, which is primary source verified by the Medical Staff Office with the provider's malpractice carrier(s).

3.2.4. Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the Medical Staff Office verifies this additional information and notifies the provider of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

3.3. Evaluation of Application for Reappointment of Membership and/or Privileges

The reappointment application will be reviewed and acted upon as described in Section 3. For the purpose of reappointment an "adverse recommendation" by the Board of Trustees as used in Section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant to a Fair Hearing under Part II of the Medical Staff Bylaws. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "staff appointee" and "reappointment."

Section 4. Clinical Privileges

4.1. Exercise of Privileges

- 4.1.1. A provider exercising clinical services at the hospital may exercise only those privileges granted to him/her by the Board of Trustees or emergency or disaster privileges as described herein. Privileges may be granted by the Board of Trustees, upon recommendation of the MEC to providers who are not members of the Medical Staff. Such individuals may be Advanced Practice Professionals, Allied Health Professionals, physicians serving short locum tenens positions, telemedicine physicians, house staff such as fellows moonlighting in the hospital, or others deemed appropriate by the MEC and Board.
- 4.1.2. The Medical Staff and Hospital will ensure individuals with clinical privileges provide services only within the scope granted by sending a confirmation of privileges granted to each practitioner at the time of appointment and reappointment and by making a list of current clinical privileges for all providers available via the electronic, on-line, Privilege Inquiry system so that those involved in scheduling and patient care can confirm privileges granted.

4.2. Requests

When applicable, each application for appointment or reappointment to the Medical Staff or for privileges must contain a request for the specific clinical privileges the applicant desires. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

4.3. Basis for Privileges Determination

- 4.3.1. Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its Board of Trustees approved criteria for clinical privileges.
- 4.3.2. Requests for clinical privileges will be consistently evaluated based on prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs and the hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the practitioner's performance improvement program activities. Privilege determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.
- 4.3.3. The procedure by which requests for clinical privileges are processed are as outlined in Section 3 above.

4.4. Special Conditions for Providers Eligible for Privileges Without Membership

- 4.4.1. Requests for privileges from providers who are not eligible for membership are processed in the same manner as requests for clinical privileges by providers eligible for Medical Staff membership.
- 4.4.2. Only those categories of providers approved by the Board of Trustees for providing services at the hospital are eligible to apply for privileges.

- 4.4.3. These providers are subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care.
- 4.4.4. The privileges of APPs and AHPs shall terminate immediately, without right to due process, if the employment of the APP or AHP with the hospital is terminated for any reason or if the employment contract or sponsorship of the APP or AHP with a physician member of the Medical Staff organization is terminated for any reason.
- 4.4.5. Only Active Medical Staff physician members may supervise APPs and/or AHPs. Physicians cannot supervise procedures and services that they do not have clinical privileges to provide. Physicians who fail to provide adequate supervision are subject to practice review and corrective action consistent with these bylaws.

4.5. Special Conditions for Residents or Fellows in Training

- 4.5.1. Residents or fellows in training in the hospital shall not normally hold membership on the Medical Staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols reviewed and approved by the CMO in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate Medical Staff and hospital leaders.
- 4.5.2. The CMO must communicate periodically with the MEC and the Board of Trustees about the performance of residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

4.6. Telemedicine Privileges

- 4.6.1. Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications. Practitioners providing only telemedicine services to the hospital from a distant site will not be appointed to the Medical Staff but must be granted privileges at this hospital. The governing body or responsible individual may grant privileges through one of the following four mechanisms:
- a. When telemedicine services are furnished to the hospital's patients through an agreement with a **distant-site hospital**, the governing body of the hospital whose patients are receiving the telemedicine services may choose, in lieu of fully credentialing and privileging the practitioner, to have its Medical Staff rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the hospital's governing body ensures, through its written agreement with the distant-site hospital, that all of the following provisions are met:
 - i. The distant-site hospital providing the telemedicine services is a Medicare-participating hospital,
 - ii. The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which approves a current list of the distant site physician's or practitioner's privileges at the distant-site hospital,

- iii. The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the critical access hospital is located, and
 - iv. With respect to a distant-site physician or practitioner, who holds current privileges at the critical access hospital whose patients are receiving the telemedicine services, the critical access hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the critical access hospital's patients and all complaints the critical access hospital has received about the distant-site physician or practitioner.
- b. When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site **telemedicine entity**, the governing body of the hospital whose patients are receiving the telemedicine services may choose, in lieu of the requirements for full credentialing and privileging the practitioner, to have its Medical Staff rely upon the credentialing and privileging decisions made by the distant-site telemedicine entity when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the hospital's governing body ensures, through its written agreement with the distant-site telemedicine entity, that the distant-site telemedicine entity furnishes services that, in accordance with requirements stated above, permit the hospital to comply with all applicable conditions of participation for the contracted services. The hospital's governing body must also ensure, through its written agreement with the distant-site telemedicine entity, that all of the following provisions are met:
- i. The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.
 - ii. The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital.
 - iii. The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located.
 - iv. With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients and all complaints the hospital has received about the distant-site physician or practitioner.
- c. For the Medical Staff to utilize the credentialing and privileging information from the distant-site **hospital/telemedicine entity** when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, the hospital's governing body ensures, through its written agreement with the distant-site hospital/telemedicine entity, that all of the above provisions are met. Once there is

approval of a recommendation for privileges from the Medical Staff, the governing body shall decide whether to grant privileges through the usual credentialing process.

- d. The Medical Staff and hospital fully privileges and credentials the practitioner. Once there is approval of a recommendation for privileges from the Medical Staff, the governing body shall decide whether to grant privileges through the usual credentialing process.

4.7. Admitting Privileges and History & Physicals

4.7.1. Admitting privileges must be specifically requested and are granted only to qualified requestors meeting the clinical criteria established by the relevant clinical department and approved by the MEC. This provision does not prohibit exclusive contracts for clinical services, however, admitting privileges are not exclusive to hospital employees, members with hospital contracts, or to any single specialty.

4.7.2. Only those granted privileges to do so may conduct and update history and physicals. Those who are eligible or entitled to History & Physical privileges include:

- a. Physicians

- b. Podiatrists – Podiatrists co-admit with a Medical Staff member with admitting privileges who is responsible for the podiatric patient’s inpatient care and medical problem or condition that may exist at the time of admission (including performing admission history and physicals), or problems that may arise during hospitalization that exceed the Podiatrists privileges or scope of licensure and practice.

- c. Dentists/Oral and Maxillofacial Surgeons – Dentists/Oral and Maxillofacial Surgeons co-admit with a Medical Staff member with admitting privileges who is responsible for the dental patient’s inpatient care and medical problem or condition that may exist at the time of admission (including performing admission history and physicals), or problems that may arise during hospitalization that exceed the Dentists/Oral and Maxillofacial Surgeons privileges or scope of licensure and practice.

4.7.3. Requirements for the History and Physical

- 4.7.3.1. History and physical privilege must be exercised prior to surgery or a procedure requiring anesthesia services so that each patient is provided a history and physical examination within 30 days before admission (or registration, in an outpatient procedure) or within 24 hours after admission.

- 4.7.3.2. When the medical history and physical examination are completed within 30 days before admission, an updated examination of the patient, including any changes in the patient’s condition must be completed and documented within 24 hours after admission or registration, but prior to surgery or any procedure requiring anesthesia services.

4.8. Other Privileging Processes

4.8.1. Temporary Privileges

- 4.8.1.1. The CEO, or designee, acting on behalf of the Board of Trustees and based on the recommendation of the President of the Medical Staff or designee may grant temporary privileges. Temporary privileges may be granted for no longer than one hundred and twenty (120) days, with the exception of locum tenens (see Section 10.3).

- 4.8.1.2. Temporary privileges may be granted only in two (2) circumstances:

- **Urgent Patient Care Need.** Temporary privileges may be granted on a case-by-case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice. When granting such privileges, the organized Medical Staff verifies current licensure and current competence as described below.
- When an application is complete without any negative or adverse information before action by the Medical Staff or Board. However, it is recommended that this type of application is processed using the expedited credentialing process defined in these Bylaws.

4.8.1.3. Requirements for granting of temporary privileges:

- a. Primary verification of education (AMA/AOA Profile is acceptable)
- b. Demonstration of current competence
- c. Primary verification of State professional licenses
- d. Receipt of professional references (including current competence), and
- e. Receipt of database profiles from AMA, AOA, NPDB, and OIG Medicare/Medicaid Exclusions.

4.8.1.4. Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the provider has agreed in writing to abide by the Bylaws, rules, and regulations and policies of the Medical Staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these Bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

4.8.1.5. Rights of the provider with temporary privileges: A provider is not entitled to the procedural rights afforded in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

4.8.2. **Emergency Privileges.** In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, regardless of Department affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

4.8.3. **Disaster Privileges**

- 4.8.3.1. If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution's Disaster Plan with similar authority, may, on a case-by-case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected providers. These providers must present 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:
- a. A current picture hospital ID card that clearly identifies professional designation.
 - b. A current license to practice,
 - c. Primary source verification of the license,

- d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups.
 - e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
 - f. Identification by a current hospital or Medical Staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.
- 4.8.3.2. The Medical Staff has a mechanism (i.e., badging) to readily identify volunteer providers who have been granted disaster privileges.
- 4.8.3.3. The Medical Staff oversees the professional performance of volunteer providers who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.
- 4.8.3.4. 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 organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.
- 4.8.3.5. Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the provider's disaster privileges will terminate immediately.
- 4.8.3.6. Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

4.8.4. **Locum Tenens**

- 4.8.4.1. The CEO or authorized designee may permit a physician serving as a locum tenens for a named member of the Medical Staff to attend patients without applying for membership on the Medical Staff for a period not to exceed -ninety (90) days, providing all credentials have first been verified by the Medical Staff office and approved by the relevant departmental chair, reviewed by the Credentials Committee Chair, and authorized the President of the Medical Staff.
- 4.8.4.2. The application shall require detailed information concerning the applicant's professional qualifications as follows:
- a. Current Iowa Medical License
 - b. Proof of current malpractice liability insurance. The amount of minimum coverage per claim or per medical incident provided and maintained throughout the Medical Staff year must be at or above the level recommended by the MEC and the Governing Body. The applicant must report any final judgments or settlements made personally or on the applicant's behalf related to any professional liability action.

- c. Current Federal and State DEA/CSR certificates
 - d. Absence of current or past exclusion from Medicare or Medicaid or other federally funded programs
 - e. Absence of any prior Office of Inspector General sanctions
 - f. Criminal Background Check
 - g. Recent hospital affiliation (2 years)
 - h. At least 2 peer references
 - i. National Practitioner Data Bank query
- 4.8.4.3. Special requirements for supervision and reporting may be imposed by the departmental chairperson on anyone granted temporary privileges. Temporary privileges may be immediately terminated by the CEO with the written concurrence of the relevant department chair, and President of the Medical Staff upon notice of any failure by the individual to comply with such special conditions.

Section 5. Quality Performance Monitoring

5.1. Quality Performance Monitoring

All privileges granted to providers are subject to quality performance monitoring as outlined in the hospital's Quality Performance Monitoring policy.

5.1.1. Initial Quality Performance Monitoring

New providers granted initial privileges or providers granted new privileges may have their privileges granted subject to a period of initial quality performance monitoring at the recommendation of the department chair.

5.1.2. Ongoing Quality Performance Monitoring

All privileges granted to providers are subject to ongoing quality performance monitoring and review. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. At the time of reappointment, the department chair will be provided with quality performance monitoring data to assist in making recommendations regarding the approval or denial of requested privileges.

5.1.3. Focused Quality Performance Monitoring

In addition, each practitioner may be subject a focused quality monitoring plan when issues affecting the provision of safe, high quality patient care are identified through the ongoing QPM and other peer review processes. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

Section 6. Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies

6.1. Reapplication After Adverse Credentials Decision

Except as otherwise determined by the MEC or Board of Trustees, a provider who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is never eligible to reapply to the Medical Staff or for clinical privileges.

6.2. Request for Modification of Appointment Status or Privileges

A provider, either in connection with reappointment or at any other time, may request modification of staff category, Department assignment, or clinical privileges by submitting a written request to the Medical Staff Office. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment. A provider who determines that s/he no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that s/he has been granted shall send written notice, through the Medical Staff Office, to the Credentials Committee, and MEC. A copy of this notice shall be included in the provider's credentials file.

6.3. Resignation of Staff Appointment or Privileges

A provider who wishes to resign his/her staff appointment and/or clinical privileges must provide written notice to the appropriate Department Chair or President of the Medical Staff. The resignation shall specify the reason for the resignation and the effective date. A provider who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which s/he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

6.4. Exhaustion of Administrative Remedies

Every provider agrees that s/he will exhaust all the administrative remedies afforded in the various sections of this manual, the Governance and the Investigation, Corrective Action, Hearing and Appeal Plan before initiating legal action against the hospital or its agents.

6.5. Reporting Requirements

The CEO or his/her designee shall be responsible for assuring that the hospital satisfies its obligations under State law and the Health Care Quality Improvement Act of 1986 and its successor statutes. Whenever a practitioner's privileges are limited, revoked, or in any way constrained, the hospital must, in accordance with State and Federal laws or regulations, report those constraints to the appropriate State and Federal authorities, registries, and/or data bases, such as the NPDB. Actions that must be reported include, but are not limited to, any negative professional review action against a physician or dentist related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 7. Leave of Absence

7.1. Leave Request

A leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities longer than one hundred twenty (120) days, unless due to maternity or paternity leave, and whether such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently. A leave of absence should be requested thirty (30) days before the anticipated absence, unless it is a medical emergency. Under such circumstances, either the CEO or CMO, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the President of the Medical Staff stating the reasons for the leave and approximate period of time of the leave, which may not exceed one year except for military service or express permission by the Board, and should not exceed the timeframe of the current appointment. Requests for leave must be approved by the MEC. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities. Leaves of absence are matters of courtesy, not of right. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

7.2. Termination of Leave

At least forty-five (45) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the President of the Medical Staff. The practitioner must submit a written summary of relevant activities during the leave if the MEC or Board of Trustees requests. A practitioner returning from a leave of absence for health reasons must provide a report from his/her physician that answers any questions that the MEC may have as part of considering the request for reinstatement. The MEC can approve reinstatement from the leave of absence. If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the practitioner must apply for reappointment, or his/her appointment and/or clinical privileges shall lapse at the end of the appointment period.

7.3. Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Part II of these Bylaws. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.