UNIVERSITY OF IOWA

GRADUATE MEDICAL EDUCATION

GRADUATE MEDICAL EDUCATION CONTRACT ATTACHMENTS

2022-2023

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STATEMENT OF STIPENDS AND BENEFITS
FOR
GRADUATE MEDICAL EDUCATION

— 2022 - 2023 —

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STIPENDS: UIHC highly values its core mission of educating the next generation of outstanding physicians and dentists. This is reflected in the ongoing development of new educational initiatives and programming, the development of faculty and staff, and the provision of stipends that recruit and sustain GME trainees.

Annually, the stipends levels are reviewed. The ability of house staff to maintain a comfortable standard of living with the Iowa City area is a major focus. UIHC also aims to recognize the crucial importance of our house staff members' contributions by providing competitive annual stipends as they progress through their programs.

To ensure fairness, all residents and fellows appointed to GME programs at UIHC receive compensation based on a published stipend schedule. (In some situations, Fellow Associates in non-ACGME GME programs, their departments may choose to further supplement total compensation).

Stipends for the 2022-2023 fiscal year will be not be less than the stipends for the 2021 - 2022 fiscal year.

Stipends for the 2021-2022 fiscal year are:

House Staff Level	2021-2022 Annual Stipend
PGY-1	$60,000
PGY-2	$62,000
PGY-3	$64,100
PGY-4	$66,600
PGY-5	$68,800
PGY-6	$71,300
PGY-7	$73,600

House Staff level is equal to the number of years of graduate medical or dental training completed toward meeting board eligibility requirements of the specialty in which the house staff member is currently training or as otherwise approved by the GME Associate Dean/Designated Institutional Official (DIO).

Payment of stipends begins the first day of the month following the contracted start date and continues on the first day of each following month. Federal Insurance Contributions Act (FICA) and payroll taxes are withdrawn as required by the Internal Revenue Service (IRS).

BENEFITS: An extensive program provides medical, hospital care, pharmacy, dental, and counseling services for house staff physicians, dentists, and their dependents. In addition, house staff members are provided disability, and life coverage. Details about these benefits are available online: http://hr.uiowa.edu/benefits/house.

The University of Iowa reserves the right to change the benefit programs at any time. As with all benefit programs, the University of Iowa is unable to guarantee that the details listed will be in effect throughout your employment.

PROFESSIONAL LIABILITY COVERAGE: House staff members who have signed GME contracts are provided professional liability coverage at no cost via the Iowa State Tort Claims Act, Chapter 669 of the Iowa Code. The Act is the equivalent of an occurrence malpractice policy in that no tail is required. The Act is not a policy and thus has no policy number. The Act does not contain dollar limits in coverage for clinical services rendered by house staff in Iowa which are within the scope of their training program.

BOARD CERTIFICATIONS: Medical specialty certification in the United States is a voluntary process which serves multiple purposes for the trainee and the public. It is the responsibility of the resident or fellow to become familiar with the specialty specific Board eligibility requirements.
Certification:

- is one mission of the training program to produce trainees who meet board eligibility criteria;
- distinguishes a physician as someone with a distinct level of expertise;
- provides more opportunities when applying for employment;
- presents resources and tools by the American Board of Medical Specialties (ABMS);
- is a commitment to life-long improvement for providing the best patient care; and
- elevates physicians into the ranks of doctors committed to the highest standards of healthcare.

For more information visit the American Board of Medical Specialties site.

PAID TIME OFF AND LEAVES:

I. Amount of Paid Time Off: Each house staff physician and dentist is eligible for 15 working days and 6 weekend days of paid time off each year, including any time off arranged over holidays. House staff members must arrange for paid time off with their Program Director or his/her designee. All UIHC GME training programs encourage their house staff members to seek health care when needed; in that regard, programs must afford their house staff members time off for health care appointments, including medical, dental, and mental health appointments which occur during working hours. Time away from training for leaves which are necessary due to illness will be made up at the discretion of the Program Director in accord with the needs of the house staff member to complete essential components of his/her training program; in general, time missed due to illness or appointments of a few hours' or days' duration will be made up during a contract year.

II. Additional Time Off: Requests for absences which go beyond the amount stated in paragraph I above must be reviewed and approved by the Program Director. Examples of such requests are those due to family problems, deaths, board examinations, and professional meetings. Training missed as a result of prolonged illness or disability may necessitate additional training time which will be provided (and may require extension of the program) if the house staff member's performance is otherwise satisfactory. Leave requested under the federal Family and Medical Leave Act (FMLA) of 1993 is treated in accord with the rules and regulations of the University of Iowa as set forth in the University Operations Manual, Section 22.7.

III. Impact of Time Off on Board Certification Requirements: It is the responsibility of the Program Director to ensure that the house staff member is aware of current Board Certification Requirements applicable to the residents/fellows in his/her specific program. It is important to note that any request for leave beyond the amount stated in paragraph I above must be made in writing and then reviewed and approved by the Program Director to ensure that timely completion of board certification requirements can still be achieved and to apprise the house staff member of requirements and/or concerns.

IV. Time Off during Rotations External to Home Program: Taking days as paid time off and absences for other purposes during rotations outside the house staff member's residency or fellowship program must be arranged between the involved programs.

V. Last Week of Training: Requests for days of paid time off or leave are not honored during the last week of training, unless approved in writing by the Program Director.

VI. Maternity Leave:

A. *Amount of Maternity Leave*: In keeping with the recommendations of the American College of Obstetricians and Gynecologists relating to pregnancy-associated disability, female house staff members are entitled to up to 6 weeks of paid disability (maternity) leave for each pregnancy. If additional leave, either before or after delivery, is required for medical reasons associated with the pregnancy, this time is also treated as paid disability leave upon receipt of written documentation from the house staff member's physician, up to a maximum of an additional 4 weeks beyond the initial 6 weeks of maternity leave. If a house staff member wishes to arrange additional time away from the program for personal reasons, consultation with and approval by the Program Director is required and any such time is treated as an unpaid leave of absence. House staff members are not required to use maternity leave, and, in order to ensure timely completion of board eligibility requirements, a house staff member may elect to use scheduled days of paid time off in lieu of maternity leave. If the use of maternity leave leads to a need for an extension of training to complete board eligibility requirements, the house staff member must consult with the Program Director and receive his/her approval for such an extension; during the period of extension the house staff member continues to receive a stipend and benefits. A copy of any approved maternity leave must be filed in the trainee's file in the GME Office.

B. Benefit Coverage Retention: During a maternity-related unpaid leave of absence, the house staff member has the option of retaining fringe benefit coverage through payment of premium costs during the leave period.

VII. Parental Leave:

A. *Amount of Parental Leave*: The University of Iowa Hospitals and Clinics and the GME Office recognize the importance of the early development of a relationship between parent and child; thus, non-birth parent house staff members, including domestic partners as defined by UI policy, who are enrolled (with a signed and current contract) in GME residency or fellowship programs at UIHC, have available 5 working days, per event, of paid time off for parental leave related to each recent birth or adoption of their child. A qualified event for use of this leave is defined as a birth or adoption occurring at a specific time and is not defined by the number of children involved in the birth or adoption event (e.g., the birth or adoption of two children at the same time means the parent has available 5 working days of parental leave, not 10 working days). Foster care and guardianship are excluded from this policy.

B. Usage Details: Parental leave must be used within the first 3 months of the birth or adoption, but may not be used during the last 2 weeks of training, unless the child is born or adopted in the 4 weeks prior to the end of training. Parental leave is exclusive of any allotted vacation leave. However, during a parental leave, a house staff member is not required to use parental leave and may use vacation leave in lieu of parental leave in order to ensure timely completion of board eligibility requirements. Any request for parental leave must be made in writing and then reviewed and approved by the Program Director to ensure timely completion of board requirements. A copy of the approved request must be filed in the trainee's file in the GME Office.

DISABILITY ACCOMMODATION POLICY AND TECHNICAL STANDARDS FOR GME

GENERAL STATEMENT: Graduate Medical Education (GME) at the University of Iowa Hospitals and Clinics (UIHC) is governed by the overarching University of Iowa policy on *Human Rights (Operations Manual, II Community Policies, Division I Human Rights, Affirmative Action, and Equal Opportunity, Chapter 3, Section 3.1),* which states, "in no aspect of its programs shall there be differences in the treatment of persons because of race, creed, color, religion, national origin, age, sex, pregnancy, disability, genetic information, status as a U.S. veteran, service in the U.S. military, sexual orientation, gender identity, associational preferences, or any other classification that deprives the person of consideration as an individual...Consistent with state and federal law, reasonable accommodations will be provided to persons with disabilities...The University shall work cooperatively with the community in furthering these principles." GME strives to make reasonable accommodations for the functional limitations of applicant and existing residents, whether medical or dental, and fellows, (collectively, "Trainees"), with disabilities. Like all staff, faculty, and students, Trainees are protected from coercion, retaliation, interference, or discrimination for filing a complaint or assisting in the investigation of a complaint. Inquiries about anti-discrimination and retaliation policies and complaints should be directed to the Office of Equal Opportunity and Diversity (EOD).

UIHC's commitment to diversity acknowledges that physicians and dentists with disabilities offer unique perspectives. In that regard, UIHC seeks to foster an environment for Trainees based on equality of opportunity, full participation, independent living and economic self-sufficiency while also meeting the training requirements mandated by its GME programs via the Accreditation Council for Graduate Medical Education (ACGME), certifying boards, and UIHC Bylaws. All applicants and Trainees at UIHC must possess the intellectual, ethical, physical and emotional capabilities to meet the Technical Standards described in this policy, with or without accommodation.

I. TECHNICAL STANDARDS FOR ADMISSION AND RETENTION: Technical standards are criteria that go beyond academic requirements or training prerequisites for acceptance as a GME Trainee and are essential to meeting the academic and clinical requirements of the particular GME training program, though additional performance expectations may occur in certain GME programs. Trainees with or without disabilities, applying to and continuing in a GME program will be expected to meet the same requirements and will be held to the same fundamental standards. Beginning and continuing in a GME training program assumes a certain level of cognitive and technical skill. Although not all Trainees are expected to gain the same level of proficiency with all technical skills, some skills are so essential that mastery must be achieved, with the assistance of reasonable accommodations where necessary. Reasonable accommodations will be provided to assist in learning, performing and satisfying the technical standards, in compliance with the law and University policy. Applicants and active Trainees must possess the capability to complete the entire curriculum of the GME program, with or without accommodation. Abilities and skills required are noted in six areas below. Technological accommodation can be made for some disabilities in certain of these areas, but each Trainee must meet the essential technical standards in a way such that the Trainee will be able to perform in a reasonably independent manner and progress to the point of autonomous practice in the Trainee's GME specialty or sub-specialty training program. The use of a trained intermediary is not acceptable in many clinical situations as it implies that the Trainee's judgment must be mediated by someone else's power of selection and observation.

The technical standards are:

- Observation - Trainees must have the functional ability to observe and must have sufficient use of the senses necessary to perform all necessary physical examinations and patient care pursuant to their specialized area of training.
- Communication - Trainees must be able to relate reasonably to patients and establish sensitive, professional relationships with patients, peers, colleagues and staff. They must be able to communicate to the patient and to their colleagues with accuracy, clarity and efficiency.
- Motor - Trainees must be able to participate in diagnostic maneuvers, procedures and treatments required for their specialty.
- Intellectual, Conceptual, Integrative and Quantitative Abilities - Trainees must be able to analyze, synthesize, solve problems, and reach reasonable diagnostic and therapeutic judgments. Trainees must be able to display good judgment in the assessment and treatment of patients. They must be able to respond with prompt and appropriate action in emergent situations.
- Behavioral and Social Attributes - Trainees must be able to accept criticism and respond with appropriate modification of their behavior. They must possess the perseverance, diligence, and consistency necessary to complete the training program's curriculum, gain progressive independence according to the timeline outlined by the Program Director's established curriculum and enter the autonomous practice of medicine at the completion of the program. They must demonstrate professional and ethical demeanor and behavior in all dealings with peers, faculty, staff and patients.
- Cultural Competency - Trainees must be able to communicate with and care for persons whose culture, sexual orientation or religious beliefs are different from their own. They must be able to provide patient care for any patient regardless of the Trainee's and patient's race, creed, color, religion, national origin, age, sex, pregnancy, disability,

genetic information, status as a U.S. veteran, service in the U.S. military, sexual orientation, gender identity, associational preferences, or any other classification that deprives the person of consideration as an individual. Similarly, Trainees must be able to interact professionally with colleagues and other healthcare professionals without regard to race, creed, color, religion, national origin, age, sex, pregnancy, disability, genetic information, status as a U.S. veteran, service in the U.S. military, sexual orientation, gender identity, associational preferences, or any other classification that deprives the person of consideration as an individual.

II. REASONABLE ACCOMMODATIONS: Whether it is an applicant or a current Trainee, GME does not discriminate in access to its programs on the basis of disability. Reasonable accommodations for disabilities are determined on a case-by-case basis through an assessment of individual needs and an interactive process. Any documents containing disability related information are confidential and maintained securely in the Program and/or in the GME Office or in UIHC HR offices, as appropriate.

III. PROCESS: As noted above, to remain in good standing, medical residents and fellows and dental residents with and without disabilities are required to meet the technical standards set forth in this policy and any other achievement standards determined by the faculty, the particular standards of the training program and of the respective specialty or sub-specialty. The process for considering reasonable accommodation(s) for any disability (pre-dating entry to the program or newly acquired) is as follows:

- Accommodation Request – Leave and Disability –
  - A *new* (incoming) Trainee seeking reasonable accommodation(s) for a disability pre-dating entry to the program must contact the Leave and Disability (LDA) office within UI Health Care Human Resources to initiate the interactive process, preferably no later than the end of the first week of training. The LDA office will collect necessary information, including but not limited to satisfactory written documentation of the need for accommodation.
  - A *current* Trainee who is experiencing new difficulties related to an existing disability or a new disability and would like to engage in the interactive process regarding reasonable accommodation(s) must also contact the LDA office as soon as reasonably possible to initiate the process.
- Interactive Accommodation Process – The Program Director will work with the Trainee, the LDA office and in some cases, the Trainee's health care provider, in an interactive process to develop a plan for reasonable accommodation(s) consistent with the needs and the interests of the Trainee and training program.

Reviewed/Approved by the Graduate Medical Education Committee	1/3/2012
Reviewed/Approved by the Graduate Medical Education Committee	1/9/2020

GENERAL STATEMENT OF EDUCATIONAL EXPERIENCE LOCUS AND GENERAL RESPONSIBILITIES OF HOUSE STAFF

The University of Iowa Hospitals and Clinics (UIHC) provides an opportunity to fulfill the training requirements for specialty certification through inpatient and outpatient rotations at the UIHC in Iowa City and at affiliated hospitals, private practices, and programs, all which facilitate patient safety and health care quality. Many residents and fellows are assigned to rotations at the Veterans Affairs Medical Center in Iowa City, as well as other affiliated hospitals and clinics in several other Iowa cities. Some residents and fellows participate in UIHC's outreach programs, which provide screening or clinical services both at UIHC, and in other Iowa communities. The specific affiliations, programs and locations vary from year to year. Each is governed by an appropriate agreement (e.g., affiliation agreement, memorandum of understanding or program letter of agreement). Current rotations to other locations are tracked, by program, in the Graduate Medical Education Office. As required by the Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME) and in concert with the UIHC's *Institutional Commitment Statement on Graduate Medical and Dental Education*, the training programs are designed to ensure that house staff members are able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. This means that house staff members must:

- Have the requisite medical knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavioral) sciences and can apply this knowledge to patient care;
- Establish and improve learning skills that involve investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvement of patient care;
- Develop interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health professionals;
- Incorporate professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population; and
- Demonstrate an awareness of and responsiveness to the larger context and system for health and the ability to effectively call on system resources to provide care that is of optimal value.

House staff members are expected to develop a personal program of learning to foster continued professional growth. Guidance comes from the teaching staff as house staff members participate fully in the educational and scholarly activities of their programs and, as required, assume responsibility for teaching and supervising other residents and students. It is expected that house staff members will participate in appropriate institutional committees and councils to which they are appointed, elected or invited, especially those that relate to patient safety and quality of care education activities. House staff members are also expected to be responsible to evaluate their programs by submitting to the program director or to a designated institutional official, at least annually, confidential written evaluations of the faculty and of the educational experiences in their training program.

House staff members are responsible for participating in required programming and instruction, including but not limited to programs on substance abuse and physician impairment, mandatory reporting of child and elder abuse, Health Insurance Portability and Accountability Act (HIPAA), blood borne pathogens and safety in the workplace, and other activities necessary for the successful orientation to UIHC and training in the house staff member's specialty. Furthermore, it is the responsibility of the house staff member to communicate with his/her program director, coordinator and other graduate medical education (GME) personnel in a timely manner and as necessary for administration of the program, including participation in program reviews, accreditation site visits, the completion of documentation (including but not limited to EPIC and MedHub) as required for duty hours (including all approved time away from the program, time at other sites and/or moonlighting), procedures, schedules, conferences, and evaluations, and other aspects of the house staff member's work environment.

House staff members are obligated to perform their duties and at all times conduct themselves in compliance with the Bylaws, Rules, and Regulations of the University of Iowa Hospitals and Clinics and Its Clinical Staff, all Graduate Medical Education Committee policies and procedures, the established practices, procedures and policies of the trainee's program, clinical department and other institutions to which the house staff member is assigned, as well as with all state and federal rules, regulations, and laws. All house staff members must maintain through the duration of their contracts a valid license (medical or dental, as appropriate) in the State of Iowa. Appropriate visa status, in compliance with the *Policy on Visas for GME Trainees*, is the responsibility of the individual house staff member.

With respect to participation in patient care activities, overall professional training and academic affairs, the house staff members are responsible to the program director of his/her respective training program, the members of the clinical staff at UIHC under whose supervision they may serve, to the Clinical Service Head of the Department and to the GME Associate Dean.

For purposes of this policy the terms house staff, resident, and fellow mean any trainee in a medical or dental training program at UIHC who is currently party to a *GME Medical and Dental Appointment Contract*.

Reviewed/approved by the Graduate Medical Education Committee	11/1/2011
Reviewed/approved by the Graduate Medical Education Committee	3/17/2016

POLICY ON THE INTERRUPTION, REDUCTION OR CLOSURE OF GRADUATE TRAINING PROGRAMS

A recommendation to modify the resident complement of or to close a graduate training program must be made by the individual Program Director via a petition to the Graduate Medical Education Committee (GMEC) at UIHC according to the procedures outlined in the "Policy and Procedures for Adding New Programs and Program Modification," which governs both increases and decreases to the size or scope of a training program.

A recommendation to close a graduate training program, to reduce the size of the program, or to close the sponsoring institution by UIHC must be communicated to the GMEC, the DIO and the residents as soon as possible. Such recommendations will then be presented to the Hospital Advisory Committee for review and approval. The appropriate ACGME Residency Review Committee will be notified in accordance with ACGME requirements.

If UIHC is to be closed or if an individual program is closed, reduced or interrupted for any reason, including a disaster or interruption in patient care, the following procedures will govern:

1) The Program Director will give the affected residents written notice of the program reduction or closing as soon as possible following the decisions and approval by the GMEC and HAC, as applicable. This notice will include specific dates and the terms by which the program is closing or downsizing.
2) Any resident not completing the affected program will be assisted in the continuation of his/her education in one of the following ways:
   a) The resident will be allowed to complete the program, if possible, depending on the dates of the program closure/reduction and on the resident's demonstration of satisfactory progress; or
   b) The resident will be assisted by the Program Director in identifying and enrolling in another program at UIHC; or
   c) The resident will be assisted by the Program Director in identifying and enrolling in another accredited program outside of UIHC, by making the necessary communications.

   A meeting with the resident, the Program Director, and the Director of GME will occur to decide the best strategy for the affected resident.
3) The Graduate Medical Education Office will assist the resident with issues concerning stipend, benefits, contract and other administrative issues caused by the change or closure of the program.
4) Financial obligations of UIHC will follow the terms of the resident's contract, but will not include any reimbursement for expenditures due to relocation.

The term "resident" in this policy shall refer to residents and fellows at all house staff levels.

House staff residents and fellows are also governed by the UIHC "Emergency Operations Plan," which describes planning and training for on-site emergency situations and/or disasters as well as the implementation of an organized response, including but not limited to staff deployment, communications, safety and security, patient evacuation, immunization, decontamination and recovery.

Reviewed/Approved by the Graduate Medical Education Committee	8/7/2007
Reviewed/Approved by the Graduate Medical Education Committee	10/4/2011

GRADUATE MEDICAL EDUCATION COMMITTEE

MOONLIGHTING POLICY AND PROCEDURES FOR HOUSE STAFF PHYSICIANS AND DENTISTS

I. General Statement: House staff who wish to engage in professional activity outside of their graduate medical or dental training program ("moonlighting" as defined in §II of this policy) during the period of their Graduate Medical Education (GME) appointment, must follow the procedures outlined in this policy. In this policy, the terms learner, trainee, house staff member, resident and fellow may be used interchangeably.

Moonlighting must not

- be required of any house staff member during the period of his/her GME appointment
- conflict with the assigned clinical and educational responsibilities of the house staff member's training program at the University of Iowa Hospitals and Clinics (UIHC),
- interfere with the ability of the trainee to achieve the goals and objectives of his/her educational program,
- interfere with the resident's fitness for work
- compromise patient safety
- be performed by PGY-1 residents
- be performed by any trainee on a J-1 or J-2 visa with an Employment Authorization Document (EAD).

Each training program at UIHC shall meet the requirements of this policy, as well as any applicable standard set by the ACGME, the appropriate RRC, other accrediting or certifying body, or applicable statute. Questions regarding approval and scheduling of moonlighting should be directed to the respective Program Director. Failure to adhere to any part of this policy or to follow its procedures can be grounds for rescinding moonlighting approval or for immediate dismissal of the house staff member from his/her training program. .

II. Definition: Professional activity outside the training program means activities requiring the exercise of professional judgment involving a commitment of the house staff member's time. The term refers to activities involving direct patient care, which are commonly referred to as "moonlighting," as well as engagements as a consultant on patient care matters. Serving as a utilization review consultant for insurance companies and other organizations or as an expert witness solely for the purposes of advising or testifying regarding the appropriate standard of care is not permitted. However, it is not necessary for house staff to obtain permission as defined in this policy for activities arising out of professional contacts occurring as part of the training program (e.g., testifying at a disability hearing regarding the condition of a patient treated in the course of the house staff member's assigned responsibilities).

- External moonlighting is activity which is outside the responsibilities of a house staff member and occurs outside UIHC.
- Internal moonlighting is activity which is outside the responsibilities of a house staff member but occurs at UIHC. Internal moonlighting occurs infrequently.

III. Licensure: All house staff members engaged in moonlighting must be licensed for unsupervised medical practice in the state where the moonlighting occurs. A State of Iowa "Resident Physician" or "Resident Dental" license is not valid for professional activity outside of his/her UIHC GME training program. Moonlighting internal to UIHC also requires that the house staff member have a permanent Iowa license. For all moonlighting, the house staff member is solely responsible to obtain and maintain an appropriate **permanent** license that is not specific to his/her training program.

IV. Malpractice Coverage: It is the personal responsibility for each house staff member to obtain, maintain and/or ensure that he/she has professional liability insurance coverage while engaging in any moonlighting activity, internal or external to UIHC.

- External coverage: With respect to external moonlighting, during the time an individual is moonlighting, he or she is acting as a private practitioner without any sponsorship by UIHC, the UI, GME or his/her Program Director. The Iowa State Tort Claims Act does not cover external moonlighting. A house staff member engaging in external moonlighting must ensure that appropriate malpractice coverage is in place and must clearly describe that coverage on the moonlighting request form.
- Internal coverage: For each internal moonlighting request, malpractice coverage must be discussed with and approved by the GME Associate Dean prior to the completion and submission of a moonlighting request form to the GME Office.

V. Billing: Any house staff member who is in an ACGME accredited program shall **not bill** for services while moonlighting internally at UIHC.

VI. Duty Hour Limits: Time spent by residents in any moonlighting activity – both external and internal – must be counted toward the 80-hour maximum weekly hour limit when averaged over a four-week period as stated in the *UIHC Policy for*

GME Trainees on the Learning and Working Environment regarding Professionalism, Well-Being, Fatigue Mitigation, Transitions of Care, and Clinical Care and Experience.

VII. Procedures: The following steps must be followed to obtain approval of a moonlighting request:

A. Completion of a Moonlighting Request Form (MRF): Each request shall be documented by the completion in writing of an MRF, which is obtained from the Program Director or his/her designee prior to the beginning of the moonlighting activity. The MRF must specify:

1. the name, department, program and level of training of the house staff member
2. that the requesting house staff member is in good standing in the program
3. the reason for the moonlighting request
4. the type of professional activity to be engaged in
5. the number of hours (specific days and times) involved in the moonlighting request for each specific site
6. that the moonlighting dates/times/duration will not interfere with clinical or educational obligations of the house staff member
7. that the moonlighting does not cause the house staff member to violate duty hour mandates posed by the UIHC, the GMEC, the home program/department, the ACGME/RRC, and/or any other accrediting, certifying, regulating or governing body, internal or external to UIHC
8. a contact's name, phone number and other relevant contact information at the moonlighting site during the moonlighting activity
9. the site at which the moonlighting will occur (name of hospital or clinic, street address and city/state)
10. the assurance that any moonlighting internal to UIHC will have an immediately available supervisor
11. a list of all other current moonlighting sites, updated with each new request
12. the house staff member's permanent medical or dental license number and state
13. a clear description of the malpractice coverage:
    a. for external moonlighting activities, the house staff member must provide evidence for malpractice coverage that is NOT reliant on the Iowa State Tort Claims Act
    b. for internal moonlighting activities, the house staff member must meet with the GME Associate Dean to obtain his approval and to discuss and confirm adequate malpractice coverage for the specific circumstance (see also VII.D. below in this policy)

B. The MRF must be signed by:

1. the requesting house staff member
2. the Program Director (see also VII.C below in this policy)
3. other individuals, as required by the Department (i.e., Clinical Service Head, Departmental GME Director, Program Coordinator, etc.)
4. the GME Director, if the request is for internal moonlighting (see VII.D below in this policy)

C. Program Director Approval: Each respective Program Director is responsible for the initial review and approval of all moonlighting requests. The Program Director shall evaluate and respond to each request on a case-by-case basis. Program Director approval must be obtained prior to the submission of an MRF to the GME Office. Internal requests require GME Associate Dean approval of a proposal as described below.

D. GME Associate Dean Approval for Internal Moonlighting: A proposal for internal moonlighting must be submitted to the GME Office and approved by the GME Associate Dean. Following review and approval of the completed proposal, an MRF must be reviewed and approved as described above in this policy before any internal moonlighting occurs.

E. Duty Hour Report by ProgramDirector: For each house staff member who has an approved, current moonlighting request form on file in the GME Office, the respective Program Director must be able to evidence his/her monitoring of duty hour compliance by submitting a report when requested by the GME Office. Such report must clearly depict the house staff member's moonlighting hours as part of the overall tracking of work hours.

F. Duration of Approval: Approval for each request shall be for no longer than the house staff member's current GME contract term. A new request must be made for each new contract term at each moonlighting site. Approval can be revoked at any time if a resident's moonlighting activity is determined to be adversely affecting his/her performance in the training program, if the resident's well-being or fitness for work is compromised, if patient safety is at risk, if he/she does not comply with any aspect of this policy, or if program monitoring is deemed insufficient by the GME Associate Dean.

G. Filing of an Approved MRF: The approved MRF must be filed in the house staff member's GME Office file prior to the commencement of the approved moonlighting activity. It is the responsibility of the house staff member to ensure that all moonlighting activities have current and fully approved MRFs in place.

Reviewed/Approved by the Graduate Medical Education Committee	3/3/2011
Reviewed/Approved by the Graduate Medical Education Committee	8/1/2017

GRADUATE MEDICAL EDUCATION COMMITTEE

POLICY FOR GME TRAINEES ON

- ELIGIBILITY
- SELECTION
- TRANSFER

The University of Iowa Hospitals and Clinics (UIHC) policies and procedures for eligibility, selection, and transfer that affect the recruitment and appointment of graduate medical education (GME) trainees are described in this policy. UIHC through its Graduate Medical Education Committee (GMEC) and GME Office monitors each Accreditation Council for Graduate Medical Education (ACGME) program for compliance with this policy.

The terms learner, trainee, house staff member, resident and fellow may be used interchangeably in this policy.

I. Eligibility. Applicants with one of the following qualifications are eligible for appointment to an ACGME-accredited GME program at UIHC:
   A. Graduate of a medical school in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME)
   B. Graduate of a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA)
   C. Graduate of a medical school outside the United States and Canada who meets one of the following qualifications:
      1. Holds a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG); or
      2. Holds a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training.
   D. Graduate of a medical school outside the US who has completed a Fifth Pathway* program provided by an LCME-accredited medical school
   E. Fellowship eligibility for ACGME-accredited programs requires:
      1. Completed ACMGE-accredited residency program or Royal College of Physicians and Surgeons (RCPS)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency program located in Canada or verification of the entering fellow's level of competency in the required field using ACGME or CanMEDS (i.e., the Canadian competency framework) milestones from the core residency
      2 If prior residency as described in I.E.1 above cannot be verified, then to be considered an applicant must first be granted an exception by the GMEC as an exceptionally-qualified applicant prior to being extended an offer. The process of granting 'exceptional' status requires the following, at a minimum:
         a. that the specific program's Residency Review Committee (RRC) standards are met, as well as any applicable overarching ACGME standards;
         b. that the program director and fellowship selection committee assess the fellow's suitability to enter the program based on prior training and review of the applicant's summative evaluations of training and core specialty; and
         c. final review and approval by the GMEC or a workgroup designated by the GMEC.

II. Selection.
   A. The UIHC ensures that all GME programs (ACGME-accredited and non-accredited) select eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. Programs must not discriminate with regard to sex, race, age, religion, color, national origin, disability, veteran status or any other applicable legally protected status.
   B. In selecting qualified applicants, all programs sponsored by UIHC are strongly urged to participate in an organized matching program (e.g., National Resident Matching Program), as available.

III. Transfer.
   A. For a house staff member transferring to a UIHC GME program (or for an applicant who is already at UIHC but who may have prior GME training), before making a decision to accept a resident or fellow, the UIHC Program Director must:
      1. Obtain written or electronic verification of previous educational experiences ensuring the applicant is eligible. Such eligibility requires the completion of an ACGME-accredited training program or completion of a RCPS-accredited or CFPC-accredited program located in Canada or, if not complete, the UIHC residency program must obtain verification of the applicant's level of competency in the required clinical field using ACGME or CanMEDS milestone assessments from the prior training program ((advanced postgraduate year (PGY) level upon entry to a UIHC GME program must be determined by the UIHC program director in conjunction with the GME Office in cases where a prior residency or training in a different specialty exists or where milestone assessments indicate the possibility of advanced status));
      2. Obtain a summative competency-based performance evaluation of the transferring resident or fellow; and

3. Participate in an in-person phone call with the external Program Director.

B. For a house staff member transferring out of a UIHC GME program, the UIHC Program Director is responsible to:
   1. Provide a timely verification of the transferring resident or fellow's education, in written or electronic form as described above in III.A.1 of this policy;
   2. Provide a summative competency-based performance evaluation of the transferring resident or fellow; and
   3. Participate in an in-person phone call with the external Program Director.

Any change in program complement must follow the process outlined in the *UIHC Policy and Procedures for Adding New Programs and Program Modification;* in the case of an ACGME-accredited program, the Program Director must petition for GMEC approval through this program modification process PRIOR to submitting any such request to the ACGME and the respective RRC.

C. In the event a UIHC GME program should be closed, interrupted or reduced in size in any way (including disaster) that affects a current UIHC GME resident or fellow, the *UIHC Policy on Interruption, Reduction or Closure of Graduate Training Programs* is followed.

**A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following conditions: (1) have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school; (2) have studied at a medical school outside the United States and Canada but listed in the World Health Organization Directory of Medical Schools; (3) have completed all of the formal requirements of the foreign medical school except internship and/or social service; (4) have attained a score satisfactory to the sponsoring medical school on a screening examination; and (5) have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).*

Reviewed/Approved by the Graduate medical Education Committee	11/1/2011
Reviewed/Approved by the Graduate Medical Education Committee	6/6/2017

GRADUATE MEDICAL EDUCATION COMMITTEE

POLICY FOR GME TRAINEES ON THE LEARNING AND WORKING ENVIRONMENT:

- PROFESSIONALISM
- WELL-BEING
- FATIGUE MITIGATION
- TRANSITIONS OF CARE
- CLINICAL EXPERIENCE AND EDUCATION

I. Professionalism. University of Iowa Hospitals and Clinics (UIHC) recognizes that the GME program, in concert with UIHC, is responsible to educate GME learners and faculty about their professionalism duties, including their obligation to be appropriately rested and fit to provide patient care.

In this policy, the terms learner, trainee, house staff member, resident and fellow may be used interchangeably.

A. *Objectives*. Professionalism education must occur:
- Via an appropriate mix of supervised patient care duties, clinical teaching and didactic educational events;
- Without excessive reliance on GME learners to fulfill non-physicians duties; and
- While ensuring manageable patient care responsibilities.

B. *Program Director Duties.* In partnership with UIHC, it is incumbent on the Program Director to provide a culture of professionalism that supports both patient safety and personal responsibility.

C. *Learner and Faculty Member Duties.* The GME learner and program faculty members
1. Must recognize their personal roles in the:
   a. Provision of patient- and family-centered care;
   b. Safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;
   c. Assurance of their fitness for work, including:
      1) Management of their time before, during and after clinical assignments;
      2) Recognition of impairment, including from illness, fatigue and substance abuse in themselves, their peers and other members of the health care team (as resources, see the *GME Policy on Taxi Transportation for House Staff and the GME Policy on Substance Abuse Identification and Intervention)*;
      3) Commitment to lifelong learning;
      4) Monitoring of patient care improvement indicators; and
      5) Accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data.
2. Must understand when it is appropriate to transition patient care to another qualified and rested provider. It is recognized that this requires a responsiveness to patient needs that supersedes self-interest.

D. *Programs and UIHC.* The GME work and learning environment must be professional, respectful and civil, free from mistreatment, abuse or coercion of all members of the healthcare team, including students, residents/fellows, faculty and staff.
1. Supporting Policies: The policies of the University of Iowa and UIHC strictly forbid a hostile work environment, harassment and/or retaliation. Policies and reporting venues include, but are not limited to the lists below.
   a. Due Process - GME maintains guidelines for a system of due process through its *Statement of House Staff Member Concerns*, supported by the UIHC Bylaws.
   b. UIHC and University of Iowa policies providing due process, supporting non-retaliation, non-discrimination, and a non-hostile work environment and preventing harassment.
   c. Confidential reporting of concerns about unprofessional behavior can occur in various ways and may result in investigation and produce remedies specific to the situation, as appropriate. Reporting bodies include, but are not limited to the following:
      1) UIHC HELPline;
      2) Program Director;
      3) GME Office (GME Director and/or DIO/Associate Dean);
      4) GMEC;
      5) UIHC Compliance Office;
      6) UI Equal Opportunity and Diversity Office;
      7) UIHC HR; and/or the
      8) University of Iowa Omsbuds Office

II. Well-Being. It is recognized that learners and faculty in GME programs are at risk for burnout and depression in the complex health care environment. Care of their psychological, emotional and physical well-being is essential to their ability be resilient and, in turn, to provide care competently and compassionately.

A. *Responsibility*. Programs, supported by UIHC, must address the importance of well-being for physicians. To do this, the following must occur:

1. Efforts made to emphasize that the following are important to being a physician:
   a. Protecting time with patients
   b. Minimizing non-physician obligations
   c. Providing administrative support
   d. Promoting progressive autonomy and flexibility
   e. Enhancing professional relationships
2. Attention given to:
   a. Scheduling
   b. Work intensity
   c. Work compression that impacts resident well-being
3. Evaluation of and addressing:
   a. Workplace safety data
   b. The safety of learners and faculty
4. Implementation of policies and training programs that:
   a. Encourage optimal learner and faculty well-being
   b. Give the learner the opportunity to attend medical, mental and dental health appointments, including those scheduled during work hours (see the *Policy for GME Trainees on Paid Time Off and Leaves* – part of the *Statement on House Staff Stipends and Benefits*)
   c. Allow the learner to be absent (and have coverage) for concerns including but not limited to fatigue, illness, and family emergencies (see the *Policy for GME Trainees on Paid Time Off and Leaves* – part of the *Statement on House Staff Stipends and Benefits*). Time off required for these or other reasons specified in the UIHC GME Time-Off policy shall be used by the learner without fear of negative consequences for the trainee who is unable to provide clinical work.
5. Education of GME trainees and faculty to:
   a. Identify the symptoms of burnout, depression, suicidal ideation, violence potential, and substance abuse in themselves and others
   b. Be aware of resources, tools and/or self-screening available, who to contact and how to seek appropriate care for such concerns, including access to confidential and affordable mental health assessment, counseling, and treatment for urgent and emergent needs, 24x7

III. Fatigue Mitigation.

A. *Programs must*:

1. Educate all faculty and GME learners
   a. to recognize the signs of fatigue and sleep deprivation
   b. in alertness management and fatigue mitigation processes
2. Encourage all GME learners to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning
3. Ensure continuity of patient care, consistent with when concerns (as referenced in 2.4.c. above) occur due to fatigue (as well as illness or family emergency)

B. *The programs, in concert with UIHC, must provide*

1. Adequate sleep facilities (such as call rooms dedicated to house staff and rest areas including the House Staff Lounge), and/or
2. Safe transportation to safely return home when trainees are too fatigued (see the *GME Policy on Taxi Transportation for House Staff*)

IV. Transitions of Care (Transitions of Care, Clinical Responsibilities, and Teamwork).

A. *Transitions of care must:*

1. Occur in a program-designed clinical assignment that optimizes transitions in patient care, including their safety, minimal and/or appropriate frequency, and structure
2. Monitor effective, structured handover processes as ensured by the program and UIHC to facilitate continuity of care and patient safety
3. Be performed by trainees whose programs ensure that they are competent in communicating with team members in the handover process
4. Occur within schedules developed and communicated by programs at all clinical sites such that attendings and trainees are appropriately informed about their responsibility to care for patients
5. Assure continuity of patient care, as defined by program policies and procedures, to back up a trainee who is unable to perform patient care duties due to fatigue, illness or family emergency

B. *Clinical responsibilities must be based on the following* (and as further defined by the applicable RRC):

1. PGY level
2. Patient safety
3. Trainee ability

4. Severity and complexity of the patient's illness/condition
5. Available support services

C. *Teamwork means that trainees must:*
1. Care for patients in an environment that maximizes effective communication
2. Be trained as a member of effective interprofessional teams that are appropriate to the specialty's delivery of care and within the larger health system

V. Clinical Experience and Education. Programs, in concert with support from UIHC, are responsible to create an effective program structure that provides learners with educational and clinical experiences while affording them reasonable opportunities for rest and personal activities. Note: Program Directors must also adhere to any additional or varied duty hour limitations or requirements specified by their RRC standards.

A. *Hours per week:* Clinical and educational work hours must
1. Not exceed 80 hours per week when averaged over a 4-week period
2. Count all hours of the following
a. In-house clinical and educational activities (time spent on both elective and required in-house educational activities must be counted)
b. Clinical work done from home
c. Night-float hours
d. Moonlighting
e. Additional hours that occur due to rare circumstances as occur pursuant to this policy

B. *Time Free of Clinical Work and Education*: Reasonable opportunities for rest and personal well-being must be afforded. This means:
1. Eight (8) hours off between scheduled clinical work and education periods should be afforded to trainees
a. Exception: There may be circumstances when trainees choose to stay to care for patients or return to the hospital with fewer than 8 hours free of clinical experience and education, but this must occur within the 80-hour limitation and one-day-off-in-seven requirement
2. Fourteen (14) hours free of clinical work and education must be afforded to trainees after 24 hours of in-house call
3. One day in seven (1 in 7) free of clinical work and education must be scheduled for trainees, as follows:
a. The one-day-in-seven off is averaged over a 4-week period
b. At-home call cannot be assigned during this day off
c. Night-float cannot occur during this day off

C. *Periods of Clinical Work and Education*
1. Twenty-four (24) continuous hours of scheduled clinical assignments must not be exceeded
a. Exception: Up to 4 hours of additional time may be used for activities related to patient safety (such as providing effective transitions of care and/or resident education); during these 4 additional hours, additional patient care must not be assigned to the learner)
2. In-house call by learners must not be scheduled more frequently than every third night (when averaged over 4 weeks)
3. Home call
b. must not be so taxing or frequent as to preclude rest or reasonable personal time
c. must be counted toward the 80-hour work week if the work done at home is clinical
d. must not occur on the 1 day off in 7 (when averaged over 4 weeks)
e. is not subject to the every third night limitation
f. allows a trainee to return to the hospital to provide direct care for new or established patients, and any return time is counted toward the 80-hour weekly maximum (travel time is not counted toward the 80-hour weekly maximum)

D. *Exceptions*: In rare circumstances, and after handing off all other duties, a learner, may elect on his/her own initiative to remain at the site or return from home call (see V.C.3.f. above) in order to:
1. Provide care to a single severely ill or unstable patient;
2. Provide humanistic attention to the needs of a patient or family; or
3. Attend unique educational events

Additional hours that occur due to these rare circumstances must be counted toward the 80-hour weekly limit.

E. *10% Approved Duty Hour Expansion*: Not to exceed a maximum of 88 hours, a program may submit a rotation-specific petition for an up-to-10% expansion of their duty hours. Prior to expanding hours, expansion requests must be:
1. Rotation-specific
2. Based on sound educational rationale
3. Submitted by the Program Director to the GMEC and DIO for review and approval, and then
4. Submitted to the appropriate RRC for review and approval

F. *Moonlighting:*
1. Any moonlighting must not interfere with the ability of the trainee to achieve the program's goals and objectives
2. Must be counted toward the 80-hour weekly limit
3. Those not permitted to moonlight are PGY-1 house staff members and any trainee on a J-1 or J-2 visa.
4. See also the UIHC Moonlighting Policy and Procedures for House Staff Physicians and Dentists

Reviewed/Approved by the Graduate Medical Education Committee	6/6/2017

POLICY AND PROCEDURES FOR THE EVALUATION AND ADVANCEMENT OF HOUSE STAFF

All house staff members at the University of Iowa Hospitals and Clinics (UIHC) will be promoted upon the satisfactory completion of the program year and evidence of satisfactory progressive scholarship and demonstration of clinical competence and professional growth. Each house staff member receives regular and timely assessment of his/her overall performance and competencies (in patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and systems-based practice). The procedures referenced in this policy are designed to ensure that all house staff members are promoted to a higher level of responsibility at the appropriate time.

Those house staff members who have not satisfactorily completed the program year and who fail to show evidence of satisfactory progressive scholarship or to demonstrate clinical competence and professional growth, may be offered a remediation plan of action prior to promotion, as deemed appropriate by the Program Director and as described in this policy. House staff members denied promotion or reappointment are provided due process as described in the *UIHC Statement on House Staff Member Concerns* and in Article IV, Section VII of the *Bylaws, Rules and Regulations of the UIHC and its Clinical Staff*; in the case of a denial of promotion or denial of a reappointment, the Program Director should consult with the Graduate Medical Education (GME) Director who may confer with UIHC Legal Services.

Programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) must follow procedures as described below in this policy and as described by their specialty-specific Residency Review Committee (RRC).

For purposes of this policy the terms house staff and resident mean any resident or fellow in a medical or dental training program at UIHC who is currently party to a *GME Medical and Dental Education Appointment Contract.*

1. **EVALUATIONS**
   - A. Feedback and Evaluation: Each Program Director must develop objective assessments for evaluating each house staff member and ensure the following:
     1. Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment.
     2. The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones and must provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice.
     3. Each evaluation must be documented at completion of the assignment.
     4. The evaluations must utilize multiple sources (e.g., faculty, peers, patients, self, and other professional staff).
     5. Evaluations of a resident's performance must be accessible for review by the resident.
     6. The evaluation process must follow any applicable ACGME or RRC requirements for the program.
     7. At least annually, there must be a summative evaluation of each resident that includes the resident's readiness to progress to the next year of the program, if applicable.
   - B. Clinical Competency Committee: A Clinical Competency Committee, as described below, must be appointed by the program director and must ensure that the following are met:
     1. Clinical Competency Committee (CCC) Composition:
        a. The CCC must have a minimum of three members of the program faculty, at least one of whom is a core faculty member.
        b. The CCC may have additional members who must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents.
     2. The CCC must:
        a. Review all resident evaluations at least semi-annually.
        b. Determine each resident's progress on achievement of the specialty-specific milestones.
        c. Meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress.
        d. Meet and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific milestones.
        e. Assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth.
        f. Develop plans for residents failing to progress, following institutional policies and procedures.
   - C. Final Evaluation: Each Program Director must complete and provide a written final evaluation for each house staff member who completes the program. The final evaluation must:
     1. Verify that the house staff member has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; for house staff members in ACGME programs, the Program Director must use the Specialty-Specific Milestones as a tool to ensure house staff are able to engage in autonomous practice upon completion of the program.
     2. Be shared with the resident upon completion of the program
     3. Be made part of the house staff member's permanent record maintained by the institution and accessible for review by the resident in accordance with institutional policy.
     4. Be submitted to the GME Office by the Program Director within 30 days of the house staff member's completion of the program.

3. **REMEDIATION PLAN OF ACTION OR EXTENSION**: Program Director action plans for remediation and/or extension must comply with applicable accreditation and/or UIHC and GMEC requirements.
   - A. Remediation Plan: If the Program Director determines that the house staff member has not completed some portion of his/her training satisfactorily, the Program Director must determine whether or not remediation would benefit the house staff member. If remediation is deemed appropriate, the Program Director must:
     1. Establish a written remediation plan of action for the house staff member, including:
        a. A mentoring plan;

b. A plan for monitoring progress;
c. An identified date for re-evaluation; and
d. The production of a report which summarizes results.

2. Ensure that the remediation plan is signed and dated by both the house staff member and the Program Director, reviewed by the Director of GME and filed in the house staff member's file in the GME Office.

B. Extension: If the Program Director determines that the house staff member would benefit from an extension before promotion to the next level, the Program Director must:

1) Produce a written plan, monitor progress, and track results;
2) Ensure that the written plan is signed and dated by both the house staff member and the Program Director, reviewed by the Director of GME, and filed in the house staff member's file in the GME Office; and
3) Must contact the GME Office regarding the request for a contract extension by completing an online MedHub form and providing supporting documentation explaining why the extension is necessary.

4. **ADVANCEMENT PROCEDURES AND DEADLINES**: After assessing each house staff member according to this policy and any applicable accreditation requirements, the Program Director must communicate his/her decision to the GME Office to advance/promote, remediate, extend, not renew or terminate the house staff member. The GME Office reminds the Program Directors through Program Coordinators of the need to submit such plans to the GME Office at least 4 months prior to the termination date of the house staff member's current appointment contract. Program Coordinators utilize MedHub to advance house staff, to make an extension for remediation, or to make non-renewal or termination requests.

5. **RECOMMENDATION FOR CERTIFICATION**: Recommendation of certification of a house staff member by a specialty board will be made by the Program Director when the last evaluation of the resident establishes that the house staff member's knowledge, clinical skills and professional attitudes are consistent with the standards for that specialty.

Approved by the GMEC	11/1/2011
Approved by the GMEC	3/24/2016
Approved by the GMEC	1/9/2020

POLICY AND PROCEDURES FOR THE EVALUATION AND ADVANCEMENT OF HOUSE STAFF

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Approved by the GMEC	11/1/2011
Approved by the GMEC	3/24/2016
Approved by the GMEC	1/9/2020

GRADUATE MEDICAL EDUCATION COMMITTEE

POLICY REGARDING THE LEARNING AND WORKING ENVIRONMENT FOR GME TRAINEES

- PATIENT SAFETY
- QUALITY IMPROVEMENT
- SUPERVISION AND ACCOUNTABILITY

Purpose: This policy is aimed at creating and supporting a learning and working environment for medical and dental residents and fellows that promotes excellence in the safety and quality of care rendered to patients by trainees and faculty during their participation in a University of Iowa Hospital and Clinics (UIHC) Graduate Medical Education (GME) program. Incorporating the importance of quality and safety into our GME programs goes beyond the present as we recognize that carrying forward that excellence into our learners' future practices is critically important to the patient care they will provide when they are unsupervised and themselves responsible to effect quality improvement measures.

In this policy, the terms learner, trainee, house staff member, resident and fellow may be used interchangeably.

I. Patient Safety. GME at UIHC actively promotes patient safety, with both the learner and the faculty supervisor sharing responsibility for patient safety and the quality of patient care. The continuous overriding focus is on the safety, individual needs and humanity of the patients being cared for. Supervision, knowledge, skills and abilities factor into that focus. In that regard, practitioners must understand the limits of their knowledge and experience and seek assistance as required to provide optimal patient care. It is critical that residents and fellows, along with faculty members, work consistently in a well-coordinated manner with other health care professionals to achieve patient safety goals. Our GME learners must be able to demonstrate the ability to analyze the care they provide, understand their roles within the health care team, and play an active role in system improvement processes, carrying it forward into their unsupervised future practices. Programs must document that the following occur:

   A. *Safety Culture*. UIHC's mission includes an ongoing willingness to deal with safety vulnerabilities. Through each program, UIHC has formal mechanisms in place which the programs document, such as assessments of the knowledge, skills and attitudes of our learners. Learners and faculty must communicate any needed areas of improvement.

   B. *Education on Patient Safety*. Each residency and fellowship program at UIHC must provide formal educational activities that promote patient safety related goals, tools, and techniques. The program must tailor these activities appropriately for their learners and document and retain learner participation at the program level.

   C. *Patient Safety Events*. Trainees, along with faculty and other health care team members, must know their responsibilities in reporting and how to report adverse events, near misses, and unsafe conditions at the clinical site; UIHC makes available to these individuals a summary of patient safety reports that occur. Additionally, learners must be involved in real or simulated interprofessional patient safety activities, including but not limited to root cause analyses that formulate and implement actions.

   D. *Resident Education and Experience in Disclosure of Adverse Events.* Through its Compliance Office, UIHC discloses to patients (and, as necessary, families) when an adverse event has occurred. Residents must be included as participants in real or simulated disclosure events.

II. Quality Improvement. Within each program, the following must be documented:

   A. *Education in Quality Improvement*. Residents and fellows must receive training and gain experience in the quality improvement process, including an understanding of health care disparities. This means that the program must provide quality-related goals, tools, and techniques for learners to achieve quality improvement goals, especially those related to health care disparities that affect their patients.

   B. *Quality Metrics*. In order to prioritize care activities and evaluate the success of improvement efforts, trainees and faculty member must have access to and therefore receive data on quality metrics and benchmarks related to their patient population.

   C. *Engagement in Quality Improvement Activities*. For learners to develop the ability to identify and institute sustainable systems-based changes to improve patient care, they must have the opportunity in their training program to participate in interprofessional quality improvement activities, which should include activities aimed at reducing health care disparities.

III. Supervision and Accountability.

A. *Definition and Structure*. Supervision is required to provide safe and effective care to patients. It also ensures the learner's development of the skills, knowledge and attitudes required to enter the unsupervised practice of medicine and establishes a basis for continued professional growth. The attending is ultimately responsible for the care of the patient; still, every physician shares a responsibility and is accountable for their efforts in providing patient care. The training program, along with UIHC, defines, communicates and monitors a structured chain of responsibility and accountability as it relates to the supervision of all patient care at any training site. The policies of UIHC regarding supervision and accountability apply to all institutions to which a trainee rotates and are subject to ACGME and individual RRC requirements and/or other applicable accrediting or certifying bodies. Each program, regardless of accreditation, is required to follow such standards as applicable.

1. Attending: Each patient must have an identifiable and appropriately credentialed and privileged physician or licensed independent practitioner (as specified by the applicable RRC), who is responsible and accountable for the patient's care.
2. Information Available about Attending: The identity of the attending must be available to each trainee, faculty member, other health care team members and patients.
3. Roles: Each patient must be informed by the learner and faculty member as to their roles in providing the patient with care.

B. *Classification and Methods of Supervision*. The program must be able to demonstrate that the appropriate level of supervision exists for all learners, based on each learner's level of training and ability, as well as patient complexity and acuity. Teaching staff members determine the level of responsibility accorded to each trainee. On-call schedules for teaching staff and more advanced house staff members are structured to ensure that direct supervision is readily available to those on duty who require it.

Initially, PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available, as described in this policy (respectively, III.B.1 and III.B.2.a, below) and as further defined by the applicable RRC. As appropriate to the situation, the following classifications of supervision must be used to promote oversight while providing for graded authority and responsibility:

1. Direct: The supervising physician is physically present with the learner and the patient.
2. Indirect:
   a. Direct supervision is immediately available, meaning the supervising physician is physically within the hospital or other patient care site and is immediately available to provide Direct Supervision.
   b. Direct supervision available, meaning the supervising physician is NOT physically present within the hospital or other patient care site but IS available immediately by telephone or other electronic modality, and is available to provide Direct Supervision.
3. Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

C. *Assignment of Roles*. The Program Director and faculty must assign each learner the roles of progressive authority and responsibility, conditional independence, or a supervisory role in patient care. This means:

1. Evaluation of each learner guided by milestones must be performed by the Program Director.
2. Delegation of portions of care to the trainee, based on the needs of the patient and skills of the learner, must be done by the supervising physician.
3. Supervision by senior learners of junior learners must reflect the senior learner's progress toward independence, while it considers the needs of each patient and the skills of the individual residents or fellows involved.

D. *Guidelines*.

1. Communication Required: Programs must set guidelines describing events and circumstances when a learner must communicate with the supervising faculty member.
2. Limits on Learner's Scope of Authority: Each learner must know the limits of his/her scope of authority and under what circumstances action with conditional independence is permitted.
3. Duration of Faculty Supervisory Assignments: A faculty member's supervisory assignment must be of sufficient duration to assess the knowledge and skills of each learner and to delegate to the learner the appropriate level of patient care authority and responsibility.

Reviewed/Approved by the Graduate Medical Education Committee	6/6/2017

STATEMENT ON HOUSE STAFF MEMBER CONCERNS

The University of Iowa Hospitals and Clinics (UIHC) strives to make the residency and fellowship experience as rewarding as possible for the physician and dentist in training. However, questions and concerns can arise during the training period. This *Statement on House Staff Member Concerns* provides a mechanism for house staff members to obtain answers to or resolve disputes or disagreements that arise with respect to the work environment, academic performance, issues related to the program or faculty or administrative matters. The mechanisms established in this *Statement* are aimed at minimizing conflicts of interest.

I. WORK ENVIRONMENT, ACADEMIC PERFORMANCE (INCLUDING NON-PROMOTION NOT DUE TO AN APPROVED LEAVE OF ABSENCE), PROGRAM/FACULTY ISSUES, AND ADMINISTRATIVE MATTERS.

The following avenues are available for the house staff member to address/resolve concerns:

A. PROGRAM DIRECTOR:
All questions and concerns should first be directed to the Program Director or his/her designee. The Program Director or his/her designee will be best able to address most questions or concerns that arise.

B. GRADUATE MEDICAL EDUCATION OFFICE (GMEO) REVIEW:
Questions regarding benefits or other administrative matters, which cannot be answered by the Program Director or his/her designee, should be directed to the Graduate Medical Education Office (GMEO). Personnel in the GMEO can provide answers to many questions and can also direct house staff members to the appropriate source for assistance.

C. GME ADMINISTRATIVE REVIEW:
When the GMEO staff members cannot answer the question or resolve the issue, they will refer the house staff member to the Director of Graduate Medical Education (GME) and/or the Associate Dean for GME to review the matter. The house staff member will be required to meet with one or both of these individuals and present a written description of the concern or issue at hand.

D. CEO/DIRECTOR'S REVIEW:
If the house staff member is not satisfied with the response from the GME Administrative Review (and the concern is not a matter of departmental discretion), the house staff member may make a written request to the CEO/Director of UIHC to review the matter. The CEO/Director, or his/her designee, will review the matter and provide to the house staff member a written response, which is final. The CEO/Director may in his/her discretion refer the matter to the Graduate Medical Education Working Group (also known as the GME Committee or GMEC) or an ad hoc committee for its recommendation prior to review by the CEO/Director. The processing of matters of departmental discretion is further addressed in this policy under "Due Process and Grievance Procedure" (Section III).

II. GENERAL HOUSE STAFF CONCERNS.

A. GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC):
General house staff member concerns may be communicated to members of the GMEC, pursuant to a charge of the GMEC to "provide a forum for house staff issues as expressed by the house staff representatives on the Working Group or by other house staff." GMEC members include elected house staff members, active clinical staff, Program Directors, GME administrative staff from UIHC, and administrators from the Carver College of Medicine. To obtain information about contacting GMEC members, house staff members should contact the GMEO or any of their GMEC House Staff Representatives.

III. DUE PROCESS AND GRIEVANCE PROCEDURES. (SUSPENSION, DISCHARGE, DISCIPLINARY ACTIONS, NON-RENEWAL)

A. SUSPENSION OR DISCHARGE:
If a house staff member is suspended or discharged from a training program, the procedures specified in Article IV, Section 7 of the Amended and Restated Bylaws, Rules and Regulations of the University of Iowa Hospitals and Its Clinical Staff will be followed. If notice of non-renewal of a contract is given less than three months before the expiration of the contract, the non-renewal shall be considered a discharge.

B. OTHER DEPARTMENTAL ACTIONS (OTHER THAN SUSPENSION OR DISCHARGE):
Other departmental actions include individual disciplinary actions by the Program or Department and non-renewal or non-promotion of a house staff member's contract. It should be noted that non-renewal

and non-promotion require a written notice of intent no later than three months prior to the end of the resident's current agreement. The following review process shall be followed:

1. Departmental Committee Review:
   The action will be reviewed by a Departmental Committee selected by the Program Director, if the house staff member requests such a review within 10 days of his or her becoming aware of the action, unless the house staff member has already been afforded an opportunity to present the information to such a Departmental Committee which prepared recommendations to the Program Director before the action and the house staff member has been informed of the Program Director's action in writing.
   a. Composition of Departmental Committee: The Departmental Committee described above will be composed of at least two active clinical staff members and one house staff member.
   b. Departmental Committee Recommendations: After its review, the Departmental Committee will submit its recommendations to the Program Director. If the Departmental Committee recommends a change in the action, the Program Director will then reconsider the action, giving due consideration to the Departmental Committee's recommendation.
2. Program Director's Decision:
   Following receipt of the Departmental Committee's recommendations, the resulting decision of the Program Director shall be provided by the Program Director to the house staff member and to the CEO/Director of the UIHC in writing and shall be final, unless the house staff member believes that the action could significantly threaten his or her intended career development (see Director's Review of Program Director's Decision, below). Actions will not be postponed while they are being reviewed, unless the Program Director in his/her discretion decides to do so.
3. CEO/Director's Review of Program Director's Decision:
   If the house staff member submits a written request to the CEO/Director of UIHC within 10 days of receipt of the Program Director's written decision (described in III.B.2 of this policy) and the request includes the reasons for the belief that the action could significantly threaten the house staff member's intended career development, the CEO/Director will first determine if the alleged threat is significant and, if so, shall review the decision.
   a. Advice to CEO/Director: The CEO/Director may seek the advice of the Graduate Medical Education Committee, the Clinical Staff Affairs Subcommittee, and/or an ad hoc committee as part of the review.
   b. Notice and Final Decision:
      (1) Non-Renewals: If the action is non-renewal of a contract prior to completion of the training program, the decision of the CEO/Director shall be given to the house staff member and Program Director in writing and is final.
      (2) All Other Actions: For all other actions, if the CEO/Director approves the Program Director's decision, the decision of the CEO/Director shall be given to the house staff member and the Program Director in writing and is final. If the CEO/Director recommends that the Program Director modify the decision, the Program Director will then reconsider the action, in consultation with the CEO/Director; the resulting decision of the Program Director, with CEO/Director approval, shall be provided to the house staff member and the CEO/Director in writing and is final.

Approved by the Graduate Medical Education Committee	10/9/2008
Approved by the Graduate Medical Education Committee	10/4/2011
Approved by the Graduate Medical Education Committee	3/10/2016
Approved by the Graduate Medical Education Committee	2/5/2020

POLICY

ON

SUBSTANCE ABUSE IDENTIFICATION AND INTERVENTION

— HOUSE STAFF —

The University of Iowa Hospitals and Clinics (UIHC) and it Clinical Staff operate under their Bylaws, Rules and Regulations which provide a mechanism to intervene on behalf of patient care and to assist the impaired clinical staff member (dentist or physician). Substance abuse carries significant personal risk to the individual clinical staff member as well as to the staff member's patients. Chemical dependency (substance abuse) is a medical disease, and some clinical departments may have greater risks because of the availability of potent drugs. A significant prevalence of alcoholism among professional groups, including physicians, also implies a clear need for careful crisis intervention. (See Appendix A, "Risks of Abuse in Physicians").

The following policy is designed to provide guidance and consistency to the assessment and handling of house staff member work-related performance problems associated with substance abuse.

Step 1: PROGRAM DIRECTOR RECEIVES WORK-RELATED PERFORMANCE PROBLEM INFORMATION FROM STAFF, STUDENTS OR PATIENTS: The Program Director may receive reports of alleged or actual house staff member substance abuse regarding work-related performance problems (See Appendix B, "Signs, Symptoms and Considerations in Identifying Potential Chemical Dependency").

Prior to approaching the house staff member with the substance abuse work-related performance problem information, the Program Director should consult with his or her Clinical Service Head, the Medical Director of GME, the Associate Director of GME, and UIHC legal counsel (or, in their absence, the designee of each). These individuals will identify resources available to conduct an investigation, if necessary. The investigation may include pharmacy audits, consultations with the Department of Psychiatry and other relevant investigational tools.

In the event that a house staff member **voluntarily** identifies substance abuse work-related performance problems, the Program Director should follow the procedures outlined in this policy beginning with **Step 3**.

Step 2: PROGRAM DIRECTOR DISCUSSES WORK-RELATED PERFORMANCE PROBLEMS WITH HOUSE STAFF MEMBER: The Program Director will notify the house staff member with the allegations of potential substance abuse, framing the discussion in the context of information received related to work performance problems. The Program Director has the discretion to determine that a substance abuse problem does not exist and what, if any, further action is warranted.

If the house staff member indicates a desire to terminate discussions of this nature with the Program Director, s/he may do so at anytime during the conversation.

Step 3: PROGRAM DIRECTOR ASSESSES THE ACCEPTANCE OR DENIAL OF THE ALLEGED SUBSTANCE ABUSE PROBLEM. Step 4 or Step 5 is then followed as appropriate.

Step 4: ACCEPTANCE – HOUSE STAFF MEMBER AGREES THAT HE/SHE HAS A SUBSTANCE ABUSE PROBLEM.	**Step 5: DENIAL** – HOUSE STAFF MEMBER DENIES THAT HE/SHE HAS A SUBSTANCE ABUSE PROBLEM.
1. The Program Director notifies the Clinical Service Head, the GME Medical Director, the GME Associate Director, UIHC legal counsel and other entities as required (or they designee), including but not limited to the UI Administration and, as appropriate, the Iowa Board of Medicine (IBOM). 2. The house staff member seeks intervention and is entered into a treatment program with the expenses borne by the UIHC. The Program Director, the Clinical Service Head, the Medical Director of GME and the Associate Director of GME must approve the treatment program. The house staff member is encouraged to self-report the substance abuse problem to the IBOM if he/she has not already done so. 3. The Program Director will decide whether or not the house staff member may re-enter the program, contingent upon considerations including but not limited to the nature of the work-related performance problem, year in training, the effect on the training program, licensing board limits, etc. To re-enter, the Program Director must document that the treatment has been effective, that he/she has received reports on the house staff member's progress while in the treatment program, that the house staff member is in compliance with the treatment program, and that the house staff member is willing to adhere to an aftercare program. 4. If the house staff member is allowed to re-enter the program, the Program Director will monitor the house staff member's compliance with the aftercare program, as set forth by the prescribed treatment program. 5. If a relapse occurs, the aftercare program is not followed or if there is a recurrence of the work-related substance abuse problem, the Program Director may: a. terminate the house staff member immediately and rehabilitation is not provided at the expense of UIHC; or b. show evidence to and obtain a finding from the Graduate Medical Education Committee (or a body designated by the Graduate Medical Education Committee) that this is an isolated incident following a substantial period of compliance. In this instance, a second rehabilitation may be provided by UIHC. If a relapse occurs, the aftercare program is not followed or if there is a recurrence of the work-related substance abuse problem after this second rehabilitative attempt, the house staff member must be terminated from the program by the Program Director, and no third rehabilitation shall be provided by UIHC.	1. The Program Director documents his/her discussion with the house staff member, including the house staff member's denial that a problem exists. 2. The Program Director provides copies of all relevant documentation to the Clinical Service Head, the GME Medical Director, the GME Associate Director and UIHC legal counsel. The Program Director must also notify the Iowa Board of Medicine (IBOM), as required. 3. The Program Director shall not require the house staff member to submit to a drug test without first consulting with UIHC legal counsel to determine if sufficient evidence exists to satisfy a reasonable suspicion standard for drug testing. In considering whether a house staff member should be required to submit to a drug test, the Program Director must be aware that there are many other strong indicia, other than drug testing, that can point to the existence of a substance abuse problem and that a negative test result does not conclusively indicate the absence of a substance abuse problem. If a drug test result is positive, and it is the house staff member's first offense, he/she cannot be terminated but must be offered entry into an evaluation and treatment program. If the Program Director does not have sufficient grounds to request entry into a treatment program or termination, no further action will be taken. However, the Program Director will continue to monitor the house staff member's performance. If suspected substance abuse problems persist or if further allegations emerge, the Program Director will return to Step 2. 4. Termination from the program must result if: a. the house staff member <u>is required and refuses</u> to submit to a drug test; b. the house staff member agrees to a drug test, the test result is positive <u>and</u> the house staff member refuses to enter treatment; c. the house staff member does not successfully complete a substance abuse treatment program; d. sufficient information exists regarding substance abuse related work performance problems to terminate the house staff member; e. after an <u>initial</u> rehabilitative attempt, a relapse occurs, the aftercare program is not followed or a recurrence of the work-related substance abuse problem occurs and there is an isolated incident following a substantial period of compliance; or f. there is a recurrence of the work-related substance abuse problem after a <u>second</u> rehabilitative attempt.

Note: If the house staff member is terminated, then all provisions of the Statement on House Staff Member Concerns will apply. The Program Director must notify the Medical Director of GME, the Associate Director of GME and the UIHC legal counsel of the termination. The Program Director must also notify the IBOM and University Administration of the termination. The house staff member will be afforded due process as outlined in Article IV, Section 7 of the University of Iowa Hospitals and Clinics Bylaws. If termination does not result, the Program Director will continue to monitor the work performance of the house staff member and may re-visit the steps of this policy if problems persist or recur.

Reviewed/Approved by the Graduate Medical Education Committee	*12/6/05*
Reviewed/Approved by the Graduate Medical Education Committee	*10/4/11*

RISKS OF SUBSTANCE ABUSE IN PHYSICIANS

All physicians and dentists who have access to addictive drugs are at risk for substance abuse. Substances external to their work environment also present risks. Several factors contribute to the development of chemical dependency:

- Drugs are available in hospitals and operating rooms and other patient care circumstances;
- Current culture accepts alcohol consumption which can lead to potential misuse of moderate to heavy drinking where alcoholic beverages are easily available;
- Experimentation with mood-altering drugs exists in all employment venues, and they are available to all members of our society;
- Highly-skilled and achievement-oriented specialties increase job stress;
- Intense work effort associated with the provision of medical care to patients can be draining in many ways; and
- Substance abuse can be a way of dealing with psychological pain, stress, fatigue, worry and physical discomfort.

SIGNS, SYMPTOMS AND CONSIDERATIONS IN IDENTIFYING POTENTIAL SUBSTANCE ABUSE

The early clinical and behavioral characteristics of alcohol and/or substance abuse impairment may be subtle and difficult to recognize, especially when substance use is intermittent and/or the house staff member is not yet dependent or acting overtly impaired. Clues that could raise suspicion include behavioral changes, deterioration in work performance, an increased incidence of volunteering for shifts, tardiness, irresponsibility, or anti-social conduct as well as overt manifestations such as drunkenness, hallucination, euphoria, depression, anxiety and even traffic violations related to driving while intoxicated (DWI).

Social behavior, health and work performance may be variably affected by chemical dependence. Social dysfunction is not limited to but may manifest in any of the following ways:

- withdrawal from leisure activities, friends and family;
- uncharacteristic or inappropriate behavior at social gatherings and/or impulsive behavior. These may include:
  - gambling or overspending;
  - mood swings;
  - frequent illness;
  - prominent desire to work alone and undisturbed;
  - hostility; and/or
  - refusal to eat lunch or to take breaks
- domestic turmoil (e.g., separation from spouse, child abuse, sexually inappropriate behavior);
- change in behavior of children or spouse; and/or
- legal problems (e.g., DWI)

Changes in health status may manifest as follows:

- deterioration in personal hygiene;
- striking sensitivity to temperature (may mask the desire to wear long sleeves to cover puncture sites);
- increased number of accidents; and/or
- increased number of personal health complaints and/or increased need for medical attention.

Changes in professional relationships, particularly deterioration of work performance, include:

- unreliability:
  - missed appointments;
  - inappropriate responses to emergencies;
  - inappropriate volunteering for additional patient care duties;
  - absences;
  - poor record keeping;
  - poor patient care; and/or
  - anesthesia mishaps
- complaints by patients and/or other staff;
- inappropriate drug requests:
  - over-prescription of medications;
  - excessive ordering of drugs from mail-order houses; and/or
  - heavy use of adjuvant drugs
- unstable employment history (e.g., relocation to several institutions or hospitals); and
- working at a level of professional responsibility below that consistent with the physician's qualifications

Chapter 4 – Sexual Harassment and Sexual Misconduct

(President 7/28/86; 12/91; 7/1/02; 3/21/05; 12/05; 12/08; 4/09; 11/09; 8/10; 1/18/11; 8/13; 10/1/14; 7/15; 7/1/17; 6/18; 9/21/18; 1/20; 8/14/20; 1/29/21; 7/8/21; 8/13/21)

Effective August 14, 2020, this policy has been renamed and substantively revised. It replaces former policies II-4 Sexual Harassment and IV-2 Sexual Misconduct Involving Students.

Effective **January 29**, **July 8**, and **August 13, 2021**, this policy has undergone additional revisions. For individual changes, see the redlined versions of II-4.1, II-4.14, II-4.17, and II-4.23. Also effective **August 13, 2021**, this policy has been retitled to reflect the completion of the interim period.

> If you or someone you know may be a victim of sexual assault, sexual harassment, dating/domestic violence, stalking, or any other behaviors prohibited under this policy,* you are strongly encouraged to seek assistance and support. Assistance is available 24 hours a day, 7 days a week, from:
>
> > Rape Victim Advocacy Program (RVAP) —
> > confidential, certified victim advocacy services, 319-335-6000
> >
> > Domestic Violence Intervention Program (DVIP) —
> > confidential, certified victim advocacy services, 319-351-1043 or 800-373-1043
> >
> > Emergency Department, University of Iowa Hospitals & Clinics —
> > confidential medical services, 319-356-2233
> >
> > University of Iowa Department of Public Safety —
> > law enforcement services, 319-335-5022, or 911 from any campus phone
>
> Additional resources, including information about culturally specific resources, can be found at https://osmrc.uiowa.edu/victim-resources/confidential-support.

* ATIXA 2020 One Policy, Two Procedures Model. Use and adaptation of this model with citation to ATIXA is permitted through a limited license to the University of Iowa. All other rights reserved.

4.1 Glossary

(Amended 1/29/21)

Effective January 29, 2021, this policy has been revised. For individual changes, see the redlined version.

a. "Academic or administrative officers (AAOs)" are mandated reporters[1] who are required to report actual or suspected sexual harassment (including stalking, dating violence, and domestic violence), sexual misconduct, or related retaliation to the Office of the Sexual Misconduct Response Coordinator within 2 business days. For a list of who is an AAO, see II-4.16a below.

b. "Adaptable resolution" is a voluntary informal process that may encompass a broad range of conflict resolution strategies, including but not limited to shuttle diplomacy, arbitration, mediation, and restorative justice. Parties may engage in an adaptable resolution before, during, or after an investigation is completed into the alleged conduct, but prior to a determination of responsibility in either Process A or Process B. Adaptable resolution may not be appropriate in all

circumstances. During the interim period of this policy, adaptable resolution will be limited to shuttle diplomacy.

c. "Adjudicator" means the decision maker who makes findings and the determination of responsibility in the context of a formal grievance process that requires a live hearing under this policy and Process A as defined in the associated procedures.

d. "Advisor" is a person who provides support and/or advice to a party during the resolution process. The University of Iowa has three types of advisors: support advisor, hearing advisor, and legal advisor. See II-4.23e below in the Procedure for Alleged Violations of the Policy on Sexual Harassment and Sexual Misconduct for more description.

e. "Complainant" means an individual who is alleged to be the victim of conduct that could constitute sexual harassment, sexual misconduct, or related retaliation under this policy.

f. "Complaint (formal)" means a document filed/signed by a complainant or signed by the Title IX Coordinator alleging sexual harassment, sexual misconduct, or related retaliation under this policy against a respondent and requesting that the university investigate the allegation.

g. "Confidential resource" means a person from a designated organization or university office who is not an academic or administrative officer (mandated reporter) of notice of sexual harassment, sexual misconduct, and/or related retaliation (irrespective of Clery Act Campus Security Authority status). Designated confidential resources are listed in II-14.16c(1).

h. "Day" means a business day when the University of Iowa is in normal operation.

i. "Education program or activity" means locations, events, or circumstances where the University of Iowa exercises substantial control over both the respondent and the context in which the sexual harassment or sexual misconduct occurs and also includes any building owned or controlled by a student organization that is officially recognized by the University of Iowa.

j. "Employee" is a person in an employment relationship with the University of Iowa or any of its units, including full- and part-time faculty and staff members, but not including persons holding only complimentary appointments. Emeritus status does not establish an employment relationship. Volunteers are not employees.

k. "Determination of responsibility": A conclusion by a preponderance-of-the-evidence standard that the alleged conduct occurred and whether it did or did not violate policy.

l. “Finding” is a conclusion by a preponderance-of-the-evidence standard that the conduct did or did not occur as alleged.

m. “Formal grievance process” means Process A and Process B, methods of formal resolution designated by the University of Iowa to address conduct that falls within this policy.[2]

n. “Grievance process pool” includes any investigators, hearing officers, appeal officers, and advisors who may perform any or all of these roles (though not at the same time or with respect to the same case).

o. “Hearing facilitator” may attend to logistics of rooms for various parties/witnesses as they wait; flow of parties/witnesses in and out of the hearing space; ensuring recording and/or virtual conferencing technology is working as intended; copying and distributing materials to participants, as appropriate.

p. “Investigator” means the person or persons who in the context of a formal grievance process are tasked with gathering information, assessing relevance and synthesizing the evidence, and compiling this information into an investigation report and file of directly related evidence. In complaints resolved through Process B, investigators also make findings and the determination of responsibility.

q. “Notice” means that an employee, student, or third party informs the Title IX Coordinator or academic or administrator officer of the alleged occurrence of harassing, misconduct, and/or retaliatory conduct.

r. “Parties” include the complainant(s) and respondent(s), collectively.

s. “Process A” means the formal grievance process that includes an investigation and live hearing detailed below in II-4.23 Procedure for Alleged Violations of the Sexual Harassment and Sexual Misconduct Policy.

t. “Process B” means the formal grievance process that does not include a live hearing but does include findings and a determination of responsibility made by an investigator detailed below in II-4.23 Procedure for Alleged Violations of the Sexual Harassment and Sexual Misconduct Policy.

u. “Reasonable-person standard” means how a person under similar circumstances would be expected to react. A reasonable person is always a person who is both sober and exercising sound judgment.

v. “Remedies” are post-finding actions directed to the complainant and/or the community to address safety, prevent recurrence, and restore access to the University of Iowa’s educational program, activities, and workplace.

w. “Respondent” means an individual who has been reported to be the perpetrator of conduct that could constitute sexual harassment or sexual misconduct; or of retaliation for engaging in a protected activity.

x. “Resolution” means the result of an adaptable resolution or formal grievance process.

y. “Sanction” means a consequence imposed by the university on a respondent who is found to have violated this policy.

z. “Sanctioning administrator” is the person who is responsible for determining and implementing corrective measures and sanctions and who may institute formal disciplinary action, consistent with university procedures.

aa. “Sexual harassment” is the category of offenses compliant with the U.S. Department of Education Title IX Regulation 106.30 including the offenses of sexual harassment, sexual assault, stalking, and dating violence and domestic violence. See II-4.14 Prohibited Conduct for greater detail.

bb. “Sexual misconduct” is a broad term encompassing any unwelcome behavior of a sexual nature that is committed without consent or by force, intimidation, coercion, or manipulation.

cc. “Student” is any individual who has accepted an offer of admission, or who is registered or enrolled for credit or non-credit-bearing course work, and who maintains an ongoing relationship with the University of Iowa.

dd. “Title IX Coordinator”[3] is the University of Iowa–designated official to ensure compliance with Title IX and the university’s Title IX program. References to the Title IX Coordinator throughout this policy may also encompass a designee of the Title IX Coordinator for specific tasks.

ee. “Title IX team” refers to the Title IX Coordinator, deputy coordinators, or other designee, and any member of the grievance process pool.

ff. “The University of Iowa” means a postsecondary education program that is a recipient of federal funding.

Notes

1. "Mandated reporters" in this policy are not to be confused with those mandated by state law to report child abuse, elder abuse, and/or abuse of individuals with disabilities to appropriate officials, though these responsibilities may overlap with those who have mandated reporting responsibility in this Policy on Sexual Harassment and Sexual Misconduct.

2. The formal grievance process complies with requirements of 34 CFR 106.45.

3. Anywhere this policy indicates “Title IX Coordinator,” the university may substitute a trained designee.

4.2 Rationale for Policy

Members of the university community have the right to be free from all forms of sexual harassment and sexual misconduct, which subvert the university’s mission and threaten the careers, educational experience, and the well-being of students, faculty, staff, and visitors. All members of the university community are expected to conduct themselves in a manner that maintains an environment free from sexual harassment and sexual misconduct.

The university community seeks to eliminate sexual harassment and sexual misconduct through education and accountability. Everyone is encouraged to report concerns or make complaints, including third parties, when the respondent is a member of the university community or a visitor. The university is committed to stopping sexual harassment and sexual misconduct, preventing its recurrence, eliminating any hostile environment, and remedying its discriminatory effects. In accordance with regulatory requirements and institutional values, this policy defines expectations for the university community and establishes mechanisms for determining when those expectations have been violated.

4.3 Applicable Scope

The core purpose of this policy is the prohibition of all forms of sexual harassment, sexual misconduct, and related retaliation. When an alleged violation of this policy is reported and a formal complaint filed, the allegations are subject to resolution using University of Iowa’s Process A, Process B, or adaptable resolution as determined by the Title IX Coordinator, and as detailed below. When the respondent is a member of the University of Iowa community, a grievance process may be available regardless of the status of the complainant, who may or may not be a member of the University of Iowa community. This community includes, but is not limited to, students, student organizations, faculty, administrators, staff, and third parties such as guests, visitors, volunteers, invitees, and campers. The Procedure for Alleged Violations of the Policy on Sexual Harassment and Sexual Misconduct (II-4.23 below) may be applied to

incidents, to patterns, and/or to the campus climate, all of which may be addressed and investigated in accordance with this policy.

4.4 Title IX Coordinator

The Title IX Coordinator oversees implementation of University of Iowa sexual harassment and sexual misconduct policy and procedure. The Title IX Coordinator has the primary responsibility for coordinating the university's efforts related to the intake, investigation, resolution, and implementation of supportive measures to stop, remediate, and prevent sexual harassment, sexual misconduct, and retaliation prohibited under this policy. No employee is authorized to resolve reports or complaints without the involvement of the Title IX Coordinator.

4.5 Independence and Conflict of Interest

The Title IX Coordinator acts with independence and authority free from bias and conflicts of interest. The Title IX Coordinator oversees all resolutions under this policy and these procedures. The members of the Title IX team are vetted and trained to ensure they are not biased for or against any party in a specific case, or for or against complainants and/or respondents, generally.

To raise any concern involving bias or conflict of interest by the Title IX Coordinator, contact the university President (319-335-3549; president@uiowa.edu). Concerns of bias or a potential conflict of interest by any other Title IX team member should be raised with the Title IX Coordinator.

Reports of misconduct committed by the Title IX Coordinator should be reported to the university President (319-335-3549; president@uiowa.edu) or designee. Reports of misconduct committed by any other Title IX team member should be reported to the Title IX Coordinator.

4.6 Administrative Contact Information

a. Complaints or notice of alleged policy violations, or inquiries about or concerns regarding this policy and procedures, may be made internally to:

    1. Monique DiCarlo, Title IX Coordinator
       Office of the Sexual Misconduct and Title IX Coordinator
       455 Van Allen Hall
       Phone: 319-335-6200

Email: osmrc@uiowa.edu

Web: https://osmrc.uiowa.edu

2. Jennifer Modestou, Deputy Title IX Coordinator and
   Director, Office of Equal Opportunity and Diversity
   202 Jessup Hall
   Phone: 319-335-0705
   Email: diversity@uiowa.edu

3. Sara Feldmann, Deputy Title IX Coordinator and
   Assistant Director, Office of the Sexual Misconduct Response Coordinator
   455 Van Allen Hall
   Phone: 319-335-6200
   Email: osmrc@uiowa.edu

4. Lyla Clerry, Deputy Title IX Coordinator and
   Associate Athletic Director for Athletic Compliance
   S240 Carver Hawkeye Arena
   Phone: 319-335-9598
   Email: lyla-clerry@uiowa.edu

b. The University of Iowa has also classified academic and administrative officers as mandated reporters of any knowledge they have that a member of the community is experiencing sexual harassment, sexual misconduct, and/or related retaliation. The subchapter below on mandated reporting (see II-4.16) details which employees have this responsibility and their duties, accordingly.

   In addition to filing a complaint with the University of Iowa, individuals who believe they may have been the subject of discrimination prohibited by state and/or federal law(s) may contact one or more of the following agencies for advice, assistance, and explanation of filing deadlines.

   1. Office for Civil Rights (OCR)
      U.S. Department of Education
      400 Maryland Avenue, SW
      Washington, DC 20202-1100
      Customer Service Hotline: 800-421-3481

Fax: 202-453-6012

TDD: 877-521-2172

Email: OCR@ed.gov

Web: http://www.ed.gov/ocr

2. Iowa Civil Rights Commission
   Grimes State Office Building
   400 E. 14th Street
   Des Moines, IA 50319-0201
   Phone: 515-281-4121, 800-457-4416
   Fax: 515-242-5840
   Email: icrc@iowa.gov
   Web: https://icrc.iowa.gov/

c. For external complaints involving employees, contact the Equal Employment Opportunity Commission (EEOC).

4.7 Notice/Complaints of Sexual Harassment, Sexual Misconduct, and/or Related Retaliation

a. Notice or complaints of sexual harassment, sexual misconduct, and/or related retaliation may be made using any of the following options:

   1. File a complaint with, or give verbal notice to, the Title IX Coordinator at the Office of the Sexual Misconduct Response Coordinator (319-335-6200; osmrc@uiowa.edu). Such a report may be made at any time (including during nonbusiness hours) by using the telephone number or email address, or by mail to the office address listed above in II-4.6a(1) for the Title IX Coordinator at the Office of the Sexual Misconduct Response Coordinator.

   2. Report online, using the reporting form posted at https://osmrc.uiowa.edu/report-problem-0. Anonymous reports are accepted but can give rise to a need to investigate. The University of Iowa tries to provide supportive measures to all complainants, which is impossible with an anonymous report. Because reporting carries no obligation to initiate a formal response, and as the University of Iowa respects complainant requests to dismiss complaints unless there is a compelling threat to health and/or safety, the complainant is

largely in control and should not fear a loss of privacy by making a report that allows the University of Iowa to discuss and/or provide supportive measures.

3. Any person may make a report that a student, employee, or visitor has experienced or committed sexual harassment, sexual misconduct, or related retaliation by contacting the Office of the Sexual Misconduct Response Coordinator, or any academic or administrative officer of the university.

b. A formal complaint means a document filed/signed by the complainant or signed by the Title IX Coordinator alleging a policy violation by a respondent and requesting that the University of Iowa investigate the allegation(s). A complaint may be filed with the Title IX Coordinator in person, by mail, or by electronic mail, by using the contact information in II-4.6a(1) above, or as described in this subchapter. As used in this paragraph, the phrase "document filed by a complainant" means a document or electronic submission (such as by electronic mail or through an online portal provided for this purpose by the University of Iowa) that contains the complainant's physical or digital signature, or otherwise reliably indicates that the complainant is the person filing the complaint.

   If notice is submitted in a form that does not meet this standard, the Title IX Coordinator will contact the complainant to ensure that it is filed correctly.

c. Making a report to law enforcement.

   1. **In an emergency**: Call 911 from wherever you are, and a law enforcement officer will respond to assist you.

   2. In nonemergency situations: Criminal sexual harassment or sexual misconduct, including sexual assault, dating/domestic violence, and stalking may be reported to the law enforcement agency that has jurisdiction over the location where the assault or abuse occurred. Victim advocates have special training in working with law enforcement. The advocates at RVAP (24-hour crisis line, 319-335-6000) and other agencies (https://osmrc.uiowa.edu/victim-resources/confidential-support) can provide accompaniment to meetings with law enforcement officials.

4.8 Supportive Measures

a. The University of Iowa will offer and implement appropriate and reasonable supportive measures to the parties upon notice of alleged sexual harassment, sexual misconduct, and/or related retaliation.

   Supportive measures are nondisciplinary, nonpunitive, individualized services offered as appropriate, as reasonably available, and without fee or charge to the parties to restore or preserve access to the University of Iowa's education program, activity, or workplace, including measures designed to protect the safety of all parties or the University of Iowa's educational environment, and/or deter sexual harassment, sexual misconduct, and/or related retaliation.

b. The Title IX Coordinator promptly makes supportive measures available to the parties upon receiving notice or a complaint. At the time that supportive measures are offered, the University of Iowa will inform the complainant, in writing, that they may file a formal complaint with the University of Iowa either at that time or in the future, if they have not done so already. The Title IX Coordinator works with the complainant to ensure that their wishes are taken into account with respect to the supportive measures that are planned and implemented.

   The Title IX Coordinator will work with the complainant's or respondent's Senior Human Resources Leader or the Associate Dean for Faculty when implementing support measures related to the workplace or when the alleged conduct involves a nexus to the workplace.

c. Subject to applicable laws and court orders, the University of Iowa will maintain the privacy of the supportive measures, provided that privacy does not impair the University of Iowa's ability to provide the supportive measures. The University of Iowa will act to ensure as minimal an academic impact on the parties as possible and provide flexibility within the workplace when it can reasonably do so. The University of Iowa will implement measures in a way that does not unreasonably burden the other party.

d. Supportive measures may include, but are not limited to:

   1. One-on-one coaching;

   2. Referral to counseling, medical, and/or other health care services;

   3. Referral to community-based service providers;

   4. Visa and immigration assistance;

5. Student financial aid counseling;
6. Education to the community or community subgroup(s);
7. Altering campus housing assignment(s);
8. Altering work arrangements for employees or student-employees;
9. Providing parking or transportation accommodations;
10. Implementing contact limitations (no-contact directives) between the parties;
11. Academic extensions of deadlines, or other course-/program-related adjustments;
12. Crime alerts;
13. Class schedule modifications, withdrawals, or leaves of absence;
14. Increased security and monitoring of certain areas of the campus;
15. Any other actions deemed appropriate by the Title IX Coordinator.

e. Violations of no-contact directives will be referred to appropriate student or employee conduct processes for enforcement.

f. Individuals who have experienced a recent sexual assault are strongly encouraged to visit a hospital or clinic to assess and address their medical needs. The exam can assess for injuries and provide necessary medical advice and medication for concerns regarding pregnancy and sexually transmitted infections (STI). A Sexual Assault Nurse Examiner is available at both Iowa City hospitals to perform an evidentiary examination. Receiving an evidentiary examination does not mean that a victim must make a complaint to the university or to law enforcement. Rather, the examination serves to preserve evidence in the event that a victim may wish to make a complaint in the future.

   A sexual assault evidentiary exam is fully covered and paid for by the State of Iowa and will not be submitted for insurance purposes.

   To secure medical assistance and/or an evidentiary exam, visit:

University of Iowa Hospitals & Clinics
Emergency Department (open 24 hours)
200 Hawkins Drive
Roy Carver Pavilion, Level 1
Iowa City, Iowa 52242
Emergency Medicine phone: 319-356-2233
UIHC Nurseline (operated 24 hours): 319-384-8442

4.9 Emergency Removal

The University of Iowa can act to remove a respondent entirely or partially from its education program, activities, or workplace on an emergency basis when an individualized safety and risk analysis has determined that an immediate threat to the physical health or safety of any student, employee, or other individual justifies removal. This risk analysis is performed by the Title IX Coordinator in conjunction with the Threat Assessment Program (see also VI-32), using its standard objective violence risk assessment procedures. Paid administrative leave does not constitute emergency removal and does not require an individualized safety and risk analysis.

In all cases in which an emergency removal is imposed, the student, the employee, or two representatives from a student organization will be given notice of the action and the option to request to meet with the Title IX Coordinator prior to such action/removal being imposed, or as soon thereafter as reasonably possible, to show cause why the action/removal should not be implemented or should be modified.

This meeting is not a hearing on the merits of the allegation(s), but rather is an administrative process intended to determine solely whether the emergency removal is appropriate. When this meeting is not requested in a timely manner, objections to the emergency removal will be deemed waived. A complainant and their advisor may be permitted to participate in this meeting if the Title IX Coordinator determines it is equitable to do so. There is no appeal process for emergency removal decisions.

A respondent may be accompanied by their advisor when meeting with the Title IX Coordinator for this meeting. The respondent will be given access to a written summary of the basis for the emergency removal prior to the meeting to allow for adequate preparation.

The Title IX Coordinator has sole discretion under this policy to implement or stay an emergency removal and to determine the conditions and duration. Violation of an emergency removal under this policy will be grounds for discipline, which may include expulsion or termination.

The University of Iowa will implement the least restrictive emergency actions practical in light of the circumstances and safety concerns. As determined by the Title IX Coordinator, these actions could include, but are not limited to: removing a student from a residence hall; temporarily reassigning an employee; restricting a student's or an employee's access to or use of facilities or equipment; allowing a student to withdraw or take grades of incomplete without financial penalty; authorizing an administrative leave; and suspending a student's participation in extracurricular activities, student employment, student organizational leadership, or intercollegiate/intramural athletics.

At the discretion of the Title IX Coordinator, alternative course work options may be pursued to ensure as minimal an academic impact as possible on the parties.

4.10 Promptness

All allegations are acted upon promptly by the University of Iowa once it has received notice or a formal complaint. The University of Iowa will avoid all undue delays within its control.

Any time the general time frames for resolution outlined in University of Iowa procedures will be delayed, the University of Iowa will provide written notice to the parties of the delay, the cause of the delay, and an estimate of the anticipated additional time that will be needed as a result of the delay.

4.11 Privacy

Every effort is made by the University of Iowa to preserve the privacy of reports.[1] The University of Iowa will not share the identity of any individual who has made a report or complaint of sexual harassment, sexual misconduct, or related retaliation; any complainant; any individual who has been reported to be the perpetrator of sexual harassment, sexual misconduct, or related retaliation; any respondent; or any witness, except as permitted by the Family Educational Rights and Privacy Act (FERPA), 20 USC 1232g; FERPA regulations, 34 CFR 99; or as required by law, court order, or legal process; or to carry out the purposes of 34 CFR 106, including the conducting of any investigation, hearing, grievance, or resolution proceeding arising under University of Iowa policies and procedures.

The University of Iowa reserves the right to determine which University of Iowa officials have a legitimate educational interest in being informed about incidents that fall within this policy, pursuant to the Family Educational Rights and Privacy Act (FERPA).

Only a small group of officials who have a business need to know will typically be told about the complaint; they may include, but are not limited to: the Office of the Sexual Misconduct Response Coordinator, the Office of Equal Opportunity and Diversity, the Office of Student Accountability, Senior Human Resources Leader or Associate Dean for Faculty, the Office of the Executive Vice President and Provost, University Human Resources, the departmental executive officer, Department of Public Safety, and the Threat Assessment Program. Information will be shared as necessary with response coordinators, investigators, adjudicators, witnesses, and the parties. The circle of people with this knowledge will be kept as tight as possible to preserve the parties' rights and privacy.

Confidentiality and mandated reporting are addressed more specifically below (see II-4.16).

Note

1. For the purpose of this policy, "privacy" and "confidentiality" have distinct meanings. "Privacy" means that information related to a complaint will be shared with a limited number of University of Iowa employees who "need to know" in order to assist in the assessment, investigation, and resolution of the report. All employees who are involved in the University of Iowa's response to notice under this policy receive specific training and guidance about sharing and safeguarding private information in accordance with state and federal law. The privacy of student education records will be protected in accordance with the Family Educational Rights and Privacy Act (FERPA), as outlined in the University of Iowa's FERPA policy. The privacy of employee records will be protected in accordance with the law and university policies. "Confidentiality" exists in the context of laws that protect certain relationships, including those who provide services related to medical and clinical care, certified victim advocacy, mental health providers, counselors, and ordained clergy. The law creates a privilege between certain health care providers, mental health care providers, attorneys, victim advocates, clergy, spouses, and others, with their patients, clients, parishioners, and spouses. The University of Iowa has designated individuals who have the ability to have privileged communications as confidential resources. For more information about confidential resources, see II-4.16c(1). When information is shared by a complainant with a confidential resource, the confidential resource cannot reveal the information to any third party except when an applicable law or a court order requires or permits disclosure of such information. For example, information may be disclosed when: 1) the individual gives written consent for its disclosure; 2) there is a concern that the individual will likely cause serious physical harm to self or others; or 3) the information concerns conduct involving suspected abuse or neglect of a minor under the age of 18, elders, or individuals with disabilities. Non-identifiable information may be shared by confidential resources for statistical tracking purposes as required by the federal Clery Act. Other information may be shared as required by law.

4.12 Jurisdiction of the University of Iowa

a. This policy applies to the education program and activities of the University of Iowa, to conduct that takes place on the campus or on property owned or controlled by the University of Iowa, at University of Iowa–sponsored events, or in buildings owned or controlled by University of Iowa's recognized student organizations. The respondent must be a member of the University of Iowa's community, including patients, visitors, vendors, and contractors, in order for its policies to apply.

   This policy can also be applicable to the effects of off-campus misconduct that effectively deprive someone of access to the University of Iowa's educational program, activities, or workplace. The University of Iowa may also extend jurisdiction to off-campus and/or to online conduct when the Title IX Coordinator determines that the conduct affects a substantial University of Iowa interest.

b. Regardless of where the conduct occurred, the University of Iowa will address notice/complaints to determine whether the conduct occurred in the context of its employment or educational program or activity and/or has continuing effects on campus or in an off-campus sponsored program or activity. A substantial University of Iowa interest includes:

   1. Any action that constitutes a criminal offense as defined by law. This includes, but is not limited to, single or repeat violations of any local, state, or federal law;

   2. Any situation in which it is determined that the respondent poses an immediate threat to the physical health or safety of any student or other individual;

   3. Any situation that significantly impinges upon the rights, property, or achievements of oneself or others or significantly breaches the peace and/or causes social disorder; and/or

   4. Any situation that is detrimental to the educational interests or mission of the University of Iowa.

c. If the respondent is unknown or is not a member of the University of Iowa community, the Title IX Coordinator will assist the complainant in identifying appropriate campus and local resources and support options and/or, when criminal conduct is alleged, in contacting local or campus law enforcement if the individual would like to file a police report.

Further, even when the respondent is not a member of the University of Iowa's community, supportive measures, remedies, and resources may be accessible to the complainant by contacting the Title IX Coordinator or a confidential advocate (https://osmrc.uiowa.edu/victim-resources/confidential-support).

d. All vendors serving the University of Iowa through third-party contracts are subject to the policies and procedures of their employers and to these policies and procedures to which their employer has agreed to be bound by their contracts.

e. When the respondent is enrolled in or employed by another institution, the Title IX Coordinator can assist the complainant in liaising with the appropriate individual at that institution, as it may be possible to allege violations through that institution's policies.

   Similarly, the Title IX Coordinator may be able to assist a student or employee complainant who experiences sexual harassment, sexual misconduct, or related retaliation in an externship/internship or other environment external to the University of Iowa where sexual harassment or sexual misconduct policies and procedures of the facilitating or host organization may give recourse to the complainant.

4.13 Time Limits on Reporting

There is no time limitation on providing notice/complaints to the Title IX Coordinator. However, if the respondent is no longer subject to the University of Iowa's jurisdiction and/or significant time has passed, the ability to investigate, respond, and provide remedies may be more limited or impossible.

Acting on notice/complaints significantly impacted by the passage of time (including, but not limited to, the rescission or revision of policy) is at the discretion of the Title IX Coordinator, who may document allegations for future reference, offer supportive measures and/or remedies, and/or engage in adaptable resolution or formal action, as appropriate.

When notice/complaint is affected by significant time delay, the university will typically apply the policy in place at the time of the alleged misconduct and the procedures in place at the time of notice/complaint.

4.14 Prohibited Conduct

(Amended 1/29/21; 7/8/21; 8/13/21)

Effective **January 29**, **July 8**, and **August 13, 2021**, this policy has been revised. For individual changes, see the redlined version.

4.14(1) Relevant Terms and Definitions

The following terms and definitions are relevant to understanding prohibited conduct in this section.

a. "Consent." Consent is knowing, voluntary, and clear permission by word or unambiguous action to engage in sexual activity.

   Since individuals may experience the same interaction in different ways, it is the responsibility of each party to determine that the other has consented before engaging in the activity.

   If consent is not clearly provided prior to engaging in the activity, consent may be ratified by word or action at some point during the interaction.

   For consent to be valid, there must be a clear expression in words or actions that the other individual consented to that specific sexual conduct. Reasonable reciprocation can be implied. For example, if someone kisses you, you can kiss them back (if you want to) without the need to explicitly obtain their consent to being kissed back.

   Consent can also be withdrawn once given, as long as the withdrawal is reasonably communicated. If there is confusion as to whether anyone has consented or continues to consent to sexual activity, the participants must stop the activity until each consents to it.

   Consent to some sexual contact (such as kissing or fondling) cannot be presumed to be consent for other sexual activity (such as intercourse). A current or previous intimate relationship is not sufficient to constitute consent.

   The existence of consent is based on the totality of the circumstances evaluated from the perspective of a reasonable person in the same or similar circumstances, including the context in which the alleged incident occurred and relationship between the parties.

   Consent in relationships must also be considered in context. When parties consent to BDSM or other forms of kink, non-consent may be shown by the use of a safe word. Resistance, force,

violence, or even saying “no” may be part of the kink and thus consensual, so the University of Iowa’s evaluation of communication in kink situations should be guided by reasonableness, rather than strict adherence to policy that assumes non-kink relationships as a default.

b. "Incapacitation." Incapacitation occurs when someone cannot make rational, reasonable decisions because they lack the capacity to give knowing/informed consent (e.g., to understand the “who, what, when, where, why, or how” of their sexual interaction). A person cannot consent if they are unable to understand what is happening or are disoriented, helpless, asleep, or unconscious, for any reason, including by alcohol or other drugs (including medication). Subsequent memory loss alone, which may not be observable at the time of events, is not sufficient to establish that someone was incapacitated.

   Incapacitation is determined through consideration of all relevant indicators of the complainant’s state and is not synonymous with intoxication, impairment, blackout, and/or being drunk. As stated above, a respondent violates this policy if they engage in sexual activity with someone who is incapable of giving consent. This policy covers a person whose incapacity results from:

   1. A temporary or permanent physical or mental health condition,
   2. Involuntary physical restraint, and/or
   3. The consumption of alcohol or drugs.

   It is a defense to a sexual harassment and sexual misconduct policy violation that the respondent neither knew nor should have known the complainant to be physically or mentally incapacitated, regardless of the reason. A determination whether a respondent “should have known” that a complainant was incapacitated is made by looking at the particular facts available from an objective, reasonable-person standard. The definition of “a reasonable person” includes a person who is both sober and exercising sound judgment.

4.14(2) Prohibited Conduct Defined

Paragraph a contains definitions required in Part 106.3 of the U.S. Department of Education Title IX Regulations. These definitions also apply in situations that are otherwise not covered by Title IX (e.g., off campus).

a. "Sexual harassment I" means conduct on the basis of sex that satisfies one or more of the following:

1. An employee of the university conditioning the provision of an aid, benefit, or service of the university on an individual’s participation in unwelcome sexual conduct;

2. Unwelcome conduct determined by a reasonable person to be so severe, pervasive, and objectively offensive that it effectively denies a person equal access to the university's education program or activity; or

3. “Sexual assault” as defined in 20 USC 1092(f)(6)(A)(v) means an offense classified as a forcible or nonforcible sex offense under the uniform crime reporting system of the Federal Bureau of Investigation. A sex offense is any sexual act directed against another person, without the consent of the victim, including instances where the victim is incapable of giving consent. Sexual assault includes:

    1. "Fondling": The touching of the private body parts of another person for the purpose of sexual gratification, without the consent of the victim, including instances where the victim is incapable of giving consent because of their age or because of their temporary or permanent mental incapacity.

    2. "Incest": Sexual intercourse between persons who are related to each other within the degrees wherein marriage is prohibited by law.

    3. "Statutory rape": Sexual intercourse with a person who is under the statutory age of consent.

    4. "Rape": The penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim.

4. "Dating violence" as defined in 34 USC 12291(a)(10) means violence committed by a person:

    1. Who is or has been in a social relationship of a romantic or intimate nature with the victim; and

2. Where the existence of such a relationship shall be determined based on a consideration of the following factors:

    1. The length of the relationship;

    2. The type of relationship;

    3. The frequency of interaction between the persons involved in the relationship.

5. "Domestic violence" as defined in 34 USC 12291(a)(8) means a felony or misdemeanor crime of violence committed:

    1. By a current or former spouse or intimate partner of the victim;

    2. By a person with whom the victim shares a child in common;

    3. By a person who is cohabitating with or has cohabitated with the victim as a spouse or intimate partner;

    4. By a person similarly situated to a spouse of the victim under the domestic or family violence laws of the jurisdiction receiving grant monies; or

    5. By any other person against an adult or youth victim who is protected from that person's acts under the domestic or family violence laws of the jurisdiction.

6. Stalking as defined in 34 USC 12291(a)(30):

    1. "Stalking" means engaging in a course of conduct directed at a specific person that would cause a reasonable person to:

        1. Fear for their safety or the safety of others; or

        2. Suffer substantial emotional distress.

    2. Examples of stalking include:

        1. Attempting to gather information about the target of unwelcome conduct;

2. Vandalism, including attacks on data and equipment;

3. Direct physical and/or verbal threats against a target of unwelcome conduct or loved ones of a target of unwelcome conduct, including animal abuse;

4. Gathering of information about a target of unwelcome conduct from family, friends, coworkers, and/or classmates;

5. Manipulative and controlling behaviors such as threats to harm oneself, or threats to harm someone close to the target of unwelcome conduct;

6. Defamation or slander against the target of unwelcome conduct; posting false information about the target of unwelcome conduct; posing as the complainant in order to post to websites, news groups, blogs, or other sites that allow public contributions; and/or encouraging others to harass the target of unwelcome conduct;

7. Posing as someone other than oneself to initiate transactions, financial credit, loans, or other contractual agreements;

8. Arranging to meet the target of unwelcome conduct under false pretenses.

b. "Sexual misconduct" is a broad term encompassing any unwelcome behavior of a sexual nature that is committed without consent or by force, intimidation, coercion, or manipulation.

1. "Sexual harassment II" is persistent, repetitive, or egregious conduct directed at a specific individual or group of individuals that a reasonable person would interpret, in the full context in which the conduct occurs, as harassment of a sexual nature.

   Harassment of a sexual nature has the effect of limiting or denying another person's work or educational performance or creating an intimidating, hostile, or demeaning environment for employment, education, on-campus living, or participation in a university program or activity.

   Examples of this type of behavior include:

1. Unwanted behavior of a sexual nature;
2. Persistent unwelcome efforts to develop a romantic or sexual relationship;
3. Unwelcome commentary about an individual's body or sexual activities;
4. Repeated unwanted sexual attention;
5. Repeated and unwelcome sexually oriented teasing, joking, or flirting;
6. Verbal abuse of a sexual nature;
7. Conditioning the provision of an aid, benefit, service, or an employment decision on submission to unwelcome behavior of a sexual nature;
8. An expressed or implied threat to take adverse action against someone for rejecting sexual advances.

2. "Non-consensual sexual contact" is any intentional sexual contact, however slight, with any body part or object, by any individual upon another. "Sexual contact" includes intentional contact with the breasts, buttock, groin, or genitals, touching another with any of these body parts or an object, making another touch you or themselves with or on any of these body parts, or any intentional bodily contact in a sexual manner. Non-consensual sexual contact that occurs within the context of an individual's authorized responsibilities will be evaluated for reasonableness within that context. Non-consensual sexual contact may be found where the contact is:
    1. Without consent,
    2. By force,
    3. By coercion, or
    4. Upon an individual without capacity to consent because of:
        1. Age ,
        2. Temporary or permanent mental incapacity, or
        3. Temporary or permanent physical incapacity.

3. "Sexual exploitation" is conduct that takes non-consensual sexual advantage of another individual, often without the knowledge of that person, for any purpose, including sexual gratification, financial gain, personal benefit, or any other nonlegitimate purpose.

   Examples of sexual exploitation include but are not limited to:

   1. Non-consensual streaming, audio or video recording, photographing, or transmitting intimate or sexual utterances, sounds, or images without consent of all parties involved;
   2. Engaging in any form of voyeurism (e.g., “peeping”);
   3. Allowing others to view sexual acts (whether in person or via a video camera or other recording device) without the consent of all parties involved;
   4. Arranging for others to have non-consensual sexual contact or penetration with a person;
   5. Compelling another individual to touch their own or another individual’s (third-party's) private parts without consent;
   6. Threatening another person that you will commit a sex act against them;
   7. Engaging in indecent exposure.

4.15 Retaliation

Protected activity under this policy includes reporting an incident that may implicate this policy, participating in the grievance process, supporting a complainant or respondent, assisting in providing information relevant to an investigation, and/or acting in good faith to oppose conduct that constitutes a violation of this policy.

Acts of alleged retaliation should be reported immediately to the Title IX Coordinator and will be promptly investigated. The University of Iowa is prepared to take appropriate steps to protect individuals who fear that they may be subjected to retaliation.

It is prohibited for the University of Iowa or any member of the University of Iowa’s community to take materially adverse action by intimidating, threatening, coercing, harassing, or discriminating against any

individual for the purpose of interfering with any right or privilege secured by law or policy, or because the individual has made a report or complaint, testified, assisted, or participated or refused to participate in any manner in an investigation, proceeding, or hearing under this policy and procedure.

Charges against an individual for code of conduct violations that do not involve sexual harassment or sexual misconduct but arise out of the same facts or circumstances as a report or complaint, or a report or complaint of sexual harassment, for the purpose of interfering with any right or privilege secured by Title IX, constitutes retaliation.

The exercise of rights protected under the First Amendment does not constitute retaliation.

Charging an individual with a code of conduct violation for making a materially false statement in bad faith in the course of a grievance proceeding under this policy and procedure does not constitute retaliation, provided that a determination regarding responsibility, alone, is not sufficient to conclude that any party has made a materially false statement in bad faith.

4.16 Mandated Reporting

All academic or administrative officers (AAOs) are mandated reporters who are required to report actual or suspected sexual harassment (including sexual assault, stalking, and dating and domestic violence), sexual misconduct, or related retaliation to the Office of the Sexual Misconduct Response Coordinator within 2 business days.

a. "Academic or administrative officer" includes the following:

    1. Collegiate deans (including associate deans and assistant deans);

    2. Faculty members with administrative responsibilities at the level of departmental executive officer (DEO) or above;

    3. Any staff member whose primary job responsibility is to provide advice regarding a student's academic pursuits or other university-related activities;

    4. Any faculty or staff member serving as departmental (or collegiate) director or coordinator of undergraduate or graduate studies, or as a director or coordinator of any departmental, collegiate, or university off-campus academic program (including any study-abroad program);

5. The President, Director of Equal Opportunity and Diversity, Sexual Misconduct Response Coordinator, vice presidents (including assistant and associate vice presidents), and Provost (including assistant and associate provosts), and those persons' designees;

6. Directors and supervisors in an employment context, including faculty and staff who supervise student employees, in relation to matters involving the employees they supervise (other than Department of Public Safety personnel when receiving criminal complaints or reports); and

7. Human resources representatives (including all central University Human Resources staff).

Any academic or administrative officer of the university who observes sexual harassment, sexual misconduct, or related retaliation, or who becomes aware of allegations of such behavior through a report from a complainant or third party shall take the actions described in this section, even if the complainant does not wish any action to be taken, and must notify the Office of the Sexual Misconduct Response Coordinator of the allegations within 2 business days.

b. The AAO must:

1. Inform the complainant or third-party reporter of the options available under this policy (i.e., support measures, formal complaint, adaptable resolution) and that certified victim advocacy services are available from the Rape Victim Advocacy Program or the Domestic Violence Intervention Program; and,

2. Provide notice of the allegations to the Office of the Sexual Misconduct Response Coordinator within 2 business days; and

3. When the alleged prohibited conduct occurs in the context of the respondent's employment, provide notice of the allegations to the Senior Human Resources Leadership Representative or Associate Dean for Faculty of the unit in which the alleged conduct occurred or, when incidents do not occur within a unit, notify the Senior Human Resources Leadership Representative or Associate Dean for Faculty of the respondent.

c. In order to make informed choices, it is important to be aware of confidentiality and mandatory reporting requirements when consulting campus resources. On campus, some resources may maintain confidentiality and are not required to report actual or suspected sexual harassment,

sexual misconduct, or related retaliation. They may offer options and resources without any obligation to inform an outside agency or campus official unless a complainant has requested the information be shared.

If a complainant expects formal action in response to their allegations, reporting to any AAO can connect them with resources to report crimes and/or policy violations, and these employees within 2 business days to the Title IX Coordinator (and/or police, if desired by the complainant), who will take action when an incident is reported to them.

The following sections describe the reporting options at the University of Iowa for a complainant or third party:

1. Confidential resources. If a complainant would like the details of an incident to be kept confidential, the complainant may speak with:

    1. Office of the Ombudsperson (for faculty, other instructors, staff, or students), 308 Jefferson Building;

    2. Employee Assistance Program (for faculty or staff), 121-50 University Services Building;

    3. University Counseling Service (for students), 3223 Westlawn;

    4. Women's Resource and Action Center (for faculty, other instructors, staff, students, or visitors), Bowman House;

    5. Rape Victim Advocacy Program (certified advocates) (for faculty, other instructors, staff, students, or visitors), 108 River Street;

    6. Domestic Violence Intervention Program (certified advocates) (for faculty, other instructors, staff, students, or visitors), 1105 South Gilbert Court, Iowa City.

    All of the above-listed individuals will maintain confidentiality when acting under the scope of their licensure, professional ethics, and/or professional credentials, except in extreme cases of immediacy of threat or danger or abuse of a minor/elder/individual with a disability, or when required to disclose by law or court order.

2. Academic and administrative officers and formal notice/complaints. All University of Iowa academic and administrative officers (AAO) are mandated reporters and must promptly share with the Title IX Coordinator/Office of the Sexual Misconduct Response Coordinator all known details of a report made to them.

   Complainants may want to carefully consider whether they share personally identifiable details with non-confidential AAOs as those details must be shared with the Title IX Coordinator.

   Generally, disclosures in climate surveys, classroom writing assignments or discussions, human subjects research, or at events such as "Take Back the Night" marches or speak-outs do not provide notice that must be reported to the Coordinator by employees, unless the complainant clearly indicates that they desire a report to be made or seek a specific response from the University of Iowa.

   Supportive measures may be offered as the result of such disclosures without formal University of Iowa action.

   Failure of an AAO, as described above in this section, to report an incident of sexual harassment, sexual misconduct, or related retaliation of which they become aware is a violation of University of Iowa policy and can be subject to disciplinary action for failure to comply.

4.17 When a Complainant Does Not Wish to Proceed

(Amended 1/29/21)

Effective January 2021, this policy has been revised. For individual changes, see the redlined version.

If a complainant does not wish for an investigation to take place, or does not want a formal complaint to be pursued, they may make such a request to the Title IX Coordinator, who will evaluate that request in light of the duty to ensure the safety of the campus and to comply with state or federal law.

The Title IX Coordinator has ultimate discretion over whether the University of Iowa proceeds when the complainant does not wish to do so, and the Title IX Coordinator may sign a formal complaint to initiate a grievance process.

Compelling reasons to initiate a grievance process may result from evidence of patterns of misconduct, predatory conduct, threats, abuse of minors, use of weapons, and/or violence. The University of Iowa may be compelled to act on alleged employee misconduct irrespective of a complainant's wishes.

The Title IX Coordinator must also consider the effect that non-participation by the complainant may have on the availability of evidence and the University of Iowa's ability to pursue a formal grievance process fairly and effectively.

When the Title IX Coordinator executes the written complaint, they do not become the complainant. The complainant is the individual who is alleged to be the victim of conduct that could constitute a violation of this policy.

When the University of Iowa proceeds, the complainant may have as much or as little involvement in the process as they wish. The complainant retains all rights of a complainant under this policy irrespective of their level of participation.

The University of Iowa's ability to remedy and respond to notice may be limited if the complainant does not want the University of Iowa to proceed with an investigation and/or grievance process. The goal is to provide the complainant with as much control over the process as possible, while balancing the University of Iowa's obligation to protect its community.

In cases in which the complainant requests confidentiality or no formal action and the circumstances allow the University of Iowa to honor that request, the University of Iowa will offer adaptable resolution options (see below), supportive measures, and remedies to the complainant and the community, but will not otherwise pursue formal action.

If the complainant elects to take no action, they can change that decision if they decide to pursue a formal complaint at a later date. Upon making a formal complaint, a complainant has the right, and can expect, to have allegations taken seriously by the University of Iowa, and to have the incidents investigated and properly resolved through these procedures.

4.18 Federal Timely Warning Obligations

Parties reporting sexual assault, domestic violence, dating violence, and/or stalking should be aware that, under the Clery Act, the University of Iowa must issue timely warnings, called "crime alerts," for incidents

reported to them that pose a serious or continuing threat of bodily harm or danger to members of the campus community.

The University of Iowa will ensure that a complainant's name and other identifying information is not disclosed, while still providing enough information for community members to make safety decisions in light of the potential danger.

4.19 False Allegations and Evidence

Deliberately false and/or malicious accusations under this policy, as opposed to allegations which, even if erroneous, are made in good faith, are a serious offense and will be subject to appropriate disciplinary action.

Additionally, witnesses and parties knowingly providing false evidence, tampering with or destroying evidence after being directed to preserve such evidence, or deliberately misleading an official conducting an investigation can be subject to discipline under University of Iowa policy.

4.20 Amnesty for Complainants and Witnesses

The University of Iowa community encourages the reporting of misconduct and crimes by complainants and witnesses. Sometimes, complainants or witnesses are hesitant to report to University of Iowa officials or participate in grievance processes because they fear that they themselves may be in violation of certain policies, such as underage drinking or use of illicit drugs at the time of the incident. Respondents may hesitate to be forthcoming during the process for the same reasons.

It is in the best interests of the University of Iowa community that complainants choose to report misconduct to University of Iowa officials, that witnesses come forward to share what they know, and that all parties be forthcoming during the process.

To encourage reporting and participation in the process, the University of Iowa maintains a policy of offering parties and witnesses amnesty from minor policy violations — such as underage consumption of alcohol or the use of illicit drugs — related to the incident.

Amnesty does not apply to more serious allegations such as physical abuse of another or illicit drug distribution. The decision not to offer amnesty to a respondent is based on neither sex nor gender, but on the fact that collateral misconduct is typically addressed for all students within a progressive discipline

system, and the rationale for amnesty — the incentive to report serious misconduct — is rarely applicable to the respondent with respect to a complainant.

Sometimes, students are hesitant to assist others for fear that they may get in trouble themselves (for example, an underage student who has been drinking or using marijuana might hesitate to help take an individual who has experienced sexual misconduct to the Department of Public Safety). The University of Iowa maintains a policy of amnesty for students who offer help to others in need. While policy violations cannot be overlooked, the University of Iowa may provide purely educational options with no official disciplinary finding, rather than punitive sanctions, to those who offer their assistance to others in need.

4.21 Federal Statistical Reporting Obligations

Certain campus officials — those deemed Campus Security Authorities — have a duty to report the following for federal statistical reporting purposes. All personally identifiable information is kept private, but statistical information must be passed along to campus law enforcement regarding the type of incident and its general location (on or off campus or in the surrounding area, but no addresses are given) for publication in the Annual Security Report and daily campus crime log.

Campus Security Authorities include: student affairs/student conduct staff, campus law enforcement/public safety/security, coaches, athletic directors, residence life staff, student activities staff, human resources staff, advisors to student organizations, and any other official with significant responsibility for student and campus activities.

4.22 Education Programs

a. Educational efforts are essential to the establishment of a campus that is free of sexual harassment and sexual misconduct. Several goals to be achieved through education include:

    1. Ensuring that complainants and respondents (and potential complainants) are aware of their rights;

    2. Notifying individuals of conduct that is prohibited;

    3. Informing administrators about the proper way to address complaints of violations of this policy; and

    4. Educating the community about the problems this policy addresses.

b. Primary prevention and awareness programs for incoming students and employees that include information on sexual harassment/sexual misconduct, bystander intervention, and risk reduction, along with information on other forms of protected-class discrimination and harassment:

    1. All faculty, staff, and students meeting the following criteria are required to complete an approved course offered by the university.

        1. Faculty: All faculty, any title, who hold at least a 50 percent appointment.

        2. Staff (P&S): All regular staff, employed at least 50 percent or greater time,

        3. Staff (merit): All regular staff, employed at least 50 percent or greater time,

        4. Medical residents and fellows: All who hold at least a 50 percent appointment during the academic year,

        5. Postdoctoral scholars/fellows: All who hold at least a 50 percent appointment during the academic year,

        6. Students (graduate/professional): All graduate/professional students who hold a teaching assistantship for a period of one semester or longer, and any other students as determined by the Provost,

        7. Students (undergraduate): University housing resident assistants, and any other student employees as determined by the Office of the Vice President for Student Life.

    2. Current faculty/staff: All current faculty and staff members meeting the criteria set out in paragraph b(1) above are required to participate in an approved harassment prevention course every 3 years (i.e., 3 calendar years from the date of their most recent training), unless more frequent training is required by the employing unit or college.

    3. New hires: All faculty and regular staff members who hold a 50 percent or greater appointment shall receive sexual harassment prevention education in the first 6 months of their employment (except for those whose positions fall under the definition of "academic and administrative officers"). Options for satisfying this requirement may include:

instructor-led sessions, specifically designated online courses, and/or annual new faculty orientations

4. Academic and administrative officers (AAOs): All faculty/staff hired into and/or promoted to a position defined by II-4.1c(1) of this policy as an academic/administrative officer (e.g., vice president, dean, DEO, student advisor, supervisor) shall complete an approved sexual harassment prevention course for supervisors within the first 2 months of their appointment. Academic and administrative officers are responsible for knowing and understanding the contents of this policy and the procedures for processing complaints brought to them pursuant to this policy.

5. The Title IX Coordinator has the centralized oversight and monitoring responsibility for ensuring members of the grievance process pool and the Title IX Team are free from conflict of interest or bias for or against complainants or respondents, and receive appropriate training to carry out their respective roles. Materials used to train members must be publicly available on the Office of the Sexual Misconduct Response Coordinator website.

6. The Offices of Equal Opportunity and Diversity and Student Wellness are designated with centralized oversight and monitoring of compliance with the mandatory harassment prevention education for the campus community on sexual harassment, sexual misconduct, and other forms of protected-class discrimination and harassment.

c. Preparation and dissemination of information. University Human Resources is charged with distributing information about this policy to all current members of the university community and to all those who join the community in the future. An annual notification from the university is provided to all students, faculty, and staff to remind them of the contents of this policy. Information about this policy will be made available continually at appropriate campus centers and offices and on the University of Iowa website.

d. Review of policy. This policy will be reviewed within 3 years after the latest revisions are implemented and revised as appropriate by the Title IX Coordinator. This policy is subject to review at any other time deemed necessary by the President, the General Counsel, or the Title IX Coordinator.

4.23 Procedure for Alleged Violations of the Policy on Sexual Harassment and Sexual Misconduct

(Amended 1/29/21; 7/9/21; 8/13/21)

Effective January 29 and July 9, 2021, this policy has been revised. For individual changes, see the redlined version.

Effective **August 13, 2021**, this policy has been retitled to reflect the completion of the interim period.

a. Procedure overview. The University of Iowa will act on any notice or complaint of a violation of the policy that is received by the Title IX Coordinator[1] or any other academic or administrative officer by applying these procedures, which include three possible methods for resolution known as Process A, Process B, and adaptable resolution.

   The procedures below apply to all allegations of sexual harassment, sexual misconduct, or related retaliation involving students, staff, faculty, or visitors. Process B will be used to resolve formal complaints involving patients of University of Iowa Health Care. A set of technical dismissal requirements within the Title IX regulations may apply as described below, but when a technical dismissal under the Title IX allegations is required, any remaining allegations may proceed using these same grievance procedures, clarifying which aspects of the policy are applicable.

   1. Process A is a formal grievance process that includes an investigation and live hearing.

   2. Process B is a formal grievance process that includes an investigation and does not include a live hearing.

   3. An adaptable resolution includes resolving a complaint informally.

      The procedures below may be used to address related misconduct arising from the investigation of or occurring in conjunction with reported misconduct (e.g., vandalism, physical abuse of another). All other allegations of misconduct unrelated to incidents covered by the policy will be addressed through procedures elaborated in the Student Accountability Procedure, Faculty Dispute Procedures (III-29), Equal Opportunity and Diversity Complaint Discrimination Procedure, or procedures noted in this *Operations Manual.*

b. Notice/complaint. Upon receipt of a complaint or notice to the Title IX Coordinator of an alleged violation of the policy, the University of Iowa initiates a prompt initial assessment to determine the next steps the University of Iowa needs to take.

The University of Iowa will initiate at least one of three responses:

1. Offering supportive measures because the complainant does not want to proceed formally; and/or

2. An adaptable resolution; and/or

3. A formal grievance process in accordance with Process A or Process B based on the following considerations:

    1. Process A applies in cases involving students, staff, faculty, or visitors where the alleged behavior meets the definition of sexual harassment as defined in the U.S. Department of Education Title IX Regulation 106.30. Process A also applies when the alleged sexual harassment or sexual misconduct, if true, could result in a student being suspended or expelled from the University of Iowa.

    2. Process B applies in cases involving students, staff, faculty, or visitors where the alleged behavior falls outside the definition of sexual harassment as defined by Title IX regulation, but nonetheless does meet the definition of prohibited behavior within the Policy on Sexual Harassment and Sexual Misconduct and, if true, would not result in a student being suspended or expelled.

    Both formal grievance processes will determine whether or not the policy has been violated. If so, the University of Iowa will promptly implement remedies to ensure that it is not deliberately indifferent to harassment, its potential recurrence, or its effects. Both formal grievance processes also provide the respondent the opportunity to accept responsibility for violating the policy as charged at any point prior to the issuance of the notice of outcome.

c. Initial assessment. Following receipt of notice or a complaint of an alleged violation of the Policy on Sexual Harassment and Sexual Misconduct, the Title IX Coordinator[2] engages in an initial assessment, which is typically 1 to 5 business days in duration. The steps in an initial assessment can include:

1. The Title IX Coordinator reaches out to the complainant to offer supportive measures and explain resolution options.

2. The Title IX Coordinator works with the complainant to ensure they are aware of the right to have an advisor.

3. If a formal complaint is received, the Title IX Coordinator assesses its sufficiency and works with the complainant to make sure it is correctly completed.

4. The Title IX Coordinator works with the complainant to determine whether the complainant prefers a supportive response, an adaptable resolution option, or a formal investigation and grievance process.

    1. If only supportive measures are preferred, the Title IX Coordinator works with the complainant to identify their wishes and then seeks to facilitate implementation. No formal grievance process is initiated, though the complainant can elect to initiate one later, if desired.

    2. If an adaptable resolution is preferred, the Title IX Coordinator determines in consultation with the investigator if the misconduct alleged falls within the scope of the Policy on Sexual Harassment and Sexual Misconduct, assesses whether the complaint is suitable for adaptable resolution, assesses which adaptable mechanism may serve the situation best or is available, and may seek to determine if the respondent is also willing to engage in an adaptable resolution.

    3. If a formal grievance process is preferred, the Title IX Coordinator determines in consultation with the investigator if the misconduct alleged falls within the scope of the Policy on Sexual Harassment and Sexual Misconduct:

        1. If it does, the Title IX Coordinator will initiate the formal investigation and grievance process under Process A or Process B, directing the investigation to address:

            1. An incident, and/or

            2. A pattern of alleged misconduct, and/or

            3. A culture/climate issue, based on the nature of the complaint.

2. If it does not, the Title IX Coordinator will determine if the complaint should be referred to the Office of Student Accountability, the Office of Equal Opportunity and Diversity, or Human Resources staff for resolution under another policy.

4. If the complainant does not wish to make a formal complaint, the Title IX Coordinator determines whether to initiate a complaint because of indicators that suggest a compelling threat to campus or to the health and/or safety of campus members.

5. Dismissal (mandatory and discretionary).[3] The U.S. Department of Education Title IX regulations require that schools clearly differentiate in their process whether a complaint is subject to the protections afforded under Title IX. The regulations use the term "dismissal" to indicate that something has been determined outside the scope of Title IX. If a complaint is dismissed under Title IX, it may still be resolved through a formal grievance process (Process A or Process B). Though it is possible that a complaint or allegation could be dismissed from the formal grievance process altogether, this section covers mandatory and discretionary dismissal under Title IX only. A formal complaint, or any allegations therein, **must** be dismissed in accordance with Title IX if, at any time during the investigation or hearing, it is determined that:

    1. The conduct alleged in the formal complaint would not constitute sexual harassment as defined in Part 106.3 of the U.S. Department of Education's Title IX regulations, even if proved; and/or

    2. The conduct did not occur in an education program or activity controlled by the University of Iowa (including buildings or property controlled by recognized student organizations), and/or the University of Iowa does not have control of the respondent; and/or

    3. The conduct did not occur against a person in the United States; and/or

    4. At the time of filing a formal complaint, a complainant is not participating in or attempting to participate in the education program or activity of the University of Iowa.

6. The University of Iowa **may** dismiss a formal complaint or any allegations in it if, at any time during the investigation or hearing:

    1. A complainant notifies the Title IX Coordinator in writing that the complainant would like to withdraw the formal complaint or any allegations; or

    2. The respondent is no longer enrolled in or employed by the University of Iowa; or

    3. Specific circumstances prevent the University of Iowa from gathering evidence sufficient to reach a determination as to the formal complaint or allegations.

7. Upon any dismissal, the University of Iowa will promptly send written notice of the dismissal under Title IX and may continue with a formal grievance process or an adaptable resolution.

8. The decision to dismiss or not to dismiss is appealable by any party at the conclusion of a formal grievance process. A complainant who decides to withdraw a complaint may later request to reinstate it or refile it.

d. Counterclaims. The University of Iowa is obligated to ensure that the grievance process is not abused for retaliatory purposes. The University of Iowa permits the filing of counterclaims but uses an initial assessment, described above, to assess whether the allegations in the counterclaim are made in good faith. Counterclaims by the respondent may be made in good faith, but are, on occasion, also made for purposes of retaliation. Counterclaims will be dismissed if not made in good faith.

    Counterclaims determined to have been reported in good faith will be processed using the grievance procedures below. Investigation of such claims may take place after resolution of the underlying initial allegation, in which case a delay may occur.

    Counterclaims may also be resolved through the same investigation as the underlying allegation, at the discretion of the Title IX Coordinator or the investigator. When counterclaims are not made in good faith, they will be considered retaliatory and may constitute a violation of this policy.

e. Right to advisors. Parties have a right to receive support and advice throughout the university's resolution process. They may have up to two people providing these services who may attend all

meetings and interviews at which the party is entitled to be present. The university has identified the following roles to meet this need.

1. Support advisor:
    1. May be a friend, victim advocate, mentor, family member, or any other individual a party chooses to support them throughout the resolution process.
    2. May be present with their advisee, at the advisee's discretion, at all stages of the process.
    3. May ask for breaks or other assistance on behalf of the advisee, but not permitted to ask or answer questions or provide information on any substantive issues of the complaint.
    4. Someone who serves as a support advisor is not permitted to serve as a witness.
2. Hearing advisor:
    1. May be a friend, mentor, family member, attorney, or any other individual a party chooses to advise them related to the hearing. The parties may choose a hearing advisor from outside of the university or one will be provided to them from the university pool.
    2. Primary role is to ask questions of parties and witnesses at the hearing in consultation with the advisee.
    3. Participates only in the hearing and meetings related to the hearing.
    4. Is not permitted to speak on behalf of the advisee outside the context of asking questions at the hearing.
    5. Someone who serves as a hearing advisor is not permitted to serve as a witness.
3. Legal advisor:
    1. Complainants and respondents may have a legal advisor throughout the process. Legal advisors are not provided by the university.

2. May be present with their advisee, at the party's discretion, at all stages of the process.

3. If attending hearing, will serve as hearing advisor.

4. At the hearing, legal advisors may not communicate on behalf of their client outside the context of asking questions.

5. Someone who serves as a legal advisor is not permitted to serve as a witness

   The parties may select whoever they wish to serve as their advisors as long as the advisors are willing, eligible and available.

4. Hearing advisors/University of Iowa–appointed advisor. Under U.S. Department of Education regulations applicable to Title IX, cross-examination is required during the hearing, but must be conducted by the parties' advisors. The parties are not permitted to directly question each other or any witnesses. If a party does not have a hearing advisor, the University of Iowa will appoint someone for the limited purpose of asking questions of the parties and witnesses at a hearing.

   The University of Iowa cannot guarantee equal advisory rights, meaning that if one party selects an advisor who is an attorney, but the other party does not, the University of Iowa is not obligated to provide an attorney.

   A party may reject this appointment and choose their own advisor, but they may not proceed without a hearing advisor. If the party's hearing advisor will not conduct cross-examination, the University of Iowa will appoint an advisor who will do so, regardless of the participation or nonparticipation of the advised party in the hearing itself. Questioning of the parties and witnesses will also be conducted by the adjudicator during the hearing.

   Communications between a university-appointed advisor and their advisee are confidential for purposes of this administrative process; however, such communications may be subject to disclosure pursuant to court order or other legal process. University-appointed advisors do not provide legal advice, even if the appointed advisor has a license to practice law.

5. Expectations of advisors. The University of Iowa generally expects an advisor to adjust their schedule to allow them to attend University of Iowa meetings when planned, but may change scheduled meetings to accommodate an advisor's inability to attend, if doing so does not cause an unreasonable delay.

   The University of Iowa may also make reasonable provisions to allow an advisor who cannot attend in person to attend a meeting by telephone, video conferencing, or other similar technologies, as may be convenient and available.

   Advisors should help the parties prepare for each meeting and are expected to advise ethically, with integrity, and in good faith.

   All advisors are subject to the University of Iowa's policies and procedures, whether they are university-appointed or not. Advisors are expected to advise their advisees without disrupting proceedings. Advisors should not address University of Iowa officials in a meeting or interview unless invited to (e.g., asking procedural questions). The advisor may not make a presentation or represent their advisee[4] during any meeting or proceeding and may not speak on behalf of the advisee to the investigator(s) or adjudicator except during a hearing proceeding, during cross-examination.

   The parties are expected to ask and respond to questions on their own behalf throughout the investigation phase of the resolution process. Although an advisor generally may not speak on behalf of their advisee, the advisor may consult with their advisee, either privately as needed, or by conferring or passing notes during any resolution process meeting or interview. For longer or more involved discussions, the parties and their advisors should ask for breaks to allow for private consultation.

   Any advisor who oversteps their role as defined by this policy will be warned only once. If the advisor continues to disrupt or otherwise fails to respect the limits of the advisor role, the meeting will be ended, or other appropriate measures implemented, including that the University of Iowa may require the party to use a different advisor. Subsequently, the Title IX Coordinator will determine how to address the advisor's non-compliance and future role.

6. Sharing Information with advisors. The University of Iowa expects that the parties may wish to have the university share documentation and evidence related to the allegations with their advisors. Parties may share this information directly with their advisor or other individuals if they wish. Doing so may help the parties participate more meaningfully in the resolution process.

   The university requires a consent and privacy form that authorizes the University of Iowa to share such information directly with their advisor. The parties must either complete and submit the form to the Title IX Coordinator or provide similar documentation demonstrating consent to a release of information to the advisor before University of Iowa is able to share records with an advisor.

   If a party requests that all communication be made through their advisor, the University of Iowa will not comply with that request.

7. Privacy of records shared with advisors. Advisors are expected to maintain the privacy of the records shared with them. These records may not be shared with third parties, disclosed publicly, or used for purposes not explicitly authorized by the University of Iowa. University of Iowa may seek to restrict the role of any advisor who does not respect the sensitive nature of the process or who fails to abide by the University of Iowa's privacy expectations.

8. Expectations of the parties with respect to advisors. A party may elect to change advisors during the process and is not obligated to use the same advisor(s) throughout. The parties are expected to inform the investigator(s) of the identity of their advisor(s) at least 2 business days before the date of their first meeting with investigators.

   The parties are expected to provide timely notice to the Title IX Coordinator if they change advisors at any time. Once notified of a change in advisors, consent to share information with the previous advisor is terminated, and a release for the new advisor must be provided. Parties are expected to inform the Title IX Coordinator of the identity of their hearing advisor at least 2 business days before the hearing.

   As a public entity, the University of Iowa fully respects and accords the Weingarten rights of employees (https://hr.uiowa.edu/support/laborunion-relations/weingarten-rights-

employees). For parties who are entitled to union representation, the University of Iowa will allow the unionized employee to have their union representative (if requested by the party) as well as an advisor of their choice present for all resolution-related meetings and interviews. To uphold the principles of equity, the other party (regardless of union membership) will also be permitted to have two advisors. Witnesses are not permitted to have union representation or advisors in grievance process interviews or meetings.

f. Adaptable resolution. Adaptable resolution is an alternative to the formal grievance process by which a mutually-agreed-upon resolution of an allegation is reached. All parties must consent to the use of an adaptable resolution. Adaptable resolution is not available to resolve allegations by a student against an employee for sexual harassment as defined in Section 106.3 of the Department of Education Title IX regulations. Resolution proceedings are private. All persons present at any time during the resolution process are expected to maintain the privacy of the proceedings in accordance with university policy. While there is an expectation of privacy around what adaptable resolution facilitators share with parties during meetings, the parties have discretion to share their own knowledge and evidence with others if they so choose. The University of Iowa encourages parties to discuss this with their advisors before doing so.

1. Adaptable resolution options. Adaptable resolution can include three different approaches:

    1. When the parties agree to resolve the matter through a mechanism like mediation, restorative practices, etc.;

    2. When the respondent accepts responsibility for violating policy, and desires to accept a sanction and end the formal grievance process; or

    3. When the parties reach a resolution through shuttle diplomacy.

    To initiate an adaptable resolution, a complainant needs to submit a formal complaint, as defined above. If a respondent wishes to initiate an adaptable resolution, they should contact the Title IX Coordinator to so indicate. When the Title IX Coordinator makes the formal complaint, the Title IX Coordinator may initiate an adaptable resolution with the respondent.

    If a complainant wants to initiate an adaptable resolution, but the respondent

declines to participate, the complainant may opt to use the formal grievance process. If a respondent wants to initiate an adaptable resolution upon receiving notice of a complaint, but the complainant declines to participate, the formal grievance process will continue. If the Title IX Coordinator wants to initiate an adaptable resolution, but the respondent declines to participate, the formal grievance process will continue.

It is not necessary to pursue an adaptable resolution first in order to pursue a formal grievance process, and any party participating in an adaptable resolution can stop the process at any time and begin or resume the formal grievance process.

Prior to implementing the adaptable resolution, the University of Iowa will provide the parties with written notice of the complaint and any consequences or measures that may result from participating in such a process, including information regarding any records that will be maintained or shared by the University of Iowa.

The University of Iowa will obtain voluntary, written confirmation that all parties wish to resolve the matter through the adaptable resolution process before proceeding and will not pressure the parties to participate. When the Title IX Coordinator makes the formal complaint and initiates the adaptable resolution process, the Title IX Coordinator may consult with and inform any non-participating complainant about the adaptable resolution.

2. Considerations for proceeding with an adaptable resolution. The Title IX Coordinator may look to the following factors to assess whether an adaptable resolution is appropriate, or which form of resolution may be most successful for the parties:

    1. The parties' amenability to adaptable resolution;

    2. Likelihood of potential resolution, taking into account any power dynamics between the parties;

    3. The parties' motivation to participate;

4. Civility of the parties;
5. Ongoing safety and risk analysis;
6. Disciplinary history;
7. Whether an emergency removal is needed;
8. Availability of an adaptable resolution facilitator with the needed skills to assist with the complaint;
9. Complaint complexity;
10. Goals of the parties;
11. Adequate resources to invest in adaptable resolution (time, staff, etc.)

The ultimate determination of whether adaptable resolution is available or successful is to be made by the Title IX Coordinator or designee. The Title IX Coordinator maintains records of any resolution that is reached, and failure to abide by the resolution agreement may result in appropriate responsive/disciplinary actions. Results of complaints resolved by adaptable resolution are not appealable.

3. Restorative practices, mediation, etc. (to be developed post interim period).

4. Respondent. The respondent may accept responsibility for all of the alleged policy violations at any point during the resolution process, prior to a notice of outcome (Process A or Process B). If the respondent indicates an intent to accept responsibility for all of the alleged misconduct, the formal process will be paused, and the Title IX Coordinator will determine whether adaptable resolution can be used according to the criteria in that section above.

If adaptable resolution is applicable, the Title IX Coordinator will determine whether all parties and the University of Iowa are able to agree on responsibility, sanctions, and/or remedies. If so, the Title IX Coordinator implements the accepted finding that the respondent is in violation of University of Iowa policy and implements agreed-upon sanctions and/or remedies, in coordination with other appropriate administrator(s), as

necessary.

This result is not subject to appeal once all parties indicate their written assent to all agreed-upon terms of resolution. When the parties cannot agree on all terms of resolution, the formal grievance process will resume at the same point where it was paused.

When a resolution is accomplished, the appropriate sanction or responsive actions are promptly implemented in order to effectively stop the harassment or discrimination, prevent its recurrence, and remedy the effects of the discriminatory conduct, both on the complainant and the community.

5. Shuttle diplomacy. The Title IX Coordinator or the adaptable resolution facilitator, with the consent of the parties, may negotiate and implement an agreement to resolve the allegations that satisfies all parties and the University of Iowa. Negotiated resolutions are not appealable.

   A negotiated resolution, reached through shuttle diplomacy, is a voluntary agreement between the parties to a resolution that addresses the party's concerns. The process starts with a proposed resolution from either party. The facilitator brings the proposed resolution to the other party for consideration. The party receiving the proposal may accept the resolution with no alterations, may propose alterations, conditions, or additional terms, or may reject the proposal outright and make a counterproposal. Proposed alterations, or the addition of conditions or terms, function as a rejection of the initial proposal and the creation of a counterproposal.

   The facilitator will continue to bring counterproposals between parties until one of these conditions is met:

   1. The parties achieve a mutually agreeable resolution;
   2. One of the parties withdraws from participation;
   3. The facilitator determines that an impasse has been reached.

      The facilitator remains neutral between the parties. During the process, the facilitator may assist the parties in developing the terms of the resolution and may

assist the parties in obtaining information from relevant units on the workability of proposed terms if they affect a party in a university context such as employment, the academic setting, or university housing.

When the process is concluded, the facilitator will memorialize the outcome in a memorandum to both parties. If the parties achieved a mutually agreeable resolution, the Title IX Coordinator will review the memorandum to ensure for compliance with university policy. If the resolution conflicts with university policy, or is deemed unworkable, the parties may continue to work with the facilitator to negotiate a resolution as described above.

g. Grievance process pool. The formal grievance process relies on a pool of administrators ("the pool") to carry out the process. Members of the pool are announced in an annual distribution of this policy to all students, parents/guardians of students, employees, prospective students, and prospective employees. They are also listed in the Office of the Sexual Misconduct Response Coordinator's Annual Report. Changes that occur during the year will be updated on the website and included in the following year's distribution.

    1. Pool member roles. Members of the pool are trained annually, and can serve in in the following roles, at the direction of the Title IX Coordinator:

        1. To provide appropriate intake of and initial guidance pertaining to complaints;
        2. To act as a university-appointed advisor to the parties during a hearing;
        3. To serve as an adaptable resolution facilitator;
        4. To perform or assist with initial assessment;
        5. To investigate complaints;
        6. To serve as a hearing facilitator (process administrator, no decision-making role);
        7. To serve as a hearing adjudicator;
        8. To serve as an appeal decision maker.

2. Pool member appointment. The Title IX Coordinator appoints the pool,[5] which acts with independence and impartiality. Appointments may be made to serve in all roles or only in one or more specific role.

h. Formal grievance process. The Title IX Coordinator will work with the Office of Equal Opportunity and Diversity or the Office of Student Accountability to provide written notice of formal complaint (NOFC) to the respondent upon commencement of the formal grievance process. This facilitates the respondent's ability to prepare for the interview and to identify and choose their own advisor to accompany them. The NOFC is also copied to the complainant.

The NOFC will include:

1. A specific and meaningful summary of all allegations,
2. The identity of the involved parties (if known),
3. The date and location of the alleged incident(s) (if known),
4. The specific policies implicated,
5. A description of the applicable procedures,
6. A statement of the potential sanctions/responsive actions that could result,
7. A statement that the University of Iowa presumes the respondent not responsible for the reported misconduct unless and until the evidence supports a different determination,
8. A statement that determinations of responsibility are made at the conclusion of the process,
9. A statement that the parties will be given an opportunity to inspect and review all directly related and/or relevant evidence obtained during the review and comment period,
10. A statement about the University of Iowa's policy on retaliation,
11. Information about the privacy of the process,
12. Information on the opportunity for each party to have up to 2 advisors of their choosing and the requirement that parties have a hearing advisor in the event of a hearing

13. A statement informing the parties that the University of Iowa's policy prohibits knowingly making false statements, including knowingly submitting false information during the resolution process,

14. Detail on how the party may request disability accommodations during the interview process,

15. A link to the University of Iowa's Resource and Referral Guide,

16. The name(s) of the investigator(s), along with a process to identify, in advance of the interview process, to the Title IX Coordinator any conflict of interest that the investigator(s) may have, and

17. An instruction to preserve any evidence that is directly related to the allegations.

18. A statement that the respondent can accept responsibility for violating the policy as charged, and accept sanctions, to end the formal grievance process at any point prior to the issuance of the notice of outcome.

    Amendments and updates to the NOFC may be made as the investigation progresses and more information becomes available regarding the addition or dismissal of various charges.

    Notice will be made in writing and may be delivered by one or more of the following methods: in person, mailed to the local or permanent address(es) of the parties as indicated in official University of Iowa records, or emailed to the parties' University of Iowa–issued email or designated accounts. Once mailed, emailed, and/or received in-person, notice will be presumptively delivered.

i. Resolution time line. The University of Iowa will make a good faith effort to complete the resolution process within a 90-business-day time period, including appeal, which can be extended as necessary for appropriate cause by the Title IX Coordinator, who will provide notice and rationale for any extensions or delays to the parties as appropriate, as well as an estimate of how much additional time will be needed to complete the process.

j. Appointment of investigators. Once the decision to commence a formal investigation is made, the Title IX Coordinator, in consultation with the Office of Student Accountability or the Office of Equal

Opportunity and Diversity, appoints pool members to conduct the investigation usually within 2 business days of determining that an investigation should proceed.

k. Ensuring impartiality. Any individual materially involved in the administration of the resolution process including the Title IX Coordinator, investigator, and adjudicators may have no actual or apparent conflicts of interest or bias for a party generally, or for a specific complainant or respondent.

   The Title IX Coordinator will vet the assigned investigator to ensure impartiality by ensuring there are no actual or apparent conflicts of interest or disqualifying biases. The parties may, at any time during the resolution process, raise a concern regarding bias or conflict of interest, and the Title IX Coordinator will determine whether the concern is reasonable and supportable. If so, another pool member will be assigned and the impact of the bias or conflict, if any, will be remedied. If the source of the conflict of interest or bias is the Title IX Coordinator, concerns should be raised with the President.

   The formal grievance process involves an objective evaluation of all relevant evidence obtained, including evidence which supports that the respondent engaged in a policy violation and evidence which supports that the respondent did not engage in a policy violation. Credibility determinations may not be based solely on an individual's status or participation as a complainant, respondent, or witness.

   A respondent is presumed not responsible for the reported misconduct unless and until the respondent is determined to be responsible for a policy violation by the applicable standard of proof.

l. Investigation time line. Investigations are completed expeditiously, normally within 60 business days, though some investigations may take weeks or even months, depending on the nature, extent, and complexity of the allegations, availability of witnesses, police involvement, etc. The University of Iowa will make a good-faith effort to complete investigations as promptly as circumstances permit and will communicate regularly with the parties to update them on the progress and timing of the investigation.

m. Delays in the investigation process and interactions with law enforcement. The University of Iowa may undertake a short delay in its investigation or adaptable resolution (several days to a few weeks) if circumstances require. Such circumstances include, but are not limited to: a request from

law enforcement to temporarily delay the investigation, the need for language assistance, the absence of parties and/or witnesses, and/or accommodations for disabilities or health conditions.

The University of Iowa will communicate in writing the anticipated duration of the delay and reason to the parties and provide the parties with status updates if necessary. The University of Iowa will promptly resume its investigation and resolution process as soon as feasible. During such a delay, University of Iowa will implement supportive measures as deemed appropriate.

University of Iowa action(s) are not typically altered or precluded on the grounds that civil or criminal charges involving the underlying incident(s) have been filed or that criminal charges have been dismissed or reduced.

n. Role of the investigator. All investigations are thorough, reliable, impartial, prompt, and fair. Investigations involve interviews with all relevant parties and witnesses; obtaining available, relevant evidence; and identifying sources of expert information, as necessary.

   All parties have a full and fair opportunity, through the investigation process, to suggest witnesses and questions, to provide evidence and expert witnesses, and before the investigative report is issued to fully review and respond to all relevant and directly related evidence on the record.

   The investigator(s) typically take(s) the following steps, if not already completed (not necessarily in this order):

   1. Assist the Title IX Coordinator with conducting a prompt initial assessment to determine if the allegations indicate a potential policy violation.

   2. Work with the Title IX Coordinator to identify all policies implicated by the alleged misconduct and notify the complainant and respondent of all of the specific policies implicated.

   3. Prepare the initial notice of formal compliant (NOFC). The NOFC may be amended with any additional or dismissed allegations.

      Notice should inform the parties of their right to have assistance of an advisor of their choosing, who may be present for all meetings.

4. Commence a thorough, reliable, and impartial investigation by identifying issues and developing a strategic investigation plan, including a witness list, evidence list, intended investigation time frame, and order of interviews for all witnesses and the parties.

5. Meet with the complainant to finalize their interview/statement, if necessary.

6. Meet with the respondent to answer questions and conduct an interview.

7. Allow each party the opportunity to suggest witnesses and questions they wish the investigator(s) to ask of the other party and witnesses, and document in the report which questions were asked, with a rationale for any changes or omissions.

8. Interview all available, relevant witnesses and conduct follow-up interviews as necessary.

9. Take steps to obtain evidence, including electronic or photographic, as applicable.

10. Provide each interviewed party and witness an opportunity to review and suggest corrections to the investigator's summary notes (or transcript) of the relevant evidence/testimony from their respective interviews and meetings.

11. Complete the investigation promptly and without unreasonable deviation from the intended time line.

12. Write a comprehensive investigation report fully summarizing the investigation, all witness interviews, and addressing all relevant evidence.

    1. May include a summary of observations, assessment of evidence, or factors which may impact credibility for each party and witness.

    2. Appendices, including relevant nontestimonial evidence, will be included.

13. Prior to the conclusion of the investigation, provide the parties and their respective advisors (if so desired by the parties) with a list of witnesses whose information will be used to render a finding.

14. If the formal complaint is resolved using Process A, the investigator(s) gather(s), assess(es), and synthesize(s) evidence, but make no conclusions, engage in no policy analysis, and render no recommendations as part of their report.

Investigators may note which alleged policy violations, in whole or part, lack any evidence to support a conclusion that the policy was or was not violated.

15. If the formal complaint is resolved using Process B, the investigator will prepare a written report and deliver it to the Title IX Coordinator, detailing the determination, rationale, and evidence used in support of their determination as well as any evidence disregarded. This includes findings of fact supporting the determination and conclusions regarding the application of the policy to the facts. Additionally, the investigator's report will include credibility assessments and any sanctioning recommendation. The determination will be based on the preponderance-of-evidence standard.

16. Prior to the conclusion of the investigation, provide the parties and their respective advisors (if so desired by the parties) a secured electronic copy of the draft investigation report as well as an opportunity to inspect and review all of the evidence obtained as part of the investigation that is directly related to the reported misconduct, including evidence upon which the university does not intend to rely in reaching a determination, for a 10-business-day review and comment period so that each party may meaningfully respond to the evidence.

    1. The parties may elect to waive the full 10 days.

    2. The investigator(s) may elect to respond in writing in the investigation report to the parties' submitted responses and/or to share the responses between the parties for additional responses.

17. The investigator(s) will note relevant elements of the parties' written responses into the final investigation report, include any additional relevant evidence, make any necessary revisions, and finalize the report. The investigator(s) should document all rationales for any changes made after the review and comment period.

18. The investigator(s) share(s) the report with the Title IX Coordinator for their review and feedback. The investigator will incorporate any relevant feedback, and the final report is then shared with all parties and their advisors through secure electronic transmission at least 10 business days prior to a hearing. The parties are also provided with a file of any directly related evidence that was not included in the report. The investigator will consult with the Title IX Coordinator when they believe all or part of a complaint should be dismissed based on dismissal provisions defined above in paragraph c(4)(d)(i).

o. Role and participation of witnesses in the investigation. Witnesses (as distinguished from the parties) who are employees of the University of Iowa are expected to cooperate with and participate in the University of Iowa's investigation and resolution process.

While in-person interviews for parties and all potential witnesses are ideal, circumstances (e.g., study abroad, summer break, work arrangements) may require individuals to be interviewed remotely. Skype, Zoom, FaceTime, WebEx, or similar technologies may be used for interviews if the investigator(s) determine that timeliness or efficiency dictate a need for remote interviewing. The University of Iowa will take appropriate steps to reasonably ensure the security/privacy of remote interviews.

Witnesses may also provide written statements in lieu of interviews or choose to respond to written questions, if deemed appropriate by the investigator(s), though not preferred. If a witness submits a written statement but does not intend to be and is not present for questioning at a hearing, their written statement may not be used as evidence.

p. Recording of interviews. No unauthorized audio or video recording of any kind is permitted during investigation meetings. If investigator(s) elect to audio and/or video record interviews, all involved parties must be made aware of audio and/or video recording.

q. Evidentiary considerations in the investigation. The investigation does not consider: 1) incidents not directly related to the possible violation, unless they evidence a pattern; 2) the character of the parties; or 3) questions and evidence about the complainant's prior sexual behavior, unless such questions and evidence about the complainant's prior sexual behavior are offered to prove that someone other than the respondent committed the conduct alleged by the complainant, or if the questions and evidence concern specific incidents of the complainant's prior sexual behavior with respect to the respondent and are offered to prove consent.

r. Referral for hearing. Provided that the complaint is not dismissed, resolved through Process B, or resolved through an adaptable resolution, or that the respondent has not accepted responsibility for violating the policy as charged, once the final investigation report is shared with the parties, the Title IX Coordinator will refer the matter for a hearing. The Title IX Coordinator will select an appropriate adjudicator from the pool.

The hearing cannot be less than 10 business days from the conclusion of the investigation — when

the final investigation report is transmitted to the parties and the adjudicator — unless all parties and the adjudicator agree to an expedited timeline.

s. Hearing adjudicator. The University of Iowa will designate an adjudicator from the pool, at the discretion of the Title IX Coordinator.

The adjudicator will not have had any previous involvement with the investigation. The Title IX Coordinator may elect to have an alternate from the pool sit in throughout the resolution process in the event that a substitute is needed for any reason.

Those who have served as investigators will be witnesses in the hearing and therefore may not serve as adjudicators. Those who are serving as advisors for any party may not serve as the adjudicator in that matter.

The Title IX Coordinator may not serve as an adjudicator in the matter but may serve as an administrative facilitator of the hearing if their previous role(s) in the matter do not create a conflict of interest. Otherwise, a designee may fulfill this role. The hearing will convene at a time determined by the Title IX Coordinator.

t. Evidentiary considerations in the hearing. Any evidence that the adjudicator determines is relevant and credible may be considered. The hearing does not consider: 1) incidents not directly related to the possible violation, unless they evidence a pattern; 2) the character of the parties; or 3) questions and evidence about the complainant's prior sexual behavior, unless such questions and evidence about the complainant's prior sexual behavior are offered to prove that someone other than the respondent committed the conduct alleged by the complainant, or if the questions and evidence concern specific incidents of the complainant's prior sexual behavior with respect to the respondent and are offered to prove consent.

After post-hearing deliberation, the adjudicator renders a determination, based on the preponderance of the evidence, whether it is more likely than not that the respondent violated the policy as alleged.

u. Notice of hearing. No less than 10 business days prior to the hearing, the Title IX Coordinator or designee will send notice of the hearing to the parties. Once mailed, emailed, and/or received in-person, notice will be presumptively delivered.

The notice will contain:

1. A description of the alleged violation(s), a list of all policies allegedly violated, a description of the applicable procedures, and a statement of the potential sanctions/responsive actions that could result.

2. A description of how a party may request to move to an adaptable resolution

3. A statement that the respondent can accept responsibility for violating the policy as charged, accept sanctions, and end the formal grievance process at any point prior to the issuance of the notice of outcome.

4. The time, date, and location of the hearing.

5. Any technology that will be used to facilitate the hearing.

6. Information about the option for the live hearing to occur with the parties located in separate rooms using technology that enables the adjudicator and parties to see and hear a party or witness answering questions. Such a request must be raised with the Title IX Coordinator at least 5 business days prior to the hearing.

7. A list of all those who will attend the hearing, along with an invitation to object to the appointed adjudicator. This must be raised with the Title IX Coordinator at least 2 business days prior to the pre-hearing meeting.

8. Information on how the hearing will be recorded and on access to the recording for the parties after the hearing.

9. A statement that if any party or witness does not appear at the scheduled hearing, the hearing may be held in their absence, and the party's or witness's testimony and any statements given prior to the hearing will not be considered by the adjudicator. For compelling reasons, the adjudicator may reschedule the hearing.

10. Notification that the parties may have the assistance of a hearing advisor of their choosing at the hearing and will be required to have one present for any questions they may desire to ask. The party must notify the Title IX Coordinator if they do not have a hearing advisor,

and the University of Iowa will appoint one. Each party must have a hearing advisor present. There are no exceptions.

11. A copy of all the materials provided to the adjudicator about the matter, unless they have been provided already.[6]

12. An invitation to contact the Title IX Coordinator to arrange any disability accommodations, language assistance, and/or interpretation services that may be needed at the hearing, at least 7 business days prior to the hearing.

    Hearings for possible violations that occur near or after the end of an academic term (assuming the respondent is still subject to this policy) and are unable to be resolved prior to the end of term will typically be held immediately after the end of the term or during the summer, as needed, to meet the resolution time line followed by the University of Iowa and remain within the 90-business-day goal for resolution.

    In these cases, if the respondent is a graduating student, a hold may be placed on graduation and/or official transcripts until the matter is fully resolved (including any appeal).

v. Alternative hearing participation options. If a party or parties prefer not to attend or cannot attend the hearing in person, the party should request alternative arrangements from the Title IX Coordinator at least 5 business days prior to the hearing.

   The Title IX Coordinator or the hearing facilitator can arrange to use technology to allow remote testimony without compromising the fairness of the hearing. Remote options may also be needed for witnesses who cannot appear in person. Any witness who cannot attend in person should let the Title IX Coordinator or the hearing facilitator know at least 5 business days prior to the hearing so that appropriate arrangements can be made.

w. Pre-hearing preparation. The adjudicator, after any necessary consultation with the parties, investigator(s), and/or Title IX Coordinator, will provide the names of persons who will be participating in the hearing, all pertinent non-testimonial evidence, and the final investigation report to the parties at least 10 business days prior to the hearing.

   Any witness scheduled to participate in the hearing must have been first interviewed by the

investigator(s) (or have proffered a written statement or answered written questions), unless all parties and the adjudicator assent to the witness's participation in the hearing. The same holds for any evidence that is first offered at the hearing. If the parties and adjudicator do not assent to the admission of evidence newly offered at the hearing, the adjudicator will delay the hearing and instruct that the investigation needs to be reopened to consider that evidence.

All objections to any adjudicator must be raised in writing, detailing the rationale for the objection, and must be submitted to the Title IX Coordinator as soon as possible and no later than 2 business days prior to the pre-hearing meeting. Adjudicators will only be removed if the Title IX Coordinator concludes that their bias or conflict of interest precludes an impartial hearing of the allegation(s).

Any adjudicator who cannot make an objective determination must recuse themselves from the proceedings when notified of the identity of the parties, witnesses, and advisors in advance of the hearing. If an adjudicator is unsure of whether a bias or conflict of interest exists, they must raise the concern to the Title IX Coordinator as soon as possible.

During the 10-business-day period prior to the hearing, the parties have the opportunity for continued review and written comment on the final investigation report and available evidence. That review and comment can be shared with the adjudicator at the pre-hearing meeting or at the hearing and will be exchanged between each party by the adjudicator.

x. Pre-hearing meetings. The adjudicator may convene a pre-hearing meeting(s) with the parties and their advisors to invite them to submit the questions or topics they (the parties and their advisors) wish to ask or discuss at the hearing, so that the adjudicator can rule on their relevance ahead of time to avoid any improper evidentiary introduction in the hearing or to provide recommendations for more appropriate phrasing. However, this advance review opportunity does not preclude the advisors from asking at the hearing for a reconsideration based on any new information or testimony offered at the hearing. The adjudicator must document and share their rationale for any exclusion or inclusion at this pre-hearing meeting.

The adjudicator, only with full agreement of the parties, may decide in advance of the hearing to stipulate to some facts including that certain witnesses do not need to be present if their testimony can be adequately summarized by the investigator(s) in the investigation report or during the hearing.

At each pre-hearing meeting with a party and their advisor, the adjudicator will consider arguments that evidence identified in the final investigation report as relevant is, in fact, not relevant. Similarly, evidence identified as directly related but not relevant by the investigator(s) may be argued to be relevant. The adjudicator may rule on these arguments pre-hearing and will exchange those rulings between the parties prior to the hearing to assist in preparation for the hearing. The pre-hearing meeting(s) will be recorded.

y. Hearing procedures. At the hearing, the adjudicator has the authority to hear and make determinations on all allegations of sexual harassment, sexual misconduct, and/or related retaliation and may also hear and make determinations on any additional alleged policy violations that have occurred in concert with the sexual harassment, sexual misconduct, or related retaliation, even though those related allegations may not specifically fall within the policy on Sexual Harassment and Sexual Misconduct. The adjudicator also has the authority to determine non-Title IX sexual misconduct violations that would result in suspension or expulsion; see paragraph II-4.23b(3)(a).

Participants at the hearing will include the adjudicator, the hearing facilitator, the investigator(s) who conducted the investigation, the parties (or up to three organizational representatives when an organization is the respondent), advisors to the parties, any called witnesses, and anyone providing authorized accommodations or assistive services. Non-party witnesses are not allowed in the hearing except to testify.

The adjudicator will answer all questions of procedure. Anyone appearing at the hearing to provide information will respond to questions on their own behalf.

The adjudicator will allow witnesses who have relevant information to appear at a portion of the hearing in order to respond to specific questions from the adjudicator and the parties and will then be excused.

z. Joint hearings. In hearings involving more than one respondent or in which two or more complainants have accused the same individual of substantially similar conduct, the default procedure will be to hear the allegations jointly.

However, the Title IX Coordinator may permit the investigation and/or hearings pertinent to each respondent to be conducted separately if there is a compelling reason to do so. In joint hearings,

separate determinations of responsibility will be made for each respondent with respect to each alleged policy violation.

aa. The order of the hearing. The adjudicator explains the procedures and introduces the participants. The adjudicator, assisted by the hearing facilitator, then conducts the hearing according to the hearing script. They manage the hearing, the recording, witness logistics, party logistics, curation of documents, separation of the parties, and other administrative elements. The hearing facilitator may attend to: logistics of rooms for various parties/witnesses as they wait; flow of parties/witnesses in and out of the hearing space; ensuring recording and/or virtual conferencing technology is working as intended; copying and distributing materials to participants, as appropriate, etc.

    The investigator(s) will then present a summary of the final investigation report, including items that are contested and those that are not, and will be subject to questioning by the adjudicator and the parties (through their advisors). The investigator(s) will be present during the entire hearing process.

    Neither the parties nor the adjudicator should ask the investigator(s) their opinions on credibility, recommended findings, or determinations, and the investigators, advisors, and parties will refrain from discussion of or questions about these assessments. If such information is introduced, the adjudicator will disregard it.

bb. Testimony and questioning. Once the investigator presents their report and are questioned, the parties and witnesses may provide relevant information in turn, beginning with the complainant, and then in the order determined by the adjudicator. The parties/witnesses will submit to questioning by the adjudicator and then by the parties through their hearing advisors.

    All questions are subject to a relevance determination by the adjudicator. The hearing advisor, who will remain seated during questioning, will pose the proposed question orally, electronically, or in writing (orally is the default, but other means of submission may be permitted by the adjudicator on request or agreed to by the parties and the adjudicator), the proceeding will pause to allow the adjudicator to consider it, and the adjudicator will determine whether the question will be permitted, disallowed, or rephrased.

    The adjudicator may explore arguments regarding relevance with the advisors, if the adjudicator

so chooses. The adjudicator will then state their decision on the question for the record and advise the party/witness to whom the question was directed, accordingly. The adjudicator will explain any decision to exclude a question as not relevant, or to reframe it for relevance.

The adjudicator will limit or disallow questions on the basis that they are irrelevant, unduly repetitious (and thus irrelevant), or abusive. The adjudicator has final say on all questions and determinations of relevance, subject to any appeal. The adjudicator may consult with legal counsel on any questions of admissibility. The adjudicator may ask advisors to frame why a question is or is not relevant from their perspective but will not entertain argument from the advisors on relevance once the adjudicator has ruled on a question.

If the parties raise an issue of bias or conflict of interest of an investigator or adjudicator at the hearing, the adjudicator may elect to address those issues, consult with legal counsel, and/or refer them to the Title IX Coordinator, and/or preserve them for appeal. If bias is not in issue at the hearing, the adjudicator should not permit irrelevant questions that probe for bias.

cc. Refusal to submit to cross-examination and inferences. If a party or witness chooses not to submit to questioning at the hearing, either because they do not attend or because they attend but refuse to participate in questioning, then the adjudicator may not rely on any prior statement made by that party or witness at the hearing (including those contained in the investigation report) in the ultimate determination of responsibility. The adjudicator must disregard that statement. Evidence provided that is something other than a statement by the party or witness may be considered.

If the party or witness attends the hearing and answers some questions, only statements related to the questions they refuse to answer cannot be relied upon.

The adjudicator may not draw any inference **solely** from a party's or witness's absence from the hearing or refusal to answer questions.

If charges of policy violations other than sexual harassment (as defined in the U.S. Department of Education Title IX Regulation 106.3) are considered at the same hearing, the adjudicator may consider all evidence deemed relevant, may rely on any relevant statement as long as the opportunity for cross-examination is afforded to all parties through their hearing advisors, and may draw reasonable inferences from any decision by any party or witness not to participate or respond to questions.

If a party's advisor of choice refuses to comply with the University of Iowa's established rules of decorum for the hearing, the University of Iowa may require the party to use a different advisor. If a University of Iowa–provided advisor refuses to comply with the rules of decorum, the University of Iowa may provide that party with a different advisor to conduct cross-examination on behalf of that party.

dd. Recording hearings. Hearings are recorded by the University of Iowa for purposes of review in the event of an appeal. The parties may not record the proceedings and no other unauthorized recordings are permitted.

The adjudicator, the parties, their advisors, and appropriate administrators of the University of Iowa will be permitted to listen to the recording in a controlled environment determined by the Title IX Coordinator. No person will be given or be allowed to make a copy of the recording without permission of the Title IX Coordinator.

ee. Determination and standard of proof. The adjudicator will determine whether the respondent is responsible or not responsible for the policy violation(s) in question. The preponderance-of-the-evidence standard of proof is used. The adjudicator will prepare a written report and deliver it to the Title IX Coordinator, detailing the determination, rationale, the evidence used in support of its determination as well as any evidence disregarded. This includes findings of fact supporting the determination and conclusions regarding the application of the policy to the facts. Additionally, the adjudicator's report will include credibility assessments and any sanctioning recommendation. This report typically must be submitted to the Title IX Coordinator within 7 business days of the end of a hearing, unless the Title IX Coordinator grants an extension. If an extension is granted, the Title IX Coordinator will notify the parties.

ff. Notice of outcome. Using the adjudicator's report, the investigator's finding, or a respondent's acceptance of responsibility for all charges, the Title IX Coordinator will prepare a notice of outcome. When the outcome includes a policy violation, the Title IX Coordinator will work with the sanctioning administrator to issue the notice of outcome. The Title IX Coordinator will then share the notice of outcome, including the determination of responsibility, rationale, and any applicable sanction(s) with the parties and their advisors within 5 business days of receiving the adjudicator's report (in cases where there is no policy violation in the determination), the sanctioning administrator's decision, or the investigator's finding.

The notice of outcome will be shared with the parties simultaneously. Notification will be made in writing and may be delivered by one or more of the following methods: in person, mailed to the local or permanent address of the parties as indicated in official University of Iowa records, or emailed to the parties' University of Iowa–issued email or otherwise approved account. Once mailed, emailed, and/or received in person, notice will be presumptively delivered.

The notice of outcome will identify the specific policy(ies) reported to have been violated, including the relevant policy section, and will contain a description of the procedural steps taken by the University of Iowa from the receipt of the misconduct report to the determination, including any and all notifications to the parties, interviews with parties and witnesses, site visits, methods used to obtain evidence, and hearings held.

The notice of outcome will specify the finding on each alleged policy violation; the findings of fact that support the determination; conclusions regarding the application of the relevant policy to the facts at issue; a statement of, and rationale for, the result of each allegation to the extent the University of Iowa is permitted to share such information under state or federal law; any sanctions issued which the University of Iowa is permitted to share according to state or federal law; and any remedies designed to ensure access to the University of Iowa's educational or employment program or activity, to the extent the University of Iowa is permitted to share such information under state or federal law (this detail is not typically shared with the respondent unless the remedy directly relates to the respondent).

The notice of outcome will also include information on when the results are considered by the University of Iowa to be final, any changes that occur prior to finalization, and the relevant procedures and bases for any available appeal options.

gg. Statement of the rights of the parties.

1. The right to be treated with dignity and respect throughout any process resolving alleged misconduct.

2. The right to be fully informed about the policies and procedures available to address allegations of misconduct.

3. The right to be notified of counseling and support resources as well as the right to request disability accommodations and language translations at any stage of the resolution process.

4. The right to a prompt, thorough, reliable, equitable, and impartial response, investigation, and resolution of all credible reports of sexual harassment, sexual misconduct, and related retaliation made to the university.

5. The right to timely written notice of violations alleged in a formal complaint, including the identity of the parties involved (if known), the precise misconduct being alleged, the date and location of the alleged misconduct (if known), the implicated policies and procedures, and possible sanctions.

6. The right to timely written notice of any material adjustments to the allegations in a formal complaint (e.g., additional incidents or allegations, additional complainants, unsubstantiated allegations) and any attendant adjustments needed to clarify potentially implicated policy violations.

7. The right to a presumption of being not responsible for alleged misconduct and that no determination of responsibility will be made until the end of the grievance process.

8. The right to written notice of delays in the formal grievance process, including the cause of the delay and the anticipated time needed.

9. The right to request supportive measures and to provide input regarding the implementation of supportive measures that affect the party.

10. The right to be informed of options for notifying law enforcement authorities.

11. The right to preservation of privacy, to the extent possible and permitted by law.

12. The right to have up to two advisors providing support and assistance throughout the resolution process. Advisors may attend any meetings and interviews at which the party is entitled to be present.

13. The right not to have irrelevant prior sexual history or character admitted as evidence.

14. The right to know the relevant and directly related evidence obtained and to respond to that evidence.

15. The right to review and comment on a draft copy of the investigation report.

16. The right to review the final investigation report, along with any directly related evidence not included in the report, at least 10 business days before a hearing.

17. The right to a minimum of 10 business days' advance notice of a hearing and the right to a hearing advisor if a hearing is required. The parties are entitled to receive copies of any materials provided to the adjudicator not already provided to the parties.

18. The right to have an advisor at a hearing who will ask questions of the other party and witnesses on their behalf, subject to a determination of relevance by the adjudicator.

19. The right to simultaneous notification of the outcome including the specific findings and conclusions or subsequent changes on appeal with regard to each alleged policy violation and sanction.

20. The right to be informed of the opportunity to appeal the finding(s) and sanction(s) of the resolution process and the procedures for doing so.

hh. Sanctions. The Title IX Coordinator will promptly, within 2 business days, transmit the adjudicator's report. The sanctioning administrator will consult with the Title IX Coordinator and decision maker (investigator or adjudicator) when there is a finding of responsibility on one or more of the allegations.

Factors considered when determining a sanction/responsive action may include, but are not limited to:

1. The nature, severity of, and circumstances surrounding the violation(s);

2. The respondent's disciplinary history;

3. The need for sanctions/responsive actions to bring an end to the sexual harassment, sexual misconduct, and/or related retaliation;

4. The need for sanctions/responsive actions to prevent the future recurrence of sexual harassment, sexual misconduct, and/or related retaliation;

5. The need to remedy the effects of the sexual harassment, sexual misconduct, and/or related retaliation on the complainant and the community;

6. The impact on the parties;

7. Any other information deemed relevant by the decision makers;

   Previous disciplinary action of any kind involving the respondent may be considered in determining an appropriate sanction upon a determination of responsibility. This information is not considered until the sanction stage of the process.

   The sanctions will be implemented as soon as is feasible, either upon the outcome of any appeal or the expiration of the window to appeal, if an appeal is not requested.

   The sanctions described in this policy are not exclusive of, and may be in addition to, other actions taken or sanctions imposed by external authorities.

8. Student sanctions. The following are the usual sanctions[7] that may be imposed upon students or organizations singly or in combination:[8]

   1. Warning: A formal statement that the conduct was unacceptable and a warning that further violation of any University of Iowa policy, procedure, or directive will result in more severe sanctions/responsive actions.

   2. Required counseling or educational program: A mandate to meet with and engage in either University of Iowa–sponsored or external services.

   3. Probation: A written reprimand for violation of institutional policy, providing for more severe disciplinary sanctions in the event that the student or organization is found in violation of any institutional policy, procedure, or directive within a specified period of time. Terms of the probation may include denial of specified social privileges, exclusion from co-curricular activities, exclusion from designated areas of campus, no-contact directives, and/or other measures deemed appropriate.

   4. Suspension: Termination of student status for a definite period of time not to exceed 2 years and/or until specific criteria are met. During a period of suspension, the following notation will appear on the student's official transcript: "Non-Academic Misconduct—Suspension from [semester] to [semester]."

Students who return from suspension are automatically placed on probation through the remainder of their tenure as a student at the University of Iowa.

5. Expulsion: Permanent termination of student status and revocation of rights to be on campus for any reason or to attend University of Iowa–sponsored events. This sanction will be noted permanently as a "Non-Academic Misconduct—Expulsion" on the student's official transcript.

6. Withholding diploma: The University of Iowa may withhold a student's diploma for a specified period of time and/or deny a student participation in commencement activities if the student has an allegation pending or as a sanction if the student is found responsible for an alleged violation.

7. Building or facility ban: A directive that prohibits or limits access to a building or facility.

8. Activity restriction: A directive that prohibits or limits participation in an academic and/or non-academic program or activity.

9. Organizational sanctions: Deactivation, loss of recognition, loss of some or all privileges (including University of Iowa registration) for a specified period of time.

10. Other actions: In addition to or in place of the above sanctions, the University of Iowa may assign any other sanctions as deemed appropriate.

    For further information see the student sanctioning guidelines: (https://dos.uiowa.edu/policies/sanctioning-guidelines-for-sexual-assault/)

9. Employee sanctions. Responsive actions for an employee who has engaged in sexual harassment, sexual misconduct, and/or related retaliation include:

    1. Formal written discipline,

    2. Performance improvement/management process,

    3. Required counseling,

    4. Required training or education,

5. Loss of annual pay increase,
6. Loss of oversight or supervisory responsibility,
7. Demotion,
8. Suspension with pay,
9. Suspension without pay,
10. Termination, and
11. Other actions. In addition to or in place of the above sanctions, the University of Iowa may assign any other sanctions as deemed appropriate.

ii. Withdrawal or resignation while charges pending.

1. Students: If a student has an allegation pending for violation of this Sexual Harassment and Sexual Misconduct policy, the University of Iowa may place a hold on a student's ability to graduate and/or to receive an official transcript/diploma.

   Should a student decide to not participate in the resolution process, the process proceeds absent their participation to a reasonable resolution. Should a student respondent permanently withdraw from the University of Iowa, the resolution process ends, as the University of Iowa no longer has disciplinary jurisdiction over the withdrawn student.

   However, the University of Iowa will continue to address and remedy any systemic issues, variables that may have contributed to the alleged violation(s), and any ongoing effects of the alleged sexual harassment, sexual misconduct, and/or related retaliation. The student who withdraws or leaves while the process is pending may not return to the University of Iowa. Such exclusion applies to all campuses of the University of Iowa. A hold will be placed on their ability to be readmitted. They may also be barred from University of Iowa property and/or events.

   If the student respondent only withdraws from a semester or is not currently registered, the resolution process may continue remotely and that student is not permitted to return to the University of Iowa unless and until all sanctions have been satisfied.

During the resolution process, the University of Iowa may put a hold on a responding student's transcript or place a notation on a responding student's transcript or dean's disciplinary certification that a disciplinary matter is pending.

2. Employees: Should an employee respondent resign with unresolved allegations pending, the resolution process ends, as the University of Iowa no longer has disciplinary jurisdiction over the resigned employee.

   However, the University of Iowa will continue to address and remedy any systemic issues, variables that contributed to the alleged violation(s), and any ongoing effects of the alleged sexual harassment or sexual misconduct.

   The employee who resigns with unresolved allegations pending is not eligible for rehire with the University of Iowa or any campus of the University of Iowa, and the records retained by the Title IX Coordinator will reflect that status. Should the employee want to reapply, they should contact the Title IX Coordinator to determine what steps would be necessary to resolve the complaint.

jj. Appeals. Any party may submit a request for appeal. Only requests for appeal submitted in writing to the Title IX Coordinator within 5 days of the delivery of the notice of outcome may be considered under these procedures. The Title IX Coordinator will transmit the request for appeal to the non-appealing party within 2 days of receiving a request for an appeal.

The Title IX Coordinator will deny any request for appeal not timely submitted, as well as any request for appeal that is not based on at least one of the grounds (see paragraph aj(2) below).

1. Appeal officer.

    1. Student respondent. For cases involving a student respondent that involve suspension or expulsion, the appropriate university office to review the appeal is the Office of the Executive Vice President and Provost. The Provost also reviews cases dismissed by the investigator or adjudicator that would have risen to the level of a suspension or expulsion had the allegations been founded. For all other cases involving a student respondent, the appropriate university office to review the appeal is the Office of the Vice President for Student Life.

2. P&S staff, merit staff, or visitor respondent. For cases involving a P&S staff member or visitor respondent, the appropriate university office to review the appeal is University Human Resources. For cases involving a merit staff member respondent, the appropriate university office to review the appeal is University Human Resources–Employee and Labor Relations.

3. Faculty member respondent. For cases involving a faculty member respondent, the appropriate university office to review the appeal is the Office of the Executive Vice President and Provost.

2. Grounds for appeal. The Title IX Coordinator will review the request for appeal to determine if the request is based on one of the grounds for appeal. This review is not a review of the merits of the appeal, but solely a determination whether the request is based on at least one of the grounds.

   Appeals are limited to the following grounds:

   1. Procedural irregularity that affected the outcome of the matter;

   2. New evidence that was not reasonably available at the time the determination regarding responsibility or dismissal was made, that could affect the outcome of the matter;

   3. The Title IX Coordinator, investigator(s), or adjudicator(s) had a conflict of interest or bias for or against complainants or respondents generally or the specific complainant or respondent that affected the outcome of the matter; and/or

   4. The decision, whether regarding responsibility or sanction or both, was not supported by substantial evidence when viewed as a whole.

   If the request for appeal is not based on the grounds in this policy, it will be denied by the Title IX Coordinator, who will notify the parties and their advisors in writing or email of the denial and the rationale.

3. Response to appeal. If a timely submitted request for appeal is based on any of the grounds in this policy, then the Title IX Coordinator will notify all party(ies) and their advisors, and, when appropriate, the investigators and/or the adjudicator that an appeal is

proceeding and will provide each of them the request for appeal by mail, email, and/or hard copy as appropriate.

No later than 5 business days after delivery of the appellant's request for appeal, each of the other party(ies) may submit a response to the portion of the appeal that involves them. All responses will be forwarded by the Title IX Coordinator to all parties.

Once the time to submit a response to appellant's request for appeal has lapsed, no party may submit any new requests for appeal. The Title IX Coordinator will forward all responses to the appeal officer for consideration with respect to the request for appeal.

4. Review of appeal record. The appeal officer will consider the following documents as a part of the complete appeal record:

    1. The request for appeal;

    2. The case file, including the recording of any hearing; and

    3. All responses to the notice of appeal submitted by any of the parties.

5. Appeal outcome. Barring exigent circumstances, the appeal officer will render a decision ("appeal outcome") no later than 10 business days following the appeal officer's receipt of the complete appeal record.

    The appeal outcome will be in writing and will include one or more of the following determinations based on the grounds included in the notice of appeal:

    1. Uphold or reverse, in whole or in part, the decision on responsibility;

    2. Uphold, reverse, or modify disciplinary sanctions, if imposed; and/or

    3. Remand all or part of the matter to remedy procedural errors, including bias or conflict of interest, or consider new evidence (with or without specific direction).

        The appeal officer will send the appeal outcome to the Title IX Coordinator, who will send notice of appeal outcome to all parties simultaneously. The notice of appeal outcome will specify the finding on each ground for appeal, any specific

instructions for remand or reconsideration (if applicable), any sanctions that may result which the University of Iowa is permitted to share according to state and federal law, and the rationale supporting the essential findings to the extent the University of Iowa is permitted to share under state and federal law.

Notice of appeal outcome will be made in writing (including email) and may be delivered by one or more of the following methods: in person, mailed to the local or permanent address of the parties as indicated in official institutional records, or emailed to the parties' university-issued email or otherwise approved account(s). Once mailed, emailed, and/or received in person, notice will be presumptively delivered.

6. Sanctions status during the appeal. Any sanctions imposed as a result of the hearing are stayed during the appeal process described above. Supportive measures may be reinstated, subject to the same supportive measure procedures above.

   If any of the sanctions are to be implemented immediately post-hearing, then emergency removal procedures (detailed above) for doing so must be permitted within 48 hours of implementation.

   In cases where the original sanctions included separation, the University of Iowa may place holds on official transcripts, diplomas, graduations, and course registration pending the outcome of an appeal.

7. Appeal considerations.

   1. Appeals are not intended to provide for a full re-hearing, nor for a de novo review of the evidence of the allegation(s). In most cases, appeals are confined to a review of the written documentation or record of the original hearing and pertinent documentation regarding the specific grounds for appeal.

   2. Decisions on appeal are to be deferential to the original decision, making changes to the finding only when there is clear error and to the sanction(s)/responsive action(s) only if there is a compelling justification to do so.

3. An appeal is not an opportunity for the appeal officer to substitute their judgment for that of the adjudicator merely because they disagree with the finding and/or sanction(s).

4. The appeal officer may consult with the Title IX Coordinator on questions of procedure or rationale, for clarification, if needed. Documentation of all such consultation will be maintained by the Title IX Coordinator.

5. Appeals granted based on new evidence should normally remand the matter to the original investigator(s) and/or adjudicator for consideration of the new evidence.

6. When appeals result in no change to the finding or sanction, that decision is final. When an appeal results in a new finding or sanction, that finding or sanction may be appealed one final time on the grounds listed above and in accordance with these procedures.

7. In rare cases where a procedural error cannot be cured by the original adjudicator (as in cases of bias), the appeal may order a new hearing with a new adjudicator.

8. The results of a new hearing may be appealed, once, on any of the appeal grounds.

9. In cases in which the appeal results in reinstatement to the University of Iowa or resumption of privileges, all reasonable attempts will be made to restore the respondent to their prior status.

kk. Long-term remedies/other actions. Following the conclusion of the resolution process, and in addition to any sanctions implemented, the Title IX Coordinator may implement additional long-term remedies or actions with respect to the parties and/or the campus community that are intended to stop the sexual harassment, sexual misconduct, and/or related retaliation, remedy the effects, and prevent reoccurrence.

These remedies/actions may include, but are not limited to:

1. Referral to counseling and health services,

2. Referral to the Employee Assistance Program,

3. Education to the individual and/or the community,
4. Permanent alteration of housing assignments,
5. Permanent alteration of work arrangements for employees,
6. Provision of campus safety escorts,
7. Climate surveys,
8. Policy modification and/or training,
9. Provision of transportation accommodations,
10. Implementation of long-term contact limitations between the parties,
11. Implementation of adjustments to academic deadlines, course schedules, etc.

At the discretion of the Title IX Coordinator, certain long-term support or measures may also be provided to the parties even if no policy violation is found.

When no policy violation is found, the Title IX Coordinator will address any remedies owed by the University of Iowa to the respondent to ensure no effective denial of access to an education program or activity.

The University of Iowa will maintain the privacy of any long-term remedies/actions/measures, provided privacy does not impair the university's ability to provide these services.

ll. Failure to comply with sanctions and/or interim and long-term remedies and/or responsive actions. All respondents are expected to comply with the assigned sanctions, responsive actions, and/or corrective actions within the time frame specified by the final sanctioning administrator or appeal officer.

Failure to abide by the sanction(s)/action(s) imposed by the date specified, whether by refusal, neglect, or any other reason, may result in additional sanction(s)/action(s), including suspension, expulsion, and/or termination from the University of Iowa and may be noted on a student's official transcript as determined by the Director of the Office of Student Accountability in consultation

with the Title IX Coordinator.

A suspension will only be lifted when compliance is achieved to the satisfaction of the Director of the Office of Student Accountability in consultation with the Title IX Coordinator.

mm. Record keeping. The University of Iowa will maintain for a period of at least 7 years records of:

1. Each sexual harassment investigation including any determination regarding responsibility and any audio or audiovisual recording or transcript required under federal regulation;

2. Any disciplinary sanctions imposed on the respondent;

3. Any remedies provided to the complainant or respondent designed to restore or preserve equal access to the University of Iowa's education program or activity;

4. Any appeal and the result;

5. Any adaptable resolution and the result;

6. All materials used to train Title IX coordinators, investigators, adjudicators, and any person who facilitates an adaptable resolution process; and

7. Any actions, including any supportive measures, taken in response to a report or formal complaint of sexual harassment, including:

    1. The basis for all conclusions that the response was not deliberately indifferent;

    2. Any measures designed to restore or preserve equal access to the University of Iowa's education program or activity; and

    3. If no supportive measures were provided to the complainant, document the reasons why such a response was not clearly unreasonable in light of the known circumstances.

    The University of Iowa will also maintain any and all records in accordance with state and federal laws.

nn. Disabilities accommodations in the resolution process. The University of Iowa is committed to providing reasonable accommodations and support to qualified students, employees, or others with disabilities to ensure equal access to the University of Iowa's resolution process.

Anyone needing such accommodations or support should contact the Office of Student Disability Services (https://sds.studentlife.uiowa.edu/) or Faculty and Staff Disability Services (https://hr.uiowa.edu/support/faculty-and-staff-disability-services), who will review the request and, in consultation with the person requesting the accommodation and the Title IX Coordinator, will determine which accommodations are appropriate and necessary for full participation in the process.

oo. Revision of this policy and procedures. This policy and procedures supersede any previous policies addressing sexual harassment, sexual misconduct, and/or related retaliation and will be reviewed and updated annually by the Title IX Coordinator. The University of Iowa reserves the right to make changes to this document as necessary, and once those changes are posted online, they are in effect.

During the resolution process, the Title IX Coordinator may make minor modifications to procedures that do not materially jeopardize the fairness owed to any party, such as to accommodate summer schedules. The Title IX Coordinator may also vary procedures materially with notice (on the institutional website, with the appropriate effective date identified) upon determining that changes to law or regulation require policy or procedural alterations not reflected in this policy and procedures.

If government laws or regulations change — or court decisions alter — the requirements in a way that impacts this document, this document will be construed to comply with the most recent government regulations or holdings.

This document does not create legally enforceable protections beyond the protection of the background state and federal laws which frame such policies and codes, generally.

This policy and procedures are effective August 14, 2020.

Notes

1. Anywhere this procedure indicates “Title IX Coordinator,” the University of Iowa may substitute a trained designee.

2. If circumstances require, the President or Title IX Coordinator will designate another person to oversee the process below should an allegation be made about the Coordinator or should the Coordinator be otherwise unavailable or unable to fulfill their duties.

3. These dismissal requirements are mandated by the 2020 Title IX regulations, 34 CFR 106.45.

4. Subject to the state law provisions or university policy above.

5. This does not preclude the University of Iowa from having all members of the pool go through an application and/or interview/selection process.

6. The final investigation report may be shared using electronic means that preclude downloading, forwarding, or otherwise sharing.

7. University of Iowa policies on transcript notation will apply to these proceedings.

8. Subject to University of Iowa's Code of Student Life.

AMENDED AND RESTATED BYLAWS RULES & REGULATIONS

of
the University of Iowa Hospitals and Clinics
and Its Clinical Staff

2019

Revised and Adopted by The
Clinical Systems Committee
(formerly the University Hospital Advisory Committee)
8/73, 9/75, 11/76, 4/77, 5/77, 12/77, 7/78, 8/78, 3/79, 10/79, 6/80, 8/80, 11/80, 12/80, 3/81, 4/81, 7/81,
10,81, 6/82, 9/82, 12/82, 5/86, 10/87, 8/88, 10/89, 1/90, 3/90, 4/90, 7/91, 10/92, 4/93, 3/94, 8/96, 9/97, 9/98,
12/98, 8/99, 11/00, 4/01, 8/01, 1/02; 12/02; 2/03; 4/03; 5/03; 6/04; 4/05; 10/07; 12/08; 3/10; 10/10; 4/11; 10/13, 12/15; 11/16; 7/19

Approved by the Board of Regents, State of Iowa
as Trustees of the UIHC
12/76, 1/78, 11/78, 3/79, 2/80, 9/80, 1/81, 10/81, 3/82, 3/83, 10/87, 10/88, 11/89, 5/90, 7/91, 10/92, 4/93, 3/94, 9/96, 10/97, 10/98, 3/99, 10/99, 12/00, 5/01, 9/01, 3/02; 1/03; 5/0310/03; 8/04; 6/05; 3/09; 10/10; 6/11; 2/14; 2/16; 12/16; 7/19

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UIHC Board of Trustees

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Dr. Marta VanBeek, *Dermatology*
Dr. Ronald Weigel, *Surgery*
Dr. George Weiner, *Clinical Cancer Center*
Dr. Mark Wilson, *Associate Dean, GME*
Dr. Cynthia Wong, *Anesthesia*

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

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

PREAMBLE

The bylaws, rules, and regulations herein contained shall serve as (1) a set of guidelines whereby the University of Iowa Hospitals and Clinics (UIHC) and its Clinical Staff can function effectively, and (2) a guide for responsible decision-making and goal-attainment for all departments of this teaching institution. The bylaws, rules and regulations shall: 1) establish effective cooperation through defined objectives; 2) serve as a resource document for employees, staff, and the public; 3) cause appropriate interaction and effective coordination with the public, and 4) serve to comply with accreditation and certification requirements of various accrediting and advisory bodies.

ARTICLE I: INSTITUTIONAL IDENTIFICATION

The UIHC is a major teaching hospital whose existence is predicated upon the provisions contained in Chapters 225, 262 and 263 of the Code of Iowa. The UIHC, in compliance with the Code of Iowa, serves as the teaching hospital and comprehensive health care center for the State of Iowa, thereby promoting the health of the citizens of Iowa, regardless of their ability to pay. The UIHC, in concert with the University of Iowa health science colleges, functions in support of health care professionals and organizations in Iowa and other states by: 1) offering a broad spectrum of clinical services to all patients cared for within the UIHC and through its outreach programs; 2) serving as the primary teaching hospital for the University; and, 3) providing a base for innovative research to improve health care.

The patient population of the UIHC shall include patients referred by community physicians and dentists because of the broad scope clinical competency available within the UIHC; medically indigent patients of the state admitted for observation, diagnosis, care and treatment; and other patients admitted or seen for diagnosis and treatment in outpatient clinics or through outreach programs.

No prospective patient shall ever be denied admission or treatment on the basis of sex, race, creed, color, national origin, religion, age, disability, veteran status, sexual orientation, gender identity, or associational preference. No patient who requires care on an emergency basis shall be denied such care on the basis of source of payment or any other criteria not related to medical indications.

ARTICLE II: ORGANIZATIONAL STRUCTURE

Section 1: Board of Regents, State of Iowa

The UIHC is a state institution, part of the University of Iowa, and an integral part of the health sciences complex at the University of Iowa. Chapter 262 of the Code of Iowa, which authorizes and identifies the responsibilities of the Board of Regents, State of Iowa (hereinafter referred to as the Board of Regents), delineates the authority given to the Board of Regents to act as the ultimate governing body of the UIHC as an organizational unit of the University of Iowa.

The Board of Regents is composed of nine (9) citizens of Iowa who are appointed by the governor and confirmed by the state senate. Board members serve six (6) year, staggered terms with the terms of three members expiring every second year. The Board of Regents acts to assure that the governance and development of the UIHC is in the best interests of the people of Iowa.

Section 2: Administration

A. Organization

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

B. Chief Executive Officer

The Chief Executive Officer shall report to the Vice President for Medical Affairs. The Chief Executive Officer shall be qualified by education and experience appropriate to the proper discharge of the responsibilities of the position. Such qualifications shall be judged appropriate by the Vice President for Medical Affairs. The appointment of the Chief Executive Officer shall be in accord with the rules and regulations of the University of Iowa as set forth in the University Operations Manual. The duties of the Chief Executive Officer shall include the following:

1. To be continuously responsible for the operation, programming, maintenance and administrative affairs of the UIHC commensurate with the authority conferred by the Vice President for Medical Affairs and consonant with expressed goals and policies of the UIHC;

2. To be responsible for the application and implementation of appropriate federal and state, Board of Regents, and University policies and directives in the operation of the UIHC;

3. To provide liaison with the Clinical Staff, the Clinical Services of the UIHC, the health college deans, the University Administration, the Board of Regents, and between the UIHC and the statewide community, and to work collaboratively with the health college deans to support their academic missions;

4. To provide periodically through the Vice President for Medical Affairs a report to the Board of Regents summarizing actions taken by the Clinical Systems Committee pursuant to Article III, Section 1;

5. To maintain the financial integrity and optimal utilization of the physical resources of the hospital operation; this shall include the responsibility for submission, through University of Iowa operating channels, of an annual operating budget after consultation with the Clinical Systems Committee;

6. To establish and maintain employee relations policies and procedures that adequately support sound patient care;

7. To designate an individual to act for him/her in his/her absence, in order to assure the UIHC continuous, coordinate administrative direction;

8. To organize the administrative functions of the UIHC, delegate duties and establish formal means of accountability for subordinates;

9. To establish such hospital departments as are indicated, provide for departmental and interdepartmental meetings and attend, or be represented at, such meetings;

10. To chair or send a delegate to all meetings of the Clinical Systems Committee (structure, responsibilities and authority are defined in Article III) and other meetings of pertinence;

11. To develop and transmit reports to the Clinical Staff, Vice President for Medical Affairs, President of the University, and the Board of Regents on the overall activities of the UIHC and on appropriate federal, state and local developments that affect the UIHC; and

12. Through the Vice President for Medical Affairs and President of the University of Iowa, to provide the Board of Regents with short-range and long-range hospital objectives and programs, both of an operational and capital nature, after consultation with the Clinical Systems Committee.

Section 3: Clinical Services and Administration

A. Organization

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

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

B. Clinical Service Head

The appointment of each medical and surgical Clinical Service Head shall be accomplished by the College of Medicine in accordance with rules and regulations of the University of Iowa set forth in the University Operations Manual and the Manual of Procedure of the College of

Medicine. Serving both as a department head within the College of Medicine and as a Clinical Service Head within the UIHC, the Head shall be a member of the Active Clinical Staff.

The Head of the Hospital Dentistry Clinical Service shall be jointly appointed by the Chief Executive Officer of the UIHC and the Dean of the College of Dentistry. The appointment shall be accomplished in accordance with rules and regulations of the University of Iowa as set forth in the University Operations Manual.

1. Qualifications and Responsibilities

   Each Clinical Service Head shall be qualified by education and experience appropriate to the proper discharge of the responsibilities of the position. Such qualifications shall be judged appropriate by the respective Dean of the College of Medicine or Dentistry, the Vice President for Medical Affairs, the President of the University and the Board of Regents.

2. Duties

   Each Clinical Service Head shall:

   a. Monitor all professional and administrative activities within the Clinical Service;

   b. Serve as a member of the Clinical Systems Committee providing guidance on the policies of University of Iowa Health Care;

   c. Maintain continuing review of the professional performance of all members and other practitioners with clinical privileges within the Clinical Service, including conduct of the biennial review provided in Article IV, Section 5(C);

   d. Be responsible for enforcement within the Clinical Service of these Amended and Restated Bylaws, Rules and Regulations;

   e. Be responsible for the patient care, teaching and research programs of the Clinical Service; and

f. Participate in planning and decision-making relating to his/her Clinical Service through collaborative activities with the UIHC administration in all matters affecting patient care.

C. Chief of Staff

1. Appointment

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

b. Selection by Active Clinical Staff: The nominees shall be submitted to the Active Clinical Staff, who shall select the Chief of Staff in an election conducted in the same manner as the elections of at-large members of the Clinical Systems Committee; provided, however, that members of the Clinical Systems Committee shall be permitted to vote in a Chief of Staff election.

2. Term of Appointment. The appointment of the Chief of Staff shall be for a three (3) year term. An individual may be elected to no more than two (2) terms.

3. Qualifications. The Chief of Staff shall be a member of the Active Clinical Staff, or Emeritus Staff and shall possess the background, experience and demonstrated competence to fulfill the duties of the position.

4. Removal. The Clinical Systems Committee, by a two-thirds vote, may remove the Chief of Staff for conduct detrimental to the interest of the UIHC or its Clinical Staff, or if the Chief of Staff is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office, provided that notice of the meeting at which such action shall be decided is given in writing to the Chief of Staff at least ten (10) days in advance of the meeting. The Chief of Staff shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

5. Responsibilities. The Chief of Staff shall:

a. Serve as the Vice Chair of the Clinical Systems Committee.

b. Chair the Clinical Staff Affairs Subcommittee, and in that capacity assure that the Subcommittee fulfills its responsibilities as defined in the Amended and Restated Bylaws, Rules and Regulations of the University of Iowa Hospitals and Clinics and Its Clinical Staff and monitor the activities of other Subcommittees of the Clinical Systems Committee with a focus on clinically relevant initiatives.

c. Serve as Ombudsman for the Clinical Staff and provide liaison between the Clinical Staff and the Chief Executive Officer and Deans of the Colleges of Medicine and Dentistry.

d. In cooperation with the Chief Executive Officer, provide periodically through the Vice President for Medical Affairs and the President of the University a report to the Board of Regents summarizing actions taken by Clinical Systems Committee pursuant to Article III, Section 1.

e. Advise the co-Chairs of the Clinical Systems Committee on the selection of co-chairs and members to select standing Subcommittees of the Clinical Systems Committee.

Section 4: The UIHC Departments

The UIHC departments established pursuant to Article II, Section 2(B)(9) shall be listed in an appendix to these Amended and Restated Bylaws, Rules and Regulations. When a department is established for a discipline, that discipline shall be practiced in the UIHC only by persons who meet applicable licensure requirements and are in one of the following categories:

A. persons with appointments in that department; or

B. persons with other formal means of accountability to that department approved by the head of the department and the Chief Executive Officer.

ARTICLE III: CLINICAL SYSTEMS COMMITTEE AND ITS SUBCOMMITTEES

Section 1: Name and Delegation of Authority

The UIHC administration and the Clinical Staff shall express their joint policy-making efforts regarding the clinical operations of University of Iowa Health Care via the primary internal policy-making body of the UIHC and its Clinical Staff -- the Clinical Systems Committee. The Board of Regents delegates through the President of the University of Iowa and the Vice President for Medical Affairs to the Clinical Systems Committee the responsibility to act as an internal governing body of the clinical operations of University of Iowa Health Care, including UIHC, in performing the following functions:

A. establishing and approving internal policies and procedures for UIHC;

B. receiving, reviewing, and following up reports of:

   1. studies evaluating the quality of professional services, and

   2. studies reviewing the utilization of UIHC facilities and services; and

C. granting and decreasing clinical privileges.

Section 2: Purpose

The purpose of this body shall be:

A. To cause all patients to be properly evaluated, admitted to the UIHC if appropriate, and/or treated in the clinics, receive proper diagnosis, treatment and care and to make recommendations to the Board of Regents on matters of clinical management and planning;

B. To further the objectives of this health science center in education and research;

C. To represent and act on behalf of the Clinical Staff between annual meetings of the Clinical Staff. This authority is delegated to the Clinical Systems Committee by approval of these Amended and Restated Bylaws, Rules and Regulations;

D. To provide a means whereby problems of a clinical-administrative nature may be discussed between the Clinical Staff and the UIHC administration;

E. To initiate and maintain policies, rules, and regulations relating to the coordinate operation of the Clinical Services at University of Iowa Hospitals and Clinics;

F. To provide a forum for the review of operational problems, recommended action on medical administrative matters, and the formulation of policies and procedures;

G. To provide a forum whereby the UIHC administration may discuss programs and proposals of an institution-wide nature with the Clinical Staff;

H. To pass judgment on major proposals affecting the clinical-administrative operations of the institution;

I. To designate subcommittees to conduct the business of UIHC and its Clinical Staff consistent with these Amended and Restated Bylaws, Rules and Regulations, and to receive and act upon subcommittee reports; and

J. To provide a medium for dissemination of information to the Clinical Staff.

Section 3: Membership

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

A. The Heads of the respective Clinical Services.

B. The Chief Executive Officer.

C. The Chief of Staff.

D. The Vice President of Medical Affairs.

E. The Dean of the College of Medicine (if not the same individual as the Vice President for Medical Affairs).

F. The Executive Director of University of Iowa Physicians.

G. Executive Dean of the Carver College of Medicine.

H. The Director of the Clinical Cancer Center.

I. Five at-large members of the Clinical Staff. These members shall be elected by ballot with each Active Clinical Staff member, excluding those Clinical Staff members who are already members of the Clinical Systems Committee, allotted a single vote. No more than two of the at-large members shall have clinical privileges in the same Clinical Service. Elections shall be held every three (3) years on April 1. In the event that an at-large position becomes vacant more than six (6) months prior to a scheduled election, a special election shall be held. The term of the member(s) elected in the special election will run until the next regular election. A member-at-large shall remain a member of the Committee until resignation or until replaced by a subsequent at-large election. An at-large member may be elected to no more than two (2) consecutive terms. Notwithstanding the foregoing, an at-large member of the Clinical Staff elected to the Clinical Systems Committee may resign at any time, in which instance an election shall be held. In addition, an at-large member of the Clinical Staff elected to the Clinical Systems Committee may be removed by Vice President for Medical Affairs or by the Clinical Systems Committee, by a two-thirds vote, for conduct detrimental to the interest of the UIHC or its Clinical Staff, or if the member is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office. Notwithstanding the foregoing, in the event removal is by the Clinical Systems Committee, a removal notice of the meeting at which such action shall be decided shall be given in writing to the at-large member of the Clinical Staff being considered for removal at least ten (10) days in advance of the meeting. The at-large member of the Clinical Staff shall be afforded the opportunity to speak prior to the taking of any vote on such removal by the Clinical Systems Committee.

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

Section 4: Meetings

The Clinical Systems Committee shall meet at least quarterly. The co-Chairs may schedule additional meetings as deemed necessary. Special meetings may be called at the request of any three (3) members of the Committee. An agenda shall be prepared by the co-Chairs and forwarded to Committee members prior to each meeting. Any member of the Clinical Staff may request that specific topics be included on the agenda. Any member of the Clinical Systems Committee who is unable to attend a meeting may designate a person to represent the member at the meeting. The

representative may not cast the vote of the member and does not count for purposes of meeting quorum as further described in Article III, Section 5. If a member or the member's designee is not present or represented at two (2) consecutive regularly scheduled meetings without cause acceptable to the Committee, the member shall be notified by the co-Chairs that a third consecutive absence from a regularly scheduled meeting will lead to the designation of an alternate. Upon the third consecutive unexcused failure to be present or represented, the co-Chairs, after consultation with the member and with the approval of the Committee, shall designate an alternate to serve when the member is unable to attend. In the case of an at-large member, the member shall cease to be a member, a special election shall be held to replace the member and the designated alternate shall serve as the member until the special election is completed.

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

A. Quorum. Fifty (50) percent of the total voting membership of the Committee shall constitute a quorum. Member-designated representatives shall not count toward a quorum. In the absence of a quorum at any meeting of the Clinical Systems Committee, a co-Chair or a majority of the Clinical Systems Committee present may adjourn the meeting to another date, time and place with notice to the members of the Clinical Systems Committee.

B. Action at Meetings. Unless otherwise specifically provided by law or in the Amended and Restated Bylaws, Rules and Regulations, the vote of a majority of a quorum at a meeting of the Clinical Systems Committee shall constitute an action of the Clinical Systems Committee.

C. Telephone and Electronic Conference Meetings and Participation. The members of the Clinical Systems Committee may participate in a meeting by means of telephone or other communications equipment that enables all of the Clinical Systems Committee participating in the meeting to communicate with each other (including computer, video, or other electronic equipment). Such participation shall constitute presence in person at the meeting.

D. Written Consents. Action may be taken by the Board without a meeting, if all Clinical Systems Committee consent to such action in writing, and the writing or writings are filed with the minutes of proceedings of the Clinical Systems Committee. Consents under this subsection may be given via electronic communication.

Section 6: Officers

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

B. Vice Chair. The Chief of Staff shall be the Vice Chair of the Clinical Systems Committee. The Vice Chair, or in the absence of the Vice Chair one of the co-Chairs, shall preside at all meetings.

C. Recorder. A member of the hospital administrative staff -- selected by the Chief Executive Officer -- shall be the Recorder. This function may be rotated at the Chief Executive Officer's discretion. The Recorder shall not be a member of the Committee and, thus, shall have no vote.

D. Appointment. Appointment of the Chief Executive Officer co-Chair and Vice Chair shall be ex officio. Selection of the recorder will be as set forth in Article III, Section 4(C) above. Appointment of the other co-Chair shall be a member of the Clinical Systems Committee with Active Clinical Staff privileges as determined by the Vice President for Medical Affairs.

E. Term of Appointment. The appointment of the co-Chair appointed by the Vice President for Medical Affairs from amongst the members with Active Clinical Staff privileges shall be for a three (3) year term. An individual may be reappointed to no more than two (2) terms from the adoption of these Amended and Restated Bylaws, Rules, and Regulations. The co-Chair's term will begin on January 1 and end on December 31; provided, however, that the term of the first co-Chair appointed upon adoption of these Amended and Restated Bylaws, Rules, and Regulations shall commence promptly upon appointment and therefore may be longer than two (2) years for the initial term.

1. Qualifications. The co-Chair selected from amongst the members with Active Clinical Staff privileges shall possess the background, experience and demonstrated competence to fulfill the duties of the position.

2. Removal. The co-Chair selected from amongst the members with Active Clinical Staff privileges may be removed by Vice President for Medical Affairs or by the Clinical Systems Committee, by a two-thirds vote, for conduct detrimental to the interest of the

UIHC or its Clinical Staff, or if the co-Chair is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office. Notwithstanding the foregoing, in the event removal is by the Clinical Systems Committee, a removal notice of the meeting at which such action shall be decided shall be given in writing to the co-Chair who was selected from amongst the members with Active Clinical Staff privileges at least ten (10) days in advance of the meeting. The co-Chair shall be afforded the opportunity to speak prior to the taking of any vote on such removal by the Clinical Systems Committee.

Section 7: Subcommittees

A. Structure

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

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

The Credentials Subcommittee shall be composed of one Active Clinical Staff member for each Clinical Service, designated by the Head of the Clinical Service. Clinical Service Heads and members of the Clinical Systems Committee shall not be members. The members of the Credentials Subcommittee shall be divided into Medical and Surgical Credentials Panels as follows: Medical -- Dermatology, Emergency Medicine, Family Medicine, Internal Medicine, Neurology, Pathology, Pediatrics, Psychiatry, Radiation Oncology, and Radiology; and Surgical -- Anesthesia, Dentistry, Neurosurgery, Obstetrics-Gynecology, Ophthalmology and Visual Sciences,

Orthopaedics and Rehabilitation, Otolaryngology—Head and Neck Surgery, Surgery and Urology. The Chairs of each Panel shall be selected from among the voting membership of the Panel by the co-Chairs of the Clinical Systems Committee, in conjunction with the Vice Chair. Each Panel shall also include a member of the hospital administrative staff ex officio, without vote, appointed by the Chief Executive Officer.

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

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

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

2. Terms. Subcommittee members shall be appointed to three (3) year renewable terms if the positions they occupy are not assigned by the head of the Clinical Service, associated with a specific administrative, management or supervisory position or other UIHC sponsored positions. To effectuate appropriately staggered terms, at the time of

adoption of these amended and restated Amended and Restated Bylaws, Rules and Regulations, one-third of members of each subcommittee will be given a one (1) year renewable term, one-third of members of each subcommittee will be given a two (2) year renewable term, and one-third of members of each subcommittee will be given a three (3) year renewable term

3. Subcommittee co-Chairs. Except as set forth in Article III, Section (7)(A)(1) and (3) , each subcommittee shall have two co-chairs. One co-chair will be appointed by the Chief Executive Officer of UIHC. One co-chair will be appointed by a majority vote of the members of the Clinical Systems Committee with Active Clinical Staff privileges. Subcommittee chairs shall be appointed to a three (3) year term that may be renewed for one (1) additional three (3) year term. In the event that a subcommittee co-chair's appointment is associated with a specific office or leadership position they hold within the UIHC, a subcommittee co-chair shall remain co-chair as long as the associated administrative office or leadership position is held ("Ex Officio Term"). If an existing subcommittee member is appointed a subcommittee co-chair, the term of their original membership will immediately cease, and a three (3) year term or Ex Officio Term as subcommittee co-chair will begin immediately. At the conclusion of a subcommittee co-chair's term, that individual may be reappointed as a member of that subcommittee. If a former subcommittee co-chair is reappointed as a member of that subcommittee, the term of such subcommittee membership shall begin as a new three (3) year term, subject to the paragraph above. Except as expressly set forth to the contrary herein, a subcommittee co-chair may not simultaneously hold another chair or co-chair position on the Clinical Systems Committee or on a subcommittee or working group thereof.

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

B. Subcommittee Meetings. Standing subcommittees shall meet at least annually. Working groups may meet on an as-needed basis. Minutes of subcommittees and working groups, and a listing of the members in attendance shall be kept. Any member who misses two (2) consecutive meetings without an excuse approved by a chair of the subcommittee shall be notified that a third consecutive unexcused absence may be deemed a resignation from the subcommittee. Upon a third consecutive unexcused absence, a subcommittee co-chair may

notify the member and the co-Chairs of the Clinical Systems Committee that the member's position is vacant and a new member shall be appointed by the co-Chairs of the Clinical Systems Committee subject to approval by the Clinical Systems Committee membership. Notwithstanding the foregoing, any subcommittee member may resign at any time, at which time a new member shall be appointed by the co-Chairs of the Clinical Systems Committee.

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

1. Quorum. Fifty (50) percent of the total voting membership of the subcommittee shall constitute a quorum. In the absence of a quorum at any Clinical Systems Subcommittee, a co-chair or a majority of the Clinical Systems Subcommittee members present may adjourn the meeting to another date, time and place with notice to the members of the Clinical Systems Subcommittee.

2. Action at Meetings. Unless otherwise specifically provided by law or in the Amended and Restated Bylaws, Rules and Regulations, the vote of a majority of a quorum at a meeting of a subcommittee or working group of the Clinical Systems Committee shall constitute an action of such subcommittee or working group of the Clinical Systems Committee.

3. Telephone and Electronic Conference Meetings and Participation. The members of Clinical Systems Subcommittee may participate in a meeting by means of telephone or other communications equipment that enables all of the Clinical Systems Subcommittee members participating in the meeting to communicate with each other (including computer, video, or other electronic equipment). Such participation shall constitute presence in person at the meeting.

4. Written Consents. Action may be taken by the subcommittee without a meeting, if all members of the subcommittee consent to such action in writing, and the writing or writings are filed with the minutes of proceedings Clinical Systems Subcommittee meeting. Consents under this subsection may be given via electronic communication.

D. Standing Subcommittee Charges

Standing subcommittees and their respective charges are as follows:

1. Clinical Operations Subcommittee

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

a. Review operational performance, including:
   i. Patient access and patient throughput performance;
   ii. Operational efficiency and cost management performance;
   iii. Provider satisfaction and efficiency;
   iv. Staff engagement and efficiency;
   v. Facilities and support services;
   vi. Service specific revenue cycle issues; and
   vii. Other operational issues as brought up by Clinical Staff and UIHC personnel.

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

2. Clinical Staff Affairs Subcommittee

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

a. Adjudication.
   i. Hear and adjudicate problems of a professional and ethical nature involving the clinical practice of either house staff or Clinical Staff

members.

ii. Review interdisciplinary or inter-clinical department conflicts with the corollary responsibility for recommending to the Clinical Systems Committee policy statements or protocols to remedy such occurrences and otherwise foster harmonious interdepartmental relationships aimed at ensuring quality patient care.

b. Critical Care. Through oversight of a standing Critical Care Working Group, formulate cross-departmental policies, procedures and programs, identify and seek solutions to current challenges, develop plans for future operations and to enhance the overall utilization and operating efficiency of all UIHC intensive care units, intermediate care units, and emergency treatment centers so that standards of patient care may be maintained at the highest level. The working group will also oversee the hospital-wide system for management of acute cardiopulmonary resuscitation emergencies and advise the Director of the Respiratory Care Department on policy formulation, establishment of patient care and didactic instruction programs, and on the provision of effective and efficient respiratory care services.

c. Diagnostic Services. Through oversight of the standing Diagnostic Services Advisory Working Group, provide the Clinical Staff and UIHC's administration with information and advice concerning the quality, availability, and proper use of clinical laboratory and imaging services. In fulfilling this charge, the Diagnostic Services Advisory Working Group will:

i. Assist in formulating operational policies designed to assure the most expeditious performance of diagnostic services for patients in all clinical departments in accord with available resources.

ii. Advise and make recommendations regarding optimal provision and utilization of clinical laboratory and imaging services for patients coordinate with cost considerations and market forces extant within the

health care industry and in accord with the patient care, educational and research missions of UIHC.

iii. In accord with these recommendations and other pertinent factors including regulatory provisions and accreditation standards, review and provide recommendations on additions to and deletions from UIHC publications and documents on diagnostic services such as the Pathology Department, Laboratory Services Handbook.

d. Emergency Management. Through oversight of the standing Emergency Management Working Group, organize, conduct and update an all hazards emergency management program to assure that the UIHC is prepared to deal effectively with all disaster situations and the treatment of mass casualties which may result therefrom. In fulfilling this charge, the Emergency Management Working Group will:

i. Conduct a Hazard Vulnerability Analysis (HVA) on an annual basis.

ii. Maintain a written Emergency Operations Plan which features a Hospital Incident Command System (HICS) for organizing the UIHC's response to all hazards and standard operating procedures to address the hazards identified.

iii. Arrange at least twice yearly exercises of the Emergency Operations Plan.

iv. Provide continuity of operations plans to guide the UIHC's maintenance and restoration of essential services.

v. Provide that all staff with HICS assignments and other staff designated for responding to disasters and major emergencies receive training in accord with UIHC requirements and regulatory guidelines and understand their role(s) and responsibilities for responding to various disasters and emergencies.

vi. Maintain relationships and participates in County, State and Federal programs related to emergency management.

vii. Assure that UIHC meets the Emergency Management Standards of the Joint Commission and CMS Conditions of Participation in Medicare and

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

e. Environment of Care. Through oversight of the standing Environment of Care Working Group, establish, implement and maintain the UIHC Environment of Care Program, in accordance with the requirements of The Joint Commission and applicable state and federal laws. The Subcommittee develops and/or approves recommendations and interventions to protect the well-being of patients, visitors and staff in the areas of fire protection, safety, hazardous materials and waste, medical equipment, utilities and security.

f. Graduate Medical Education. Through the oversight of the standing Graduate Medical Education Working Group, advise on all matters pertaining to the house staff training programs at UIHC, including, but not limited to the following: assist in the recruitment, orientation, and scheduling of house staff physicians and dentists; conduct periodic reviews of all UIHC residency programs in accordance with Accreditation Council for Graduate Medical Education guidelines; and provide a forum for house staff issues as expressed by the house staff representatives on the Working Group or by other house staff.

g. Health Information Management Systems. Through the oversight of the standing Health Information Management Systems Working Group, maintain broad responsibility for the ongoing management and development of the medical records and other health information systems management at the UIHC to facilitate their efficiency and effectiveness. In fulfilling this charge, the Health Information Management Systems Working Group will:

i. Review, analyze and evaluate the quality of systems and processes to enable complete, accurate medical record documentation in the UIHC in compliance with applicable regulations of governmental agencies, accrediting bodies, and payers, and make recommendations for improvement where appropriate.

ii. Oversee all medical record forms including documents created during clinical information systems downtime and make appropriate recommendations for their improvement.

iii. Review procedures for safeguarding medical records against loss, defacement, tampering, or use by unauthorized persons, and make appropriate recommendations for their improvement. Review strategic planning for application system development.

iv. Evaluate the appropriateness of security and backup procedures for health care data in all settings, including the exchange of data with other computers. Review for consistency the strategic plans of UIHC projects which have incremental computing equipment implications and/or an impact on patient and management data maintained on the health care information system.

v. Review the use of computers in UIHC administrative and patient care settings with particular regard to appropriateness of application, security of patient information, and system maintenance.

vi. Monitor system processes to ensure compliance with regulatory guidelines for safeguarding patient data security.

vii. Following review of project and equipment requests, the Subcommittee will forward recommendations to UIHC administration.

h. Pharmacy and Therapeutics. Through the oversight of the standing Pharmacy and Therapeutics Working Group, promote evidence-based, best practice standards in the formulary decision-making process to assure clinical efficacy, patient safety and cost-effective prescribing within UIHC. In fulfilling this charge, the Pharmacy and Therapeutics Working Group will:

i. Review policies and procedures related to proper medication administration to assure medications are administered safely and

appropriately.

ii. Facilitate education of healthcare providers and students regarding medication-related issues.

iii. Assure that medications are prescribed appropriately, safely and effectively through medication use evaluation processes.

iv. Assure compliance with The Joint Commission, FDA and other regulatory and accreditation guidelines related to medication use.

v. Review and support investigational medication studies to ensure patient safety and adherence to UIHC policies.

vi. Evaluate and assess point-of-care and other technology systems and processes to effectuate safe, prompt and efficient prescribing in both the inpatient and ambulatory care settings.

i. Provider Well-Being. Through oversight of the standing Provider Well-Being Working Group, care for the well-being of health care providers so that they are in the best position to care for patients, including review licensed independent provider satisfaction survey data and develop recommendations for improvement.

j. Supervision of Non-Privileged Providers. Through oversight of the standing Supervision of Non-Privileged Providers Working Group, manage supervision of other providers whose services may be independently billable but require appropriate Clinical Staff member medical direction and oversight to supervise clinically appropriate and compliant practice of non-privileged providers.

k. Utilization Management. Through oversight of the standing Utilization Management Working Group: 1) promote the efficient use of facilities (including coordination of admission and continued stay reviews); and 2) formulate, maintain and review a utilization review plan appropriate for the UIHC and consistent with applicable federal requirements. In fulfilling this

charge, the Utilization Management Working Group will:

i. Describe UIHC activities to cause services to be provided to patients that are medically necessary and at the appropriate level of care;

ii. Monitor utilization activities and outcomes;

iii. Minimize reimbursement penalties and physician sanctions through screening and appropriate documentation; and

iv. Centralize communication with external review agencies, including the quality improvement organization.

3. Compliance Subcommittee

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

a. Review and address the activities of the Joint Office for Compliance as it relates to the elements of the Federal Compliance Program Guidance including: Designation of a Compliance Officer; Development of Compliance Policies and Procedures; Developing Open Lines of Communication; Provision of Appropriate Training and Education; Internal Regulatory Monitoring and Auditing; Response to Detected Deficiencies; and Enforcement of Disciplinary Standards.

b. Annually review the "Code of Ethical Behavior, a Guide for Staff" to assure it addresses all applicable federal, state and local laws, regulations and other compliance requirements.

c. Oversee the enterprise risk assessment with the goal to align risk and strategy; enhance risk response decisions; increase operational predictability; identify and manage multiple and cross-enterprise risks; proactively manage and minimize risks while achieving strategic objectives; and align deployment of resources

with risk mitigation strategy.

4. Credentials Subcommittee

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

5. Finance and Revenue Cycle Subcommittee

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

a. Oversee proper financial systems management and reporting.

b. Facilitate timely, accurate, and complete documentation of medically necessary services rendered.

c. Enable timely, accurate, and complete submission of invoices for payment for medically necessary services rendered.

d. Provide coding and documentation accuracy oversight.

e. Oversee third party payor contracting efforts.

f. Collaborate with other UI Health Care groups further payment for quality initiatives.

g. Oversee payment processes including but not limited to prior authorization, eligibility and benefits verification, payment posting, denials management and appeals processing, and payment process reporting.

h. Collaborate with other UI Health Care groups to develop revenue cycle- and finance-related provider and staff education.

6. Quality and Safety Oversight Subcommittee

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

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

b. Ethics. Through oversight of the standing Ethics Working Group:

i. Develop and carry out educational programs that will enhance awareness and understanding of biomedical ethical issues for clinical and UIHC staff, undergraduate and graduate trainees, patients and their families, and propose policies and guidelines regarding the ethical aspects of medical, surgical and dental practice.

ii. Provide consultation on ethical issues to members of the UIHC Clinical Staff, House Staff and Professional Staff.

c. Infection Control. Through oversight of the standing Infection Control Working Group, review infection data, policies, procedures and processes, and revise policies and procedures, and recommend changes in procedures and practices as necessary so that appropriate interventions to prevent infections in the UIHC and its associated clinics are made.

d. Performance Improvement. Through the standing Performance Improvement Working Group, review, analyze and evaluate on a continuing basis the performance of the Clinical Service quality and Performance Improvement Program in formulating standards of care; measuring outcomes of care; and taking constructive intradepartmental action on the evaluation results, as specified in the UIHC Performance Improvement Program.

e. Protection of Persons. Through oversight of the standing Protection of Persons Working Group, facilitate the protection of persons, including minors and

dependent adults, to identify, treat, and as permitted or required by law, report cases of suspected child or dependent adult abuse or domestic violence.

f. Transfusion Working Group. Through oversight of the standing Transfusion Working Group, review the records of transfusions of blood and blood components so as to assess transfusion reactions, to evaluate blood utilization, and to make recommendations regarding specific improvements in the transfusion service program.

7. Surgical Services Subcommittee

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

E. Ad Hoc Subcommittees

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

ARTICLE IV: CLINICAL STAFF

Section 1: Responsibility

The Clinical Staff of the UIHC ("Clinical Staff") shall be responsible for the quality of health care within the hospitals and ambulatory care facilities of the UIHC, and shall accept this responsibility subject to the ultimate responsibility of the Board of Regents.

Section 2: Purposes

A. To cause that all patients admitted to or treated in any of the facilities, departments, or services of the UIHC to receive medical and dental diagnosis, treatment, and personalized care consistent with applicable standards of care;

B. To cause, through ongoing review and evaluation procedures, a high level of professional and ethical performance of all those persons authorized to practice within the UIHC;

C. To provide an appropriate educational setting that will lead to continuous advancement of professional knowledge and skill; and

D. To provide an optimal forum in which the Clinical Staff may conduct medical education and research.

Section 3: Clinical Staff Membership

A. Nature of Clinical Staff Membership

Membership on the Clinical Staff of the UIHC shall be extended only to professionally competent persons who are physicians, dentists or members of other health care professions and who continuously meet the qualifications, standards and requirements set forth in these Amended and Restated Bylaws, Rules and Regulations.

B. Basic Qualifications for Clinical Staff Membership

All members of the Clinical Staff shall meet the following basic qualifications and shall, in addition, satisfy the qualifications of one of the specific categories of Clinical Staff membership set forth in subsection (C) below.

1. Physicians and dentists licensed to practice in the state of Iowa and who are graduates of an approved or recognized medical, osteopathic, or dental school shall be qualified for membership on the Clinical Staff. Other health care professionals with a Ph.D. or equivalent terminal degree, who are graduates of professional schools and/or approved clinical training programs, and who hold any necessary licensure to practice in the state of Iowa, shall be qualified for membership on the Clinical Staff. Such physicians, dentists, and other health care professionals must document their appropriate experience and training, ability to form positive, productive working relationships, satisfactory health status, and demonstrated competence and adherence to the ethics of their profession with sufficient adequacy to assure that any patient treated by them on behalf of a Clinical Service within the UIHC will be provided high quality health care.

2. As a condition of membership, the Clinical Staff shall strictly abide by the code of ethics of the American Medical Association, the American Osteopathic Association, the American Dental Association, or, in the case of membership in other disciplines, the

ethical guidelines of their profession as promulgated by their comparable association.

3. No applicant for Clinical Staff membership shall be denied membership on the basis of sex, race, creed, color, national origin, religion, age, disability, veteran status, sexual orientation, gender identity, or associational preference.

C. Categories of Clinical Staff

There shall be five categories of Clinical Staff at the UIHC:

Active Clinical Staff
Emeritus Staff
Courtesy Teaching Staff
Temporary Staff
House Staff

1. Active Clinical Staff

a. Upon receiving one of the following appointments to a clinical department according to the procedure set forth in the Manual of Procedure of the College of Medicine and the University Operations Manual, a physician who meets the qualifications for membership shall be a member of the Active Clinical Staff of the UIHC:

i. tenure track appointment;
ii. salaried clinical track appointment;
iii. associate or fellow-associate appointment in a clinical department; or
iv. visiting faculty appointment.

b. Upon receiving a faculty appointment with UIHC patient treatment responsibilities from the University of Iowa College of Dentistry, according to the procedures of the College of Dentistry and the UIHC (including approval by the Head of the Hospital Dentistry Clinical Service) and the procedures of the University Operations Manual, a dentist who meets the qualifications for membership shall be a member of the Active Clinical Staff of the UIHC.

c. Upon receiving an academic appointment to a clinical department that constitutes a Clinical Service listed in Article II, Section 3(A) in the University

of Iowa College of Medicine, according to the procedures set forth in the Manual of Procedure of the College of Medicine and the University Operations Manual, a health care professional faculty member, who meets the qualifications for membership (see Article II, Section 3(B)(1)), and is continuously involved in the patient care program of a Clinical Service, shall be a member of the Active Clinical Staff of the UIHC. His/her practice shall be limited to the clinical duties and responsibilities intrinsic to his/her professional discipline and privileges granted.

d. All Active Clinical Staff members are eligible to vote. Active Clinical Staff are expected to contribute to the organizational and administrative affairs of the Clinical Staff, which may include service on committees and duties of office to which elected or appointed, and must participate in quality management, utilization review, and peer review activities.

2. Emeritus Staff

Only persons who are members of the Active Clinical Staff at the time of their retirement, and who continue to meet the qualifications for Clinical Staff membership, are qualified for membership on the Emeritus Staff of the UIHC. Emeritus status is granted according to the procedure set forth in the University Operations Manual. All Emeritus staff members with clinical privileges are expected to contribute to the organizational and administrative affairs of the Clinical Staff, which may include service on committees and duties of office to which elected or appointed, and must participate in quality management, utilization review, and peer review activities.

3. Courtesy Teaching Staff

Upon receiving an academic appointment to the non-salaried clinical track of the University of Iowa College of Medicine or Dentistry, according to the procedures of the applicable College and the University Operations Manual, a physician or dentist who meets the qualifications for membership shall be a member of the Courtesy Teaching Staff of the UIHC.

4. Temporary Staff

Upon receiving a written invitation from the Clinical Service Head to visit at the UIHC for a period of time not to exceed thirty (30) days, a physician or dentist who meets the following qualifications for membership shall be a member of the Temporary Staff of the UIHC during that visit: graduate of an approved or recognized medical; osteopathic or dental school; licensed to practice in the state of Iowa; demonstrated current competence; and adequate liability insurance.

5. House Staff

Upon receiving an appointment to the House Staff from the Chief Executive Officer of the UIHC, pursuant to nomination by the appropriate Clinical Service Head, a physician or dentist who has signed a contract with the UIHC, is a graduate of an approved or recognized medical, osteopathic or dental school, and is licensed to practice in the state of Iowa shall be a member of the House Staff of the UIHC. Physicians and dentists who have received an appointment to a residency program that has a written affiliation agreement with the University of Iowa in effect and have been assigned to a rotation at the UIHC by that program shall be a temporary member of the House Staff of the UIHC during the approved rotation, provided that they have received the written approval of the Head of the Clinical Service in which the rotation will be served, they are graduates of an approved or recognized medical, osteopathic or dental school, are licensed to practice in the state of Iowa and have signed an agreement to abide by these Amended and Restated Bylaws, Rules and Regulations directives of the Clinical Systems Committee, and rules and regulations of the applicable Clinical Service.

Section 4: Clinical Privileges

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

A. Practice Limited to Clinical Privileges

Each Clinical Staff member or practitioner who is granted privileges shall be entitled to exercise only those clinical privileges specifically granted to him or her by the Clinical Systems

Committee or by these Amended and Restated Bylaws, Rules and Regulations.

B. Qualifications for Privileges

1. Each applicant must sign an agreement to abide by these Bylaw, Rules and Regulations, directives of the Clinical Systems Committee, and rules and regulations of the applicable Clinical Service.

2. All Clinical Staff members or other practitioners with privileges must report to the Head of the Clinical Service in which privileges are held or sought any of the following items:

   a. Previously successful or currently pending challenges to any licensure or registration, the voluntary relinquishment of such licensure or registration, or any lapse in licensure or registration.

   b. Any currently pending or previously filed lawsuits, administrative claims, or other legal action(s) that allege a breach of the professional standard of care on the part of the physician, dentist, health care professional, or practitioner whether or not he or she is a named defendant.

   c. Any settlements, judgments or verdicts entered in an action in which the physician, dentist, health care professional, or practitioner was alleged to have breached the standard of care, whether or not he or she was a named defendant.

   d. Any voluntary or involuntary termination of Clinical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital.

3. Every practitioner must be free of, or have under adequate control, any significant physical or behavioral impairment that interferes with, or presents a substantial probability of interfering with, or that will or may adversely affect his/her ability to provide quality patient care services.

4. Each applicant must provide references, before initial clinical privileges are granted, verifying the applicant's professional and clinical competency.

C. Clinical Privileges of Physicians and Dentists

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

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

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

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

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

2. Clinical Privileges of Courtesy Teaching Staff

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

has clinical privileges to perform the procedures and who finds the Courtesy Teaching Staff Member qualified to participate. Members of the Courtesy Teaching Staff shall not admit patients.

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

3. Clinical Privileges of Temporary Staff

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

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

A Temporary Member of the Clinical Staff appointed pursuant to this subsection shall

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

The credentials of a Temporary Member of the Clinical Staff appointed pursuant to this subsection shall be verified in the same manner as the credentials of any other Temporary Member, except that the process may occur retrospectively. The process for verifying credentials shall begin as soon as the immediate situation that resulted in the declaration of a "full-scale disaster" is under control.

4. Clinical Privileges of House Staff

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

D. Clinical Privileges of Emeritus Staff

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

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

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

All clinical privileges granted by the Clinical Systems Committee are contingent on the health care professional (as defined in Article IV, Section 3(B)(1)) receiving and continuing to possess a faculty appointment to a clinical department in the College of Medicine. Health care professionals who are members of the Active Clinical Staff (or applicants for appointments which would qualify them for Active Clinical Staff membership whose appointments have been

recommended to the Dean by the Head of the Clinical Service in which privileges are sought) may apply for clinical privileges limited to the clinical duties and responsibilities intrinsic to his/her professional discipline (Article IV, Section 3(C)(1)(c) according to the procedure in Article IV, Section 5. Health care professionals with clinical privileges may not admit patients.

F. Clinical Privileges for Other Practitioners

Employees of the UIHC or the College of Medicine, who are employed as Advanced Registered Nurse Practitioners (ARNP) or Physician Assistants (PA), shall not be members of the Clinical Staff, but may apply for privileges as described in this Section according to the procedure set forth in Article IV, Section 5.

Advanced Registered Nurse Practitioners or Physician Assistants shall not have the authority granted to physicians and dentists to limit substitution or standardization pursuant to protocols approved by the Pharmacy and Therapeutics Working Group and shall not, unless specified in the protocol approved by the Pharmacy and Therapeutics Working Group, be authorized to override protocol or restricted drug indications.

Advanced Registered Nurse Practitioners may provide clinical services pursuant to collaborative practice agreements approved by the Head of the Clinical Service in which they practice. The collaborative practice agreements shall define privileges granted. Advanced Registered Nurse Practitioners providing clinical services pursuant to a collaborative practice agreement must be licensed by the Iowa Board of Nursing.

Delegated medical functions performed by Advanced Registered Nurse Practitioners shall be limited to those granted in the collaborative practice agreement approved by the appropriate Clinical Service Heads and shall be based upon the applicant's training, experience, and demonstrated competence. The Clinical Service Head shall submit the collaborative practice agreements to the chair of the applicable Credentials Panel according to the procedure in Article IV, Section 5. These collaborative practice agreements shall delineate specifically the methods by which the responsible attending physician shall direct the delegated medical functions performed by the Advanced Registered Nurse Practitioner.

Physician Assistants may provide medical services with the supervision of physician members of the Clinical Staff. Physician Assistants providing medical services at the UIHC shall be

licensed by the Iowa State Board of Physician Assistant Examiners in accordance with the laws of the state of Iowa.

Patient care responsibilities of Physician Assistants shall be limited to those privileges defined in the written policy, and shall be based upon the applicant's training, experience and demonstrated competence. The Clinical Service Head shall submit a written policy, including a listing of the privileges requested, to the chair of the applicable Credentials Panel according to Article IV, Section 5. This policy shall delineate specifically the methods by which the responsible attending physician shall direct and supervise the activities of the Physician Assistant. Physician Assistants shall not be authorized to order or prescribe Schedule II controlled substances which are listed as stimulants or depressants. A prescription written by a Physician Assistant shall include the name of the supervising physician.

G. Emergency Privileges

In the case of emergency, any Clinical Staff member or practitioner, with clinical privileges at the UIHC, shall be permitted to do everything possible to save the life of a patient. For the purpose of this paragraph, an "emergency" is defined as a condition which might result in permanent harm to the patient or in which the life of the patient is in immediate danger and any delay in administering treatment would add to that danger.

H. Disaster Privileges

1. Persons granted disaster privileges are not Members of the Clinical Staff and have no rights under Article IV, Sections 5-7.

2. Disaster privileges may be granted to physicians, dentists, physician assistants or advanced registered nurse practitioners who are not otherwise eligible for privileges only when the UIHC's Emergency Operations Plan has been activated in response to a disaster and the UIHC is unable to meet immediate patient needs. Disaster privileges may be granted only by the co-Chairs or Vice Chair of the Clinical Systems Committee

3. The Emergency Operations Plan shall specify how the identity of persons will be verified before disaster privileges are granted, how primary source verification will occur and how the performance of persons granted disaster privileges will be overseen.

4. Disaster privileges terminate automatically. The mechanism for termination, including notification of any persons granted disaster privileges, shall be specified in the Emergency Operations Plan.

Section 5: Procedures for Delineating Clinical Privileges

A. Initial or Increased Clinical Privileges

Each application for initial or increased clinical privileges shall be made with the assistance of the Head of the Clinical Service in which privileges are sought.

If the applicant is a physician or dentist, the Clinical Service Head shall forward the application along with his/her recommendation to the Chair of the applicable Credentials Panel (medical or surgical). That Credentials Panel shall examine the supporting documentation provided by the applicant and other available information concerning the applicant's training, experience, health status, and demonstrated competence.

If the applicant is a health care professional, as described in Article IV, Section 3(B)(1), or practitioner, as described in Article IV, Section 4(F), the Chair of the applicable Credentials Panel will forward the application to the health care professional subpanel or the PA/ARNP subpanel, respectively. This subpanel will be responsible for examining the supporting documentation provided by the applicant and other available information concerning the applicant's training, experience, health status, and demonstrated competence. Within thirty (30) days of receiving the completed application for review, the Chair of the applicable subpanel will forward a recommendation to the Chair of the applicable Credentials Panel. The Credentials Panel may return the application to the subpanel with a request to respond to delineated concerns.

All applicants shall be responsible for providing sufficient information to demonstrate their qualifications and competency in the clinical privileges sought.

Within forty-five (45) days of receiving the completed application for review or the subpanel recommendation, the Chair of the Credentials Panel shall forward a recommendation, together with the supporting documentation, to the Clinical Systems Committee for review and final action (Article IV, Section 6(D). Within thirty (30) days of receipt of the recommendation, the

Clinical Systems Committee shall make its decision and send the applicant written notification. If the decision of the Credentials Panel is not to grant privileges as requested (see Article IV, Section 6(B), the applicant will be notified of the specific reasons for the denial of privileges, his/her rights to a hearing as provided in Article IV, Section 6(C), and a summary of the applicant's rights in the hearing. Failure to make a written request for a hearing to the Chair of the Clinical Staff Affairs Subcommittee within thirty (30) days of receiving notice shall constitute waiver of the right to a hearing.

B. Provisional Status

All initial clinical privileges shall be provisional for the first six (6) months. The Head of the Clinical Service in which clinical privileges are granted shall designate one (1) or more members of the Active Clinical Staff to proctor the individual's clinical competence and professional ethical conduct for that time period. The clinical privileges shall cease to be provisional at the end of the six (6) months, following a written report from the proctor to the Clinical Service Head verifying the individual's clinical competence and professional/ethical behavior. The Clinical Service Head shall forward the report to the Chair of the appropriate Credentials Panel recommending termination of the provisional status. If necessary, the proctor shall submit a written report to the Clinical Service Head recommending additional reviews. If such a report is submitted, the Head, after consultation with the individual and the Chair of the appropriate Credentials Panel, shall take appropriate action. This includes (1) extending the provisional status or (2) recommending modification in the individual's clinical privileges. The total period of provisional status may not exceed one (1) year. If modification, including termination, of clinical privileges is recommended, the recommendation shall be handled as provided in Article IV, Section 6.

C. Biennial Review of Clinical Privileges

Biennially, the Head of each Clinical Service shall review the clinical privileges and the physical and mental condition of all members and practitioners who hold clinical privileges in that Clinical Service and forward a recommendation to the applicable Credentials Panel, along with the supporting documentation which should include the results of ongoing professional practice evaluations and, if applicable, focused professional practice evaluations. The review of clinical privileges and the physical and mental condition of the Clinical Service Heads shall

be conducted by an ad hoc review committee composed of three members of the Active Clinical Staff who have the rank of professor and who are selected by the Chair of the applicable Credentials Panel. The review shall be documented and the recommendation forwarded to the applicable Credentials Panel, along with the supporting documentation.

If the review is for a health care professional, advanced registered nurse practitioner, or physician assistant, the applicable Credentials Panel shall forward the recommendation to the applicable subpanel for review. The subpanel will review the application, supporting documentation, and the recommendation of the Clinical Service Head. The subpanel will document their review and send their recommendation to the applicable Credentials Panel.

The Credentials Panel shall submit a list of all members and practitioners, which the Heads recommend for no change in privileges and the applicable Credentials Panel affirms, to the Clinical Systems Committee. The Clinical Systems Committee shall either reaffirm the clinical privileges of each listed member or practitioner or refer the matter of the member's or practitioner's clinical privileges to the applicable Credentials Panel. The Credentials Panel, or applicable subpanel, shall conduct a review of all referred matters which shall include an opportunity for the affected member or practitioner to submit information and, within thirty (30) days of the referral, shall submit a recommendation.

If the applicable Credentials Panel recommends that the member's or practitioner's clinical privileges be reduced, not reaffirmed, or makes any other adverse recommendation, that adverse recommendation will be handled as provided in Article IV, Section 6(B). Each member's or practitioner's clinical privileges shall continue until final action by the Clinical Systems Committee, unless they are suspended under Article IV, Section 5(E) or Article IV, Section 6(F).

D. Voluntary Reduction

A voluntary reduction in privileges may occur at any time separate from reaffirmation as described in Article IV, Section 5(C). A voluntary reduction apart from reaffirmation may be initiated by a member or practitioner by requesting to the Clinical Service Head a reduction in clinical privileges. The reduction request must be signed and dated by the requesting member or practitioner and shall be effective upon a signed and dated acknowledgement from the Clinical Service Head, with the reduction effective upon the later of the date of signature of acknowledgement by the Clinical Service Head or the effective date set forth in the request.

Any reinstatement to prior privileges or increase in privileges requires an application for those privileges, consistent with the requirements for a member or practitioner's application for new privileges.

E. Professional Liability Reporting

If the items listed in Article IV, Section 4(B)(2) occur subsequent to the initial granting of clinical privileges, they must be reported to the Head of the Clinical Service in which privileges are held at the time they become known to the affected member or practitioner. The Clinical Service Head shall immediately forward the information to the Chair of the applicable Credentials Panel (Medical or Surgical). That Credentials Panel, or subpanel if the person is a health care professional or practitioner, shall review the information provided by the member or practitioner and may request that additional information be submitted. The Panel may recommend action pursuant to Article IV, Section 6 of these Amended and Restated Bylaws, Rules and Regulations.

F. Physical and Mental Examinations

Whenever the Clinical Service Head or Chair of the applicable Credentials Panel reasonably believes, based on specific conduct or activities, that the member or practitioner may be suffering from a physical or mental impairment that will, or may, adversely affect his/her ability to provide quality patient care services, he/she may request that the member or practitioner undergo a physical and/or mental examination by one or more physicians of the member's or practitioner's choice who are also acceptable to the Head or the Chair who makes the request. If the member or practitioner and the Head or Chair are unable to select a mutually acceptable examining physician within ten (10) days of the initial request, the applicable Credentials Panel shall designate the examining physician. If the member or practitioner refuses, his/her clinical privileges shall be terminated and there shall be no further consideration of continued privileges until the examination is accepted and the report of the examination is received by the Head or the Chair. Any time limit for action by the Credentials Panel shall be extended for the number of days from the request for the examination to the receipt of the report of the examination by the Chair.

Section 6: Corrective Action

A. Decreased Clinical Privileges

Clinical privileges may be reduced, suspended or terminated for activities or professional conduct considered to be lower than the standards of the UIHC and its Clinical Staff, or to be disruptive to operations of the UIHC, or for violation of these Bylaw, Rules and Regulations, directives of the Clinical Systems Committee, or rules and regulations of the applicable Clinical Service. Action may be initiated by written request from a co-Chair of the Clinical Systems Committee, Chair of the Clinical Staff Affairs Subcommittee, from the applicable Clinical Service Head, or from a majority of a review committee created pursuant to Article IV, Section 5(C), to the Chair of the applicable Credentials Panel. The request shall be supported by reference to specific activity or conduct which constitutes the grounds for the request. A copy of the request shall be sent to the affected member or practitioner. If the affected member or practitioner signs a written acceptance of the requested reduction, the reduction shall take effect when the member or practitioner signs the acceptance. If the member or practitioner does not sign such an acceptance within ten (10) days of receipt of the request, the Credentials Panel, or applicable subpanel, shall conduct an investigative review which shall include an opportunity for the affected member or practitioner to submit information. Within forty-five (45) days of receipt of the request by the Chair, the Credentials Panel shall prepare a recommendation which shall be handled as provided in Article IV, Section 6(B).

B. Credentials Panel Recommendations

The Credentials Panel, in consultation with the Clinical Service Head, may recommend a formal letter of reprimand; may recommend reduction, suspension, or termination of clinical privileges, which may include a requirement of consultation or supervision; may impose conditions on the exercise of privileges; may recommend terms of a probationary period; or may recommend the member or practitioner obtain appropriate therapy or counseling.

When the recommendation is to deny the request for decreased clinical privileges, the Chair of the Credentials Panel shall forward it, together with the supporting documentation, to the Clinical Systems Committee for review and final action. The recommendation shall specify whether or not the Panel was unanimous. If the Panel was not unanimous, dissenting members may attach a minority report.

When the recommendation is adverse to the member or practitioner, the Chair of the Credentials Panel shall send written notification to the member or practitioner within five (5) days of preparation of the recommendation, including the specific reasons for the recommended action, the right to a hearing as provided in Article IV, Section 6(C), and a summary of the affected member's or practitioner's rights in the hearing. Failure to make a written request for a hearing to the Chair of the Clinical Staff Affairs Subcommittee within thirty (30) days of receiving notice shall constitute a waiver of the right to a hearing. The Chair of the Credentials Panel shall forward the recommendation, together with supporting documentation, to the Clinical Systems Committee. If the hearing is conducted, the Credentials Panel, or in the case of a health care professional or practitioner the applicable subpanel, shall, within fifteen (15) days of receipt of the report and recommendation of the Hearing Committee, consider them and prepare a reconsidered recommendation. The Chair of the Credentials Panel shall forward the reconsidered recommendation to the Clinical Systems Committee. If the reconsidered recommendation continues to be adverse, the Chair of the Credentials Panel shall also send written notification to the affected member or practitioner within five (5) days of the preparation of the reconsidered recommendation. The affected member or practitioner shall have ten (10) days from receipt of the notice to submit a written statement in his/her own behalf to a co-Chair of the Clinical Systems Committee.

C. Hearing

1. Hearing Committee, Notice and Personal Presence

Whenever a member or practitioner or an applicant that has been rejected for membership makes a timely request for hearing pursuant to Article IV, Section 6(B), (D), or (F), the hearing date shall not be less than thirty (30) days nor more than sixty (60) days from the date of the hearing notice. The Hearing Committee shall be composed of five members of the Clinical Staff Affairs Subcommittee, the Active Clinical Staff, or the practitioners' discipline, selected by the chair of that Subcommittee, to ensure that the committee is impartial. No staff member or practitioner who has actively participated in consideration of the adverse recommendation shall be appointed a member of this Hearing Committee. Written notice of the place, time, and date of the hearing, including specific charges or reasons for the adverse recommendation and a list of witnesses if any are expected to testify,

shall be sent to the person requesting the hearing no less than thirty (30) days before the hearing. This notice shall be prepared by the Chair of the Credentials Panel for persons receiving an adverse recommendation from this Panel, by the co-Chairs of the Clinical Systems Committee for persons receiving an adverse recommendation by this Committee or suspension of privileges, and by the Training Program Director for House Staff Members. The affected person shall be given an opportunity to inspect documentary evidence against him/her. The person may be represented by legal counsel at the hearing if he/she gives written notice to the Chair of the Clinical Staff Affairs Subcommittee at least seven (7) days prior to the hearing. The person may call witnesses on his/her behalf and introduce other evidence, including patient charts, if the person gives seven (7) days' notice to the Chair of the Clinical Staff Affairs Subcommittee. Rebuttal evidence and/or witnesses may be added in response, with notice to the affected person prior to the hearing. Personal presence of the affected person or his/her representative shall be required, and failure without good cause to appear shall constitute a waiver of the right to a hearing.

At the written request of the affected person and the approval of the Chair of the Clinical Staff Affairs Subcommittee, the affected person may waive adherence to the hearing time requirements.

2. Presiding Officer

The Hearing Committee shall select from its membership a chair who shall be the presiding officer at the hearing. The presiding officer shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and present oral and documentary evidence, and to ensure that decorum is maintained. The presiding officer shall be entitled to determine the order of procedure during the hearing and shall have the authority and discretion to make rulings on all questions.

3. Conduct of the Hearing

At a hearing both sides shall have the following rights: to call and examine witnesses, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues and to rebut any evidence. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant

evidence shall be admitted by the presiding officer if it is the sort of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Committee may request such a memorandum to be filed following the close of the hearing. The Hearing Committee may interrogate witnesses or call additional witnesses if it deems it appropriate. The presiding officer shall have the discretion to take official notice of any matters relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed, they shall be noted in the record of the hearing, and the person requesting the hearing shall have the opportunity to refute the noticed matter. The Hearing Committee shall maintain a record of the hearing by one of the following methods: a shorthand reporter present to make a record of the hearing; a recording; or minutes of the proceedings. The cost of such shorthand reporter shall be borne by the party requesting the reporter. The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice.

4. Decision of the Hearing Committee

The decision of the Hearing Committee shall be based on the preponderance of the evidence produced at the hearing. Within thirty (30) days of the completion of the hearing, the Hearing Committee shall submit its written recommendation, including a statement of the basis for the recommendation(s), to the Credential Panel in the case of Part B hearings, the Clinical Systems Committee in the case of Part D or F hearings, or the Clinical Service Head if the affected member is House Staff. The affected person has the right to receive the written recommendation of the hearing panel, including a statement of the basis of the recommendation(s).

D. Clinical Systems Committee Action

When the Clinical Systems Committee receives the recommendation or reconsidered recommendation from the Chair of the Credentials Panel, it shall consider records created in the proceedings (including any recommendations, and the documentation on which the recommendations are based, of the Credentials Panel or Hearing Committee), any written

statement timely submitted by the affected person and in its discretion, other evidence. Within thirty (30) days of receipt of the recommendation or reconsidered recommendation, the Clinical Systems Committee shall make its decision and send the affected person written notification, including a statement of the basis of the decision. A member or practitioner shall also be notified of his/her right to request appellate review to the co-Chairs of the Clinical Systems Committee within thirty (30) days of the notice.

If the decision is to grant fewer clinical privileges than requested or to reduce, suspend or terminate clinical privileges and the affected member or practitioner did not have an opportunity to request a hearing under Article IV, Section 6(B) or (F), the member or practitioner shall be entitled to a hearing as provided in Article IV, Section 6(C). Failure to make a written request for a hearing to the Chair of the Clinical Staff Affairs Subcommittee within thirty (30) days of receiving notice, complying with the requirements of notice in Part B, shall constitute a waiver of the right to a hearing. If a hearing is conducted pursuant to Part C, the Clinical Systems Committee shall, within thirty (30) days of receipt of the report and recommendation of the Hearing Committee, make a reconsidered decision, and send the affected member or practitioner written notification of the decision, including a statement of the basis of the decision and his/her right to request appellate review to the co-Chairs of the Clinical Systems Committee within thirty (30) days of the notice.

E. Appellate Review

If the decision is adverse to the member or practitioner, the affected member or practitioner may request appellate review by the Clinical Systems Committee on the grounds that:

1. there was substantial failure of the Hearing Committee or the Clinical Systems Committee to comply with these Amended and Restated Bylaws, Rules and Regulations or the procedures adopted by the Clinical Systems Committee for the conduct of the hearing and decisions upon hearing so as to deny due process or a fair hearing;

2. the action was taken arbitrarily, capriciously or with prejudice; or

3. the action of the Hearing Committee or Clinical Systems Committee was not supported by substantial evidence in the record as a whole.

Failure to make a written request for appellate review to the co-Chairs of the Clinical Systems Committee within thirty (30) days of receiving notice shall be deemed an acceptance of the decision of the Clinical Systems Committee. The Clinical Systems Committee shall notify the affected member or practitioner, no less than fourteen (14) days before the appellate review, of the date, time, and place of the review. The appellate review committee shall be composed of five members of the Clinical Systems Committee, selected by the co-Chairs of the Clinical Systems Committee, to ensure that the committee is impartial. Any individual who has participated in initiating or investigating the underlying matters at issue is disqualified from serving on the appellate review committee.

At the written request of the affected member or practitioner and the approval of the co-Chairs of the Clinical Systems Committee, the affected person may waive adherence to the hearing time requirements. When the member or practitioner requesting review is under suspension, such review shall be scheduled as soon as arrangements for it may be reasonably made, upon mutual consent of the co-Chairs of the Clinical Systems Committee and the affected member or practitioner.

The affected member or practitioner shall have access to the report and record of the hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation against him/her. The affected member or practitioner shall have ten (10) days from the time of the request to submit to the co-Chairs of the Clinical Systems Committee a written statement in support of his/her position on appeal, specifying the factual or procedural matters with which he/she disagrees, which are limited to the grounds for appellate review listed above, and the reasons for such disagreement.

The appellate review committee shall review the records created in the proceedings, the written recommendation of the hearing panel, and shall consider any written statement timely submitted by the affected member or practitioner for the purpose of determining whether the adverse recommendation against the affected member or practitioner was supported by substantial evidence in the record, was not arbitrary or capricious, and whether due process and a fair hearing was provided to the affected member or practitioner. The affected member or practitioner shall be present at the appellate review and may be represented by his/her attorney. He/she shall be permitted to speak against the adverse recommendation, limited to the scope of the appellate review, and shall answer questions of any member of the appellate review

committee. The Clinical Staff may be represented by the Chair of the Clinical Staff Affairs Subcommittee, or other individual to speak in favor of the adverse recommendation, and shall answer questions of any member of the appellate review committee. The appellate review committee may not accept additional oral and written evidence. Within twenty-one (21) days of completion of the appellate review, the appellate review committee shall submit its report to the Clinical Systems Committee. The Clinical Systems Committee may affirm, modify, or reverse its prior decision, within thirty (30) days of receiving the report from the appellate review committee. The affected member or practitioner shall be sent written notification of the final decision, including a statement of the basis of the decision, within five (5) days.

The decision of the Clinical Systems Committee is final, subject only to the discretionary appeal to the Board of Regents provided in Section III-31of the University Operations Manual.

The procedures provided in Section III-29.6 of the University Operations Manual shall not be available in any action concerning clinical privileges.

F. Summary Suspension

The co-Chairs of the Clinical Systems Committee, Chair of the Clinical Staff Affairs Subcommittee, or the Clinical Service Head for the member or practitioner shall have the authority, whenever action must be taken immediately in the best interests of patient care at the UIHC, to summarily suspend all or any portion of the clinical privileges of any member or practitioner, and the suspension shall be immediately effective. The affected member or practitioner will be notified in writing of the reasons for the suspension within twenty-four hours. The affected member or practitioner shall be entitled to a hearing, within a reasonable time, as provided in Article IV, Section 6(C). Upon mutual consent of the affected member or practitioner and the Chair of the Clinical Staff Affairs Subcommittee the hearing will be held as soon as arrangements can be made. Failure to make a written request for a hearing to the Chair of the Clinical Staff Affairs Subcommittee within thirty (30) days of the suspension shall constitute a waiver of the right to a hearing. If the right to a hearing is waived, the suspended privileges can be restored only by an application for increased privileges as provided in Article IV, Section 5. If the hearing is not waived, the Hearing Committee may temporarily restore all or part of the suspended privileges, pending final determination by the Clinical Systems Committee. The Hearing Committee, in accord with Article IV, Section 5(C), shall make its

report and recommendation to the Clinical Systems Committee and they shall be handled as a recommendation of the Credentials Panel as provided in Article IV, Section 5(D). The Hearing Committee shall also send written notification to the affected member or practitioner, including a statement of the basis of the recommendation.

The Chair of the Clinical Staff Affairs Subcommittee or the applicable Clinical Service Head will be responsible for arranging for alternative medical coverage for the patients of the suspended practitioner still in the UIHC at the time of suspension.

G. Automatic Suspension

The Chair of the Clinical Systems Committee, the Chair of the Clinical Staff Affairs Subcommittee, or the applicable Clinical Service Head shall have the authority to automatically suspend the clinical privileges of any member or practitioner who fails to complete medical records in accordance with the Clinical Staff rules and regulations or whenever a member's or practitioner's license to practice in Iowa is revoked, restricted, or suspended. Procedural rights will not be available to members or practitioners who receive automatic suspension of their clinical privileges. Privileges will be reinstated by the co-Chairs of the Clinical Systems Committee or the Chair of the Clinical Staff Affairs Subcommittee upon demonstrated compliance.

The Chair of the Clinical Staff Affairs Subcommittee or the applicable Clinical Service Head will be responsible for arranging alternative medical coverage for the patients of the suspended member or practitioner still in the UIHC at the time of suspension.

Section 7: House Staff Member Rights

A. The House Staff Graduate Medical or Dental Education Appointment Contract is for no more than a twelve (12) month duration and may be renewed annually upon satisfactory performance in the training program. In the event that the Training Program Director does not recommend renewal of a house staff member's contract due to unsatisfactory progress in the training program and the training program has not been completed, the affected house staff member shall be so notified in writing at least four (3) months prior to the expiration of the contract, which shall include a statement of the grounds for the decision. A decision not to renew made within four (3) months of the expiration or a decision to cancel a renewed contract before the

beginning of the contract period shall be considered a discharge and must be based on grounds that would justify discharge during a contract period.

A Training Program Director may suspend without pay or discharge a house staff physician or dentist during a contract period for unprofessional or unethical conduct, illegal actions, gross unsatisfactory performance, or failure to observe these Amended and Restated Bylaws, Rules and Regulations, directives of the Clinical Systems Committee, or rules and regulations of the applicable Clinical Service. After explaining the grounds for suspension or discharge to the house staff member, the Training Program Director shall give written notice of the suspension or discharge to the house staff member, including a statement of the grounds for the action, the right to a hearing as provided in Article IV, Section 6(C), and a summary of the house staff member's rights.

A suspended or discharged house staff physician or dentist shall be entitled to a hearing before a body appointed by the Chair of the Clinical Staff Affairs Subcommittee. Failure to make a written request for a hearing to the Chair of the Clinical Staff Affairs Subcommittee within thirty (30) days of receiving written notice of suspension or discharge shall constitute a waiver of the right to a hearing. The Hearing Committee shall be composed of no less than four members of the Clinical Staff Affairs Subcommittee and three house staff physicians or dentists, selected so as to provide an impartial tribunal. The hearing shall be conducted in accordance with Article IV, Section 6(C), except for the composition of the Hearing Committee and the recipient of the Committee's decision. The chair of the Hearing Committee shall give written notice of the committee's decision to the affected house staff physician or dentist, the program director and the Chief Executive Officer of UIHC, including a statement of the basis for the decision. At the written request of the affected house staff physician or dentist and the approval of the Chair of the Clinical Staff Affairs Subcommittee, the house staff physician or dentist may waive adherence to the hearing time requirements.

The decision of the Hearing Committee is final, subject only to discretionary appeal to the Board of Regents provided in Sections III-31 of the University Operations Manual. This procedure and those in this Section shall be exclusive.

The procedures provided in Section III-29.6 of the University Operations Manual shall not be available in any action concerning clinical privileges.

Other concerns of house staff members shall be addressed through procedures approved by the Clinical Systems Committee.

Section 8: Patient Care Responsibility

A. Clinical Service Head

Each Clinical Service Head shall have supervision over the clinical activities of the Clinical Service.

B. Services

Each Clinical Service shall provide for one or more Services. A Service shall consist of one or more Attending Physicians or Dentists, and may include one or more House Staff members. On admission to the UIHC, each patient is assigned to the Service of his/her attending physician or dentist.

C. Attending Physicians and Dentists

An Attending Physician or Dentist shall be a member of the Active Clinical Staff or the Emeritus Staff. The Attending Physician or Dentist shall be responsible for ordering (and when appropriate, performing) all diagnostic and therapeutic procedures performed for the patients assigned to his/her Service. He/she may delegate to other members of the Service or the patient care team those procedures which, in his/her judgment, they are capable of performing legally, safely, and effectively, providing that he or she, or another Attending Physician or Dentist, is readily available for consultation during the performance of these activities. Under these circumstances, he or she retains responsibility for these clinical activities.

In the event that the Attending Physician or Dentist expects to be unavailable, it shall be his/her responsibility to designate another member of the Active Clinical Staff or the Emeritus Staff as Attending Physician or Dentist for the patient(s) and to report this action to the Clinical Service Head. If, for any reason, the Attending Physician or Dentist fails to make this designation and is not available, another member of the Clinical Staff shall be designated by the Clinical Service Head as the Attending Physician or Dentist for the patient(s) concerned.

In the discharge of this responsibility for the care of patients, on the Service, the Attending

Physician or Dentist shall comply with the regulations and policies issued by the Clinical Services.

Section 9: Clinical Service Meetings

Each Clinical Service shall meet on a regular basis, not less than once per month, and attendance by the members and practitioners with clinical privileges in the Clinical Service shall be required. Such meetings shall serve as an instrument to accomplish a critical review of all medical or dental practices within each Clinical Service. Minutes shall be maintained and shall contain at least a listing of the Clinical Service members present, the subject matter and clinical problems discussed and actions taken. Attendance will be reported to the appropriate credentials panel through the Clinical Service Head for consideration during the credentialing process.

ARTICLE V: EVALUATION OF CLINICAL CARE

Section 1: Performance Improvement Program

The Clinical Systems Committee shall adopt, annually review, and, as necessary, revise a Performance Improvement Program to evaluate the quality of professional services and to take appropriate actions based on those evaluations. The Performance Improvement Program shall include the Clinical Service quality and performance improvement committees, the Quality and Safety Oversight Subcommittee, the Clinical Systems Committee, and other committees designated by the Clinical Systems Committee.

Section 2: Medical and Dental Audit

Each Clinical Service shall have a Medical or Dental Quality and Performance Improvement Committee which shall be appointed by the Clinical Service Head and be a Working Group of the Quality and Safety Oversight Subcommittee. The Committee shall measure the extent to which patient care delivered in the Clinical Service satisfies standards of care formulated pursuant to the Performance Improvement Program and take constructive intradepartmental action on the evaluation results.

Section 3: Surgical Pathology Review

Any tissues removed surgically must be sent to Pathology unless prior written approval has been obtained by the responsible physician from the Director of Surgical Pathology, or his designee. Each

instance of normal tissue and/or variation between preoperative diagnosis and pathological findings shall be reported to the appropriate Clinical Service Head. These cases shall be prepared for presentation at a subsequent Clinical Service conference.

Section 4: Clinical Service Ongoing Review

Each Clinical Service shall maintain a continuous review of the clinical practice of those persons having clinical privileges in the Clinical Service. Particular attention shall be devoted to cases involving selected deaths, unimproved patients, nosocomial infections, questionable diagnosis or treatment, and patients with complications of their illnesses. It shall be the responsibility of the Clinical Service Heads to assure the accomplishment of this review objective and that the specific procedures as contained in Article V, Sections 2 and 3 are followed.

ARTICLE VI: CLINICAL SERVICE RULES AND REGULATIONS

Each Clinical Service Head shall adopt such clinical rules and regulations as may be necessary for proper conduct and administration of the Clinical Service. These shall relate to the proper conduct of Clinical Service organizational activities as well as the level of practice that is to be required of each person with clinical privileges in the respective Clinical Service. No rules, regulations or procedures in conflict with these Amended and Restated Bylaws, Rules and Regulations may be adopted.

ARTICLE VII: AMENDMENTS

Proposals for amendments or changes in amendments to these Amended and Restated Bylaws, Rules and Regulations must be presented in writing by a member of the Clinical Systems Committee. Such proposals shall require the approval of the Clinical Systems Committee by a majority vote of a quorum of the Committee.

Amendments to Article VIII shall take effect upon such approval by the Clinical Systems Committee. Amendments to Articles I through VII, inclusive, shall also require approval by a majority of the Board of Regents upon recommendation by the President of the University of Iowa, and shall take effect upon approval by the Clinical Systems Committee, the President and the Board of Regents. The Amended and Restated Bylaws, Rules and Regulations will be reviewed at least annually by the Clinical Systems Committee. Amendments to the Amended and Restated Bylaws, Rules and Regulations will be proposed as needed.

ARTICLE VIII: PATIENT CARE RULES AND REGULATIONS

Section 1: Patient Service Assignment

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

Section 2: Assignment Without Regard to Financial Status

Patient care activities shall be related to the institution's teaching programs without regard to the financial status of the patient. Each patient shall be assigned to a patient care team headed by an Attending Physician or Dentist. House staff physicians, dentists, and students of various health disciplines may be assigned to the patient care team of any patient.

Section 3: Admission Information

Physicians and dentists requesting admission of patients shall be responsible for providing such information as may be necessary to assure the protection of other patients and hospital personnel from those patients who constitute a source of danger from any cause whatsoever.

Section 4: Order Documentation

Orders for medication or treatment shall be in writing, shall be timed and dated, and shall be signed by the member or practitioner giving the order, with the following exceptions:

A. In cases of emergency, verbal orders may be accepted from members or practitioners

B. In cases when the member or practitioner is unable to be present to write the necessary order and delaying administering the medication or performing the treatment would be adverse to the patient's welfare,

C. All verbal orders, including those regarding bed occupancy, will be accepted and documented per hospital policy.

Medical students who have completed eighteen (18) months of medical school may write orders for

review and approval by a licensed independent provider. Written orders by medical students shall be co-signed by the patient's attending physician or a house staff member under his/her supervision before they will be carried out by the nursing staff or any other professional staff. It is the responsibility of the medical student to obtain the co-signature. For patients who have been declared brain dead per hospital policy and family has given consent to organ donation, the patient may have orders written by the Organ Donor Coordinator(s) from the Organ Procurement Organization.

For the purpose of these Patient Care Rules and Regulations, the words "sign" and "signature" include an electronic signature entered pursuant to a verification protocol approved by the Health Information Management Systems Working Group.

Section 5: Preparation of Medical Record

The Attending Physician or Dentist shall be responsible for the preparation of a complete, accurate and legible medical record for each patient. This record shall be prepared in accordance with the format issued by the Health Information Management Systems Working Group and conform to the standards of The Joint Commission, and governmental regulating bodies. Medical records shall be safeguarded against loss, defacement, tampering, or use by unauthorized persons. Records shall be removed from the hospital's jurisdiction only in accordance with a court order, subpoena, or statute.

Section 6: Standard Orders

Standard orders may be adopted, as needed by the various Clinical Services and Clinical Divisions, but they must be individually signed. Standard orders must be reviewed, revised as necessary, and readopted at least annually. Drug orders and prescriptions shall be written by the generic name unless the preparation has a simple proprietary name and a complex generic name. Drug dosages shall be written in the metric system.

Section 7: Documentation of History and Physical

A medical history and physical examination shall be completed and documented for each patient no more than thirty (30) days before, or twenty-four (24) hours after, admission or registration for a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a member of the Clinical Staff or other practitioners privileged pursuant to Article IV, Section 4(F). An updated examination must be completed prior to surgery or a

procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) days before admission or registration (in a non-inpatient setting). The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a member of the Clinical Staff or other practitioners privileged pursuant to Article IV, Section 4(F). If the circumstances are such that a delay is necessary, a brief admission note may be recorded pending completion of the history and physical examination.

Section 8: Informed Consent

A procedure shall be performed only upon the informed consent of the patient or the patient's legal representative, except in emergencies or pursuant to a court order. Operative reports dictated or written immediately after surgery record the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately. The medical record should reflect a post-anesthetic evaluation made by an individual qualified to administer anesthesia within 48 hours after surgery. This report should document the cardiopulmonary status, level of consciousness, observations and/or patient instructions given, and any complications occurring during post-anesthetic recovery. All tissues removed will be sent to the Pathology Laboratory, where such examinations will be made as may be considered necessary to arrive at a diagnosis. Reports of such examinations shall be signed by the responsible physician and filed in the medical record and in the pathology files.

In addition, when tissues that have been removed at other institutions are to be used as a basis for developing, recommending or continuing a treatment plan by an Attending Physician or Dentist, the tissues shall be sent to the Pathology Laboratory for a formal examination prior to implementing the treatment plan, unless, in the best medical judgment of the attending physician/dentist, a delay in starting treatment would constitute a significant hazard for the patient. Specific exceptions to this policy may be granted by the Diagnostic Services Subcommittee following a written petition from a clinical division or department.

Section 9: Discharge

Patients shall be discharged only upon written order of a member or practitioner. Patients who sign out against medical advice shall be requested to sign a suitable release form. Records of discharged

patients shall be completed within fourteen (14) days following discharge. The clinical resume should be concise, include information relative to the reason for hospitalization, pertinent findings; procedures performed and care, treatment and services provided, the condition of the patient on discharge; and instructions given to the patient and/or the family as appropriate. All final diagnoses shall be recorded in full.

Section 10: Autopsies

All members of the Clinical Staff are expected to be actively interested in acquiring permission to perform autopsies. No autopsy shall be performed without the written consent of a person legally authorized to consent. All autopsies shall be supervised by a member of the Active Clinical Staff of the Pathology Department. Physicians seeking permission for autopsies shall explain adequately what constitutes a routine autopsy and that the extent of the permit will not be violated. The Pathology Department shall be notified regarding exceptions in autopsy procedures so that the intent of the person giving the consent shall not be violated. The completed autopsy report shall be made part of the patient's medical record within ninety (90) days of the patient's death.

Section 11: Death Certificates

The Attending Physician or resident physician is responsible for signing the death certificate in a timely manner when requested to do so by a funeral director and/or by a Decedent Care Center staff member.

Section 12: Formulary

The Formulary and Handbook of the UIHC shall be published each year for the benefit of the Clinical Staff and other health care professionals at the UIHC. This document shall include specific policies and procedures to be followed with regard to administrative and clinical matters and shall be reviewed and approved annually by the Pharmacy and Therapeutics Working Group.

Drugs used shall be those listed in the U.S. Pharmacopeia – National Formulary, the Formulary and Handbook of the UIHC, or approved by the Pharmacy and Therapeutics Working Group. When trade or proprietary nomenclature for a drug is employed, the Clinical Staff of the UIHC authorizes generically equivalent drugs approved by the Pharmacy and Therapeutics Working Group to be dispensed by the Pharmacy Department and administered by the Department of Nursing and other

persons authorized to administer medications. Additionally, the Clinical Staff authorizes the substitution of drugs that are chemically dissimilar but have been judged by the Pharmacy and Therapeutics Working Group to be therapeutically equivalent. If substitution is not acceptable, the physician or dentist must write on the prescription that only the brand specified is acceptable. The Pharmacy will act to obtain and dispense such brand on such indication that only a specific brand is acceptable.

The Clinical Staff authorizes the conversion of ordered doses of selected drugs, as specified by the Pharmacy and Therapeutics Working Group, to standardized dosages in accord with dose conversion protocols approved by the Pharmacy and Therapeutics Working Group. The Clinical Staff authorizes the Pharmacy Department to dispense, and the Nursing Department and other persons authorized to administer medications to administer, those converted doses. If conversion is not acceptable, the physician or dentist must write on the medication order that only the exact dose specified is acceptable. Pharmacy will prepare and dispense the specified dose on such indication that only that dose is acceptable.

Section 13: Joint Patient Responsibility

Where there is joint patient responsibility among staff members of two or more Services, it shall be necessary to delineate responsibility. All members of the Services involved in the care of the patient shall accordingly know in whom basic responsibility for making the primary decisions lies and who, in turn, is performing a consultative function. Any conflicts with regard to basic responsibility for a patient shall be adjudicated by the Heads of the Clinical Services involved or, if they are unable to resolve the conflict, the Chief of Staff.

Section 14: Dental Care Coordination

In accord with The Joint Commission's standards, all inpatients of the Hospital Dentistry Clinical Service shall receive the same basic clinical appraisal as patients assigned to other Clinical Services. A physician member of the Active Clinical Staff or the Emeritus Staff shall be responsible for the care of any medical problem that may be present, or that may arise concerning a dental patient or other inpatient receiving dental care. A physician's monitoring of hospitalized dental patients is unnecessary unless a medical problem is present upon admission; the dentist does have the obligation to request consultation with an appropriate physician when a medical problem arises during hospitalization of his/her dental patient. The Head of the Department of Surgery, or his designee, shall provide overall

supervision of surgical procedures performed by dentists who are not oral surgeons, which means that he/she shall be available for consultation or involvement as necessary, but does not mean that he/she must be present.

Section 15: Emergency Services

The Director of the Emergency Treatment Center shall be a member of the Active Clinical Staff. He or she shall be designated by the Chief Executive Officer of the UIHC, in concert with the Head of the Clinical Service in which the member is appointed, to be responsible for monitoring the daily operations of the Emergency Room. Each Clinical Service Head is responsible for arranging for the availability of members of his Clinical Service to provide consultative and treatment services for emergency patients and to assure that patients presenting for specialty care are provided appropriate and timely service. All members of the Clinical Staff of the UIHC shall participate in the overall plan for the reception and treatment of emergency patients as set forth in the approved Emergency Service Operations Manual.

Section 16: Continuing Education

Members of the Clinical Staff are encouraged to participate in continuing education programs sponsored by the Clinical Services of the UIHC, the University of Iowa College of Medicine and the College of Dentistry, and organizations outside the UIHC. Participation in the roles of both students and teachers is recognized as the means of continuously improving the service rendered by the Clinical Staff.

Section 17: Professional Charges

To avoid confusing multiple billings to patients and to assure appropriate controls of costs to patients, no professional charges for services rendered by a Clinical Staff Member may be submitted to patients for services within the UIHC, except through the faculty practice plan currently known as University of Iowa Physicians and Dental Service Plan fee billings, unless prior written permission has been given by the Chief Executive Officer of the UIHC or his/her designee.

Section 18: Faculty Practice Plan and Dental Service Plan

The Faculty Practice Plan is organized for the purpose of administering certain funds received in the course of medical practice at the UIHC and other locations. The Faculty Practice Plan shall purchase collection services from the UIHC.

The Dental Service Plan is organized for the purpose of administering certain funds received in the course of dental practice at the UIHC and other locations. For services performed within the UIHC, the Dental Service Plan shall purchase collection services from the UIHC.

Section 19: Disaster Plan

In case of a civil or natural disaster, the UIHC shall follow the Disaster Plan approved by the Clinical Systems Committee.

APPENDICES

APPENDIX I

THE UNIVERSITY OF IOWA HOSPITALS AND CLINICS DEPARTMENTS

The following hospital departments have been established pursuant to Article II, Section 2(B)(9) of the Amended and Restated Bylaws, Rules and Regulations of the University of Iowa Hospitals and Clinics and its Clinical Staff:

Professional Departments

Food and Nutrition Services
Nursing Services and Patient Care
Rehabilitation Therapies
Respiratory Care
Pharmaceutical Care
Quality Improvement Program
Social Services
Spiritual Services

Other Departments

Capital Management
Emergency Management
Engineering Services
Environmental Services
Financial Operations
Guest Services
Health Care Information Systems
Health Information Management
Human Resources
Integrated Strategic Planning & Business Development
Joint Office for Compliance
Marketing and Communications
Office of the Patient Experience
Operations Excellence
Procurement and Value Implementation Services
Revenue Management
Safety and Security
Supply Chain
Volunteer Services