



Ascension

ASCENSION NE WISCONSIN

MEDICAL STAFF BYLAWS

OF

ASCENSION ST. ELIZABETH HOSPITAL CAMPUS

ASCENSION MERCY HOSPITAL CAMPUS

ASCENSION CALUMET HOSPITAL &

ASCENSION ST. ELIZABETH SURGERY CENTER

AMENDED MAY 2018

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BYLAWS OF THE MEDICAL STAFF
OF
CALUMET MEDICAL CENTER, ST. ELIZABETH HOSPITAL SURGERY
CENTER, MERCY MEDICAL CENTER AND ST. ELIZABETH HOSPITAL
PREAMBLE

WHEREAS, Ascension Mercy Hospital Campus and Ascension St. Elizabeth Hospital Campus, historically referred to as Mercy Medical Center (“MMC”) and St. Elizabeth Hospital (“SEH”) throughout these Bylaws, are general hospitals operated by Ascension (“Ascension”), a nonprofit corporation which also operates an integrated system of delivering physician, hospital and related health care services to the community Ascension serves; and

WHEREAS, Ascension St. Elizabeth Surgery Center, historically referred to as St. Elizabeth Hospital Surgery Center (“SEHSC”) throughout these Bylaws, is a general partnership organized under Chapter 178 of the Wisconsin Statutes and is an ambulatory surgery center operated by Ascension; and

WHEREAS, Ascension Calumet Hospital, historically referred to as Calumet Medical Center (“CMC”) throughout these Bylaws, is a critical access hospital affiliated with and administered by Ascension; and

WHEREAS, the physicians, dentists and podiatrists in the community Ascension serves generally apply for permission to provide patient care at multiple Campuses or Affiliated Locations within the Ascension system; and

WHEREAS, Ascension and the members of its medical staffs who provide services at CMC, SEHSC, MMC and SEH desire to form a single Medical Staff (as further defined below) providing patient care, education and research and operating at four Campuses or Affiliated Locations (individually, CMC, SEHSC, MMC and SEH; each a “Campus” or “Affiliated Location” as defined below and collectively the “Campuses or Affiliated Locations”); and

WHEREAS, the ultimate authority to discharge the purposes stated herein is vested in the Governing Body (as defined in Article I of this document), and it is recognized that the Medical Staff is actively responsible to the Governing Body for the quality of patient care, treatment and services and patient safety, and must accept and discharge this responsibility, and the cooperative efforts of the Governing Body, the Hospital Presidents, the Vice President of Medical Affairs and the medical staffs, are necessary to fulfill the hospitals’ and surgery center’s obligation to their patients;

THEREFORE, the physicians, dentists and podiatrists practicing at Ascension NEWI are hereby appointed and organized by the Governing Body into a single medical staff in conformity with these Bylaws and the Bylaws of the Governing Body, and shall be known as the Medical Staff of Ascension NE Wisconsin, hereinafter collectively referred to as the “Medical Staff”.

The Medical Staff shall be composed of physicians, dentists and podiatrists. In addition, there shall be an allied health professionals division that includes individuals granted clinical privileges, but who are not Members of the Medical Staff.

ARTICLE I. DEFINITIONS

- A. “Act” – This term means the Health Care Quality Improvement Act of 1986.
- B. “Allied Health Professional” - “AHP” – These terms mean an individual who is either an independent AHP or a dependent AHP as defined below. AHPs are not eligible for membership on the Medical Staff.
- C. “Affiliated Location” – This term means a location that is a part of Ascension and whose practitioners are Members of the Ascension NEWI Medical Staff governed by these Medical Staff Bylaws but is not necessarily defined as a Campus. Such locations include SEHSC and CMC.
- D. “Applicant” – This term means either a Practitioner who has completed an application for appointment or reappointment to the Medical Staff, or a Practitioner or an AHP who has completed an application for clinical privileges to provide patient care at one or more Campuses or Affiliated Locations.
- E. “Ascension NEWI” – This term refers to the collection of health care providers operating under one unified Medical Staff at various Ascension Wisconsin locations including, but not necessarily limited to, Calumet Medical Center (“CMC”), St. Elizabeth Hospital Surgery Center (“SEHSC”), Mercy Medical Center (“MMC”) and St. Elizabeth Hospital (“SEH”) as well as other clinics or facilities under the affiliation and control of those entities.
- F. “Campus” – This term means an Ascension NEWI location that is a part of the Ascension NEWI in terms of the unified Medical Staff. Campuses or Affiliated Locations include Mercy Medical Center (“MMC”) and St. Elizabeth Hospital (“SEH”).
- G. “Chief Medical Officer” - “CMO” Senior Medical Leader for Ascension Wisconsin that provides direction for all physician-related activities throughout Ascension Wisconsin including, but not limited to, Medical Staff governance, quality of patient care, treatment and services, patient safety and patient satisfaction.
- H. “Character” – The complex of mental and ethical traits of an individual including, but not limited to, mental and emotional stability and capabilities.
- I. “Contacts” – This term means any inpatient services, outpatient admission, outpatient testing or therapeutic intervention, procedure or consultation.
- J. “Credentials Committee” – This term means the credentials committee of the Medical Staff. This committee is a “professional review body” as defined in Section 431(11) of the Act.
- K. “Dependent AHP” This term refers to duly qualified personnel employed by a physician, dentist, podiatrist or by Ascension NEWI to function within a Campus or Affiliated Location as defined by Medical Staff policy.

- L. “Ethical Principles” – This term means those principles set forth in the Ethical and Religious Directives, the Code of Ethics of the American Medical, Dental, Osteopathic or Podiatry Association, or other Code of Ethics for a Practitioner’s or AHP’s profession, whichever is applicable. Should there be any conflict between any provisions of the applicable Code of Ethics and the Ethical and Religious Directives, the latter shall prevail.
- M. “Ethical and Religious Directives” or “ERDs” – These terms mean the Ethical and Religious Directives for Catholic Health Care Services, as promulgated by the National Conference of Catholic Bishops.
- N. “Fair Hearing Plan” – This term means the Corrective Action Plan and Fair Hearing Plan contained in these Bylaws.
- O. “Good Standing” – This term means an individual who, at the time the issue of standing is raised, is currently not under suspension or serving with any limitation of clinical privileges or voting or other rights granted by operation of these Bylaws or Medical Staff policy. Only Members in good standing are eligible to vote for the election of officers or on any other matters presented for a vote by ballot or at a departmental, committee or general meeting of the Medical Staff.
- P. “Governing Body” – This term means the governing board of Ascension St. Elizabeth Hospital Campus, Ascension Mercy Hospital Campus and Ascension Calumet Hospital for Ascension NEWI as applicable, except that, to the extent authorized in each entity’s corporate Bylaws or other governing documents, the Governing Body may delegate its authority to act on Medical Staff matters (including, but not limited,) to Medical Staff appointments and the granting of clinical privileges to its Quality and Patient Safety Committee or the equivalent body, subject to subsequent ratification by the Governing Body.
- Q. “Health Status” – This term means the physical, emotional and mental health status of an individual.
- R. “Hospital” – This term has the same definition as the term “hospital” defined in Section 431(5) of the Act and/or a “health care entity” as defined in Section 431(4) of the Act.
- S. “Hospital President” – This term means the individual appointed by the Governing Body to act on its behalf in the overall management of a Campus or Affiliated Location.
- T. “Imminent Danger” – This term means a threat or risk to persons or property that is of sufficient severity and immediacy that it cannot be dealt with through routine corrective action plan. Since invocation of the corrective action plan is a lengthy process, an exact timeline cannot be defined for an imminent danger. However, in some situations a timeframe of up to several days to a week or more may constitute an imminent danger that warrants immediate action. Regardless of time frame, the

safety and security of patients, staff, other persons, and property will be the dominant and guiding factor.

- U. “Independent AHP This term refers to doctors of clinical psychology, nurse midwives, advanced practice nurse prescribers and certified registered nurse anesthetists duly licensed in Wisconsin who have satisfied the credential requirements and have been approved to evaluate and/or treat patients in the facility.
- V. “Interpretive telemedicine” – This term means providing official readings of images, tracings, or specimens through a telemedicine link, but not engaging in interactive telemedicine.
- W. “Interactive telemedicine” – This term means responsibility (either total or shared) for patient care, treatment and services (as evidenced by having the authority to write orders and direct care, treatment and services) through a telemedicine link.
- X. “Medical Executive Committee” or “MEC” This term means the executive committee of the Medical Staff, unless specific reference is made to the executive committee of the Governing Body. This committee is a “professional review body,” as defined in Section 431(11) of the Act.
- Y. “Medical Staff Services” or “MSS” – These terms shall mean the Ascension NEWI Health System Department responsible for processing applications for Staff Membership and clinical privileges and undertaking primary source verification.
- Z. “Medical Staff Year” – This term means a 12-month period commencing the first day of October and ending the last day of September.
- AA. “Member” – This term means providers who have satisfied all credential requirements and, except for the honorary Medical Staff, have been approved as part of the Medical Staff.
- BB. “Physician” – This term, when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such function and who is acting within the scope of his license when he/she performs such functions, or (3) a doctor of podiatric medicine but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them.
- CC. “Practitioner” – This term means the following persons, possessing licenses to practice their profession: physicians, dentists, podiatrists, clinical psychologists, physician assistants, advanced practice nurse prescribers, certified nurse midwives and certified nurse anesthetists.

- DD. “Privileges” or “clinical privileges” – These terms mean the permission granted to a Medical Staff Member or AHP to render specific diagnostic, therapeutic, medical, oral maxillofacial/dental, podiatric or surgical services that may or may not include permission to admit patients, but does include unrestricted access to those Campus or Affiliated Location resources that are necessary to effectively exercise those privileges.
- EE. “Proctoring” – This term means a process of direct observation that allows for the focused evaluation of a Practitioner’s current competency in carrying out actual clinical care and takes both cognitive and procedural abilities into account. If the proctor observes potential or imminent patient harm during the proctoring process, it may be ethically appropriate for him or her to intervene.
- FF. “Provisional Appointment” – This term means the initial one-year appointment for a new member of the Medical Staff for the purpose of evaluating the performance and clinical competency of the appointee for advancement to full appointment.
- GG. “Reference” – This term means reliable written information provided by a peer of the Applicant and assessing the Applicant’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, character, and health status as relates to the Applicant’s ability to practice medicine and the requested privileges.
- HH. “Special notice” – This term means written notification sent by certified or registered mail, return receipt requested, or hand delivered to the addressee.
- II. “Staff” or “Medical Staff” – These terms mean all duly licensed Practitioners who are privileged to attend patients at one or more Campuses or Affiliated Locations and have been granted membership. The Medical Staff is a “professional review body” as that term is defined in Section 431(11) of the Act.
- JJ. “Track one application” – This term means a Medical Staff application for initial appointment that meets all Track one criteria defined in Medical Staff policy, is eligible for processing as an expedited appointment by the VPMA or Hospital President, and the Practitioner must begin providing patient care prior to the next regularly scheduled meeting of the credentials committee, MEC and/or Governing Body when the initial appointment would normally be considered for recommendation/approval.
- KK. “Track two application” – This term means a Medical Staff application for initial appointment that does not meet the criteria for a Track one application, as defined in Medical Staff policy.
- LL. “Vice President of Medical Affairs” - “VPMA” These terms mean the individual(s) appointed by the Hospital President to oversee and direct the medical activities of Ascension NEWI, including but not limited to, utilization review, quality assurance, credentialing and privileging, and performance management and clinical grievances.

ARTICLE II. PURPOSES

The purposes of the Medical Staff are:

- A. To provide that all patients admitted to or treated in any of the facilities, departments, or services of the Campuses or Affiliated Locations receive high quality, safe medical care.
- B. To provide that all patients and families receive appropriate education.
- C. To be the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by individual Practitioners and the obligations of Medical Staff membership may be fulfilled.
- D. To initiate and maintain rules and regulations for self-government of the Medical Staff.
- E. To serve as the primary means for providing assurances to the Governing Body as to the appropriateness of the professional performance and ethical conduct of its Members and to strive toward assuring that the pattern of patient care on the Campuses or Affiliated Locations is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available.
- F. To provide a means through which the Medical Staff may participate in the Campuses or Affiliated Locations' policy-making and planning process.
- G. To facilitate a high level of care and provide an appropriate level of professional performance by all Members of the Medical Staff and all Allied Health Professionals authorized to practice on the Campuses or Affiliated Locations through the appropriate delineation of the clinical privileges that each Member or Allied Health Professional may exercise in the Campuses or Affiliated Locations and through a continuing review and evaluation of each Member's and Allied Health Professional's performance on the Campuses or Affiliated Locations.
- H. To provide a continuing education program fashioned, at least in part, on the needs demonstrated through the patient care audits and other quality programs.
- I. To provide a utilization review program to allocate inpatient medical and health services based upon determinations of individual medical needs and to improve the appropriate allocation of medical and health service resources.
- J. To provide an organizational structure that allows continuous monitoring of patient care practices.

- K. To actively conduct reviews and evaluate and improve the quality of patient care through patient care audit procedures and other processes including but not limited to PDSAs (Plan, Do, Study, Act), RCAs (Root Cause Analysis) and FMEAs (Failure, Mode, and Effects Analysis), OPPE (Ongoing Professional Practice Evaluation), and FPPE (Focused Professional Practice Evaluation).
- L. To recommend to the Governing Body action with respect to appointments, reappointments, staff category and corrective action.
- M. To be actively accountable to each Governing Body for uniform standards of quality patient care, treatment and services provided to patients at the Campuses and Affiliated Locations through regular reports and recommendations regarding improvement of those processes.
- N. To initiate and pursue corrective action with respect to Members when warranted.
- O. To establish and enforce through the Medical Executive Committee (“MEC”) the criteria and standards for the Staff membership.
- P. To develop, administer and insure compliance with these Bylaws through regular reports and actions of the Medical Staff, and other patient care related Campus or Affiliated Location, Affiliated Location, and Medical Staff policies.
- Q. To assist in identifying community health needs, setting appropriate institutional goals and implementing programs to meet those needs, as well as State and Federal mandates.
- R. To conduct all of its affairs involving the Medical Staff, patients and employees in a manner and an atmosphere free of unlawful discrimination based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- S. To work with the Campuses and Affiliated Locations in obtaining and maintaining acceptable accreditation status.
- T. To carry out such other responsibilities as may be delegated by the Governing Body.

ARTICLE III. STAFF APPOINTMENT

Section 1. Nature of Appointment.

Appointment to the Medical Staff of Ascension NEWI is a privilege which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws and the Bylaws of the Governing Body, who possess skills and training needed to provide high quality, safe

patient care, treatment, and services, ¹ and for whom the applicable Campus or Affiliated Location is able to provide adequate facilities and supportive services for the Practitioner and his/her patients.

Section 2. Qualifications for Appointment.

- A. Only Practitioners licensed to practice in the State of Wisconsin, who can document their background, experience, judgment, training and demonstrated current competence in his or her specialty for all privileges requested; attest to their adherence to ethical principles (including the Ethical and Religious Directives), their adherence to the appropriate utilization of resources of each Campus or Affiliated Location at Ascension NEWI and all other hospitals and/or nursing homes at which the Practitioner has clinical privileges as determined through quality assurance and utilization review activities; their good character and reputation; their ability to work with others with sufficient adequacy to assure the Medical Staff and the Governing Body that any patient treated by them at a Campus or Affiliated Location will be given high quality, safe medical care, treatment and services, and that the operations of the Campus or Affiliated Location will not be disrupted; and who can continue to demonstrate and maintain these standards, shall be and remain qualified for appointment to the Medical Staff. No Practitioner shall be eligible for appointment to the Medical Staff or to the exercise of particular clinical privileges at a Campus or Affiliated Location merely by virtue of the fact that he/she: is duly licensed to practice medicine, dentistry, or podiatry in this or in any other state, is a member of any professional organization, specialty body or society; holds a particular certification; is fellowship trained; or in the past held, or presently holds, such Privileges at a Campus or Affiliated Location, Affiliated Location, or another hospital.

Any reference to Campus or Affiliated Location resource policies as used in these Bylaws shall not be construed as requiring use of Campus or Affiliated Location facilities and/or resources for non-hospitalized patients.

- B. No person who is otherwise qualified shall be denied appointment or reappointment to the Medical Staff, or the exercise of clinical privileges, on the basis of age, sex, race, creed, color, national origin, religion, mental or physical disability, sexual orientation, or on the basis of any other criterion unrelated to the delivery of good patient care, to professional qualifications, to the purposes, needs and capabilities of the Medical Staff, to community need, or to any requirements set forth in these Bylaws.

Section 3. Conditions and Duration of Appointment and Granting of Privileges.

- A. Initial appointments and reappointments of Practitioners and the granting of any Clinical privilege shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, the granting of clinical privileges, or

revocation of appointments or clinical privileges only after there has been an affirmative recommendation from the MEC as provided in these Bylaws; provided that in the event of unwarranted delay on the part of the MEC, the Governing Body may act without such recommendation on the basis of documented evidence of the Practitioner's professional and ethical qualifications obtained from reliable sources other than the MEC.

When acting in the event of an unwarranted delay, the Governing Body must base its decision upon the same kind of information as is usually considered by the MEC. For the purposes of this Section, unwarranted delay generally means 100 days from the date that the fully completed application (i.e. all information requested of the Applicant) has been received by Medical Staff Services.

- B. Initial appointment to the Medical Staff, except to the honorary staff, shall be of a provisional nature that shall extend for a period of not less than one year. Such provisional appointment may be further extended in three-month increments up to one additional year. The Practitioner shall be appointed to a specific department, shall have one Campus or Affiliated Location designated as his/her primary Campus or Affiliated Location, and shall be eligible to serve on Medical Staff and departmental committees and to vote on matters before such committees. The Practitioner shall not be eligible to hold office nor vote at Medical Staff meetings during the provisional appointment. It shall be the responsibility of the chair of the clinical department to which the Practitioner is assigned to monitor the performance and clinical competency of each new Practitioner consistent with Medical Staff policy. In the event the Practitioner has not satisfied the requirements for advancement to the appropriate staff category, as defined in these Bylaws, at the end of the provisional appointment, his/her provisional status shall automatically terminate. A Practitioner shall be given written notice of such termination and of his/her entitlement to procedural rights specified in the Fair Hearing Plan. All Practitioners seeking Medical Staff membership shall serve the one-year provisional period, unless extended. Thereafter reappointment shall be for a maximum period of up to two Medical Staff years.

- C. All Practitioners, excluding dentists, considered for appointment or reappointment shall either maintain current certification by a certifying board which is a member of the American Board of Medical Specialties, recognized by the American Osteopathic Association, or recognized by the American Board of Podiatric Medicine, in the specialty that the Practitioner has chosen to primarily practice in or shall have completed all of the residency or other specialized training required for admission to the examination of such a certifying board and shall have an active application for certification to include meeting any minimum years in practice requirements followed by certification within five years of the date of completion of residency or specialized training. When no qualifying certification exists in a Practitioner's primary specialty (i.e. Hospitalist, Immediate Care, etc.) current qualifying certification in the Practitioner's specialty of training most similar to the chosen specialty of practice shall be deemed acceptable.

- This qualification for current specialty board certification or being actively involved in seeking certification in the specialty that the Practitioner has chosen to primarily practice in may in unusual circumstances, involving a Practitioner who has extensive experience, qualifications and training, be waived by the Governing Body. Such waiver is reserved only for Practitioners of unusual quality and experience, shall be premised upon a favorable recommendation from the department chair of the department in which the Practitioner shall serve, and a three-fourths favorable recommendation from the MEC. Once board certified, all Practitioners are required to maintain current board status in their primary specialty or in their specialty of training most similar to the chosen specialty of practice.
- D. Each Applicant in connection with an application for appointment, reappointment or clinical privileges, must attest to freedom from physical or mental illness or incapacity that would in any way restrict his/her ability to care for patients. In accordance with Medical Staff policies and procedures, either the Governing Body, the Hospital Presidents, the VPMA, the MEC or the President of the Medical Staff may precondition appointment or reappointment, and granting or continued exercise of clinical privileges upon the Applicant undergoing mental or physical examinations and/or such test or tests as it may deem necessary at that time or any intervening time, to evaluate the Applicant's ability to provide high quality, safe care and supervision to his/her patients.
 - E. Each Applicant is required to submit and maintain on file at all times, current evidence of continued licensure, Drug Enforcement Agency (DEA) registration in the State of Wisconsin, and any other state in which the Applicant will prescribe medications (if applicable) and must hold current professional liability insurance in which coverage pertains to area of practice or profession and meets minimum requirements specified by the Wisconsin Department of Safety and Professional Services or for participation in the Wisconsin Injured Patients and Families Compensation Fund. This requirement may be satisfied by submitting copies of the Applicant's current licensure, DEA registration and insurance certificates each time these documents change, are renewed or are otherwise updated. Failure to do so may result in automatic suspension under the Fair Hearing Plan contained in these Bylaws. At a minimum, the Applicant shall provide copies his or her license at least every two years, DEA registration every three years and certificate of insurance annually or on such earlier dates as required pursuant to the reappointment process.
 - F. All Practitioners shall attest that they will not receive from or pay to another Practitioner, either directly or indirectly, any part of a fee for professional services.
 - G. Applicants must have a record that is free of current Medicare/Medicaid sanctions and not on the Office of the Inspector General's (OIG) list of excluded providers; are not excluded from participation in any federally funded health care program (i.e. not on the Office of the Inspector General's (OIG) list of excluded providers; free of Medicare/Medicaid sanctions). Each Practitioner appointed to the Medical Staff and each AHP granted clinical privileges or permission to provide patient

services shall provide written notice within five business days or sooner if so required by the Fair Hearing Plan, to the Hospital President or the VPMA of: (1) notice of investigation, revocation, limitation or suspension of his or her professional licensure; (2) any reprimand or other disciplinary action taken by any state or federal government agency; (3) the imposition of probation or any limitation of his or her practice by any state; (4) his or her voluntary or involuntary loss of Staff membership or loss or restriction of Privileges at any Campus or Affiliated Location or hospital or health care institution, whether temporary or permanent, including all suspensions; (5) the loss, cancellation or restriction of his or her professional liability coverage; (6) the revocation, suspension or voluntary relinquishment of his or her DEA number; (7) any notification by a quality improvement organization (e.g. Metastar) or a third-party payor reimbursement program concerning any utilization or quality of care review or any proposed intervention or sanctions imposed; (8) receipt of a quality inquiry letter, an initial sanction notice, notice of investigation or sanction, or the filing of criminal charges or felony conviction against him or her by any law enforcement agency or health regulatory agency of the United States, the State of Wisconsin, or any other state or political subdivision; (9) any felony conviction or pending criminal charge, and any findings by a governmental agency that the Practitioner or AHP has been found to have abused or neglected a child or patient, or has misappropriated a patient's property; (10) any proposed or actual exclusion from any federally-funded health care program, any notice to the individual or his or her representative of proposed or actual exclusion or any pending investigation of the individual from any federally-funded health care program, including Medicare and Medicaid; (11) receipt of notice of the filing of any suit against the Practitioner or submission of adversity to the Wisconsin Patients Compensation Fund alleging professional liability in connection with the treatment of any patient in or at a Campus; (12) settlement of any claim by payment from an insurance company (or by the Practitioner, AHP or any other party) or any other agreement that results in a release being given by a patient to the Practitioner or AHP relating to the treatment of any patient in or at a Campus; or (13) any circumstance(s) or change in circumstance(s), including, but not limited to health status, that would materially affect his or her ability to perform essential functions of the Medical Staff or to exercise the clinical privileges granted, or that may put patients or Campus or Affiliated Location staff at risk.

- H. As a condition of appointment to the Medical Staff or of the granting of any clinical privileges, all Applicants acknowledge they will participate in the organized health care arrangement (OHCA) composed of all clinically integrated settings in which patients receive services at the Campuses or Affiliated Locations (Ascension NEWI OHCA). As a condition of appointment or of the granting of any clinical privileges, all Applicants must follow the privacy practices of Ascension NEWI OHCA, as set forth in its notice of privacy practices, with respect to protected health information received through Ascension NEWI OHCA.
- I. Each Practitioner appointed to the Medical Staff and each AHP shall work collaboratively in a professional and collegial manner with other Medical Staff

Members, AHPs and Campus or Affiliated Location employees in the best interest of patient care. Each Practitioner and AHP will refrain from behavior or behaviors that undermine a culture of safety and that adversely affects patient care.

- J. Every application for staff appointment shall be signed by the Practitioner and shall contain the Practitioner's specific acknowledgement of every Medical Staff Member's obligations to:
1. provide continuous care and supervision of his/her patients and refrain from delegating the responsibility for diagnosis or care of hospitalized patients to an individual who is not qualified and privileged to undertake the responsibility and is not adequately supervised;
 2. abide by federal and state laws and regulations applicable to the practice of their profession;
 3. abide by the appropriate utilization of resources of the Campus or Affiliated Location and Ascension NEWI;
 4. abide by these Bylaws, rules and policies established by the MEC, or the Governing Body, including but not limited to Codes of Conduct, Corporate Compliance Plans and Conflict of Interest Policies;
 5. maintain an ethical practice;
 6. abide by ethical principles and the ERD's (Ethical and Religious Directives for Catholic Healthcare Services);
 7. accept committee and consultation assignments;
 8. agree to participate in providing specialty care coverage for the emergency department and other special care units of the Campus or Affiliated Location designated by the Practitioner as his/her primary site appropriate to the Practitioner's credentials and status, except as otherwise determined by the MEC; and
 9. agree to participate in education of patients and families and the coordination of care, treatment and services with other Practitioners and Campus or Affiliated Location personnel.
- K. The Governing Body shall solely determine whether to approve or deny appointment of any Practitioner based on limitations of Campuses or Affiliated Locations, services, equipment, staff, support capabilities or any combination of these. The Governing Body also may decide not to appoint or reappoint or grant privileges to a Practitioner in accord with criteria of a Medical Staff development plan or existence of pre-existing contracts for provision of clinical services, whether exclusive or not, with other Practitioners, or for other reasons, when consistent with the facility's purposes, needs and capabilities, or to community need.

- L. Appointments to the Medical Staff shall confer on the Practitioner only such clinical privileges as have been granted by the Governing Body upon recommendation by the MEC, in accordance with these Bylaws. A Practitioner shall designate a Campus or Affiliated Location which is the primary site for the majority of his/her hospital practice, or where the majority of his/her patients are cared for.
- M. Practitioners employed by Ascension NEWI, either full or part time, whose duties are medico-administrative in nature and include clinical responsibilities or functions with the Medical Staff involving their professional capacity as licensed Practitioners, must be appointed to the Medical Staff. They must achieve this status by the same procedure provided other Practitioners as defined in these Bylaws. Their staff appointment and granting of clinical privileges, if any, may or may not be made contingent on their continued administrative functions as provided in their contract.

Section 4. Leave of Absence.

Any Practitioner who will be absent for three months or more must apply for and receive leave of absence status from the Medical Staff prior to his or her leave, in accordance with Medical Staff policy, provided, however, that in extenuating circumstances such request may be made after the leave has commenced (e.g. military activation or sudden health condition). A Practitioner who is ready to return from leave of absence must submit a written request for reinstatement to the MEC and supply such other information as may be requested before the request is processed in accordance with Medical Staff policy.

ARTICLE IV. CATEGORIES OF THE MEDICAL STAFF

Section 1. Criteria.

The category of the Medical Staff assigned to each Member at the time of initial appointment and reappointment is based upon the request of the Practitioner, the review and recommendation of the department chair and the approval of the MEC. Eligibility criteria for each staff category are determined by patient “contacts” available to the department chair for assessment of continuing competence. (refer to Article I. G). If the Applicant/Member is ineligible for the requested category as determined by the MEC upon recommendation of the department chair, the Practitioner will be notified and asked to request an alternative category or supply additional information to support the original request. Some assessable clinical activity is required to maintain membership in a Medical Staff category that is eligible for clinical privileges (does not apply to Associate, Honorary and Administrative categories, as they are not eligible for clinical privileges).

Section 2. Change in Category.

The Member’s Medical Staff category may change:

- A. At the time of reappointment upon request of the Practitioner, recommendation of the department chair and approval of the MEC or automatically based upon criteria detailed below.

- B. Upon completion of provisional period evaluation, recommendation of the department chair, and approval of the MEC.

Section 3. Active Medical Staff.

The Active Medical Staff shall consist of those Practitioners who regularly admit patients or regularly provide services to more than 20 patient Contacts within a two-year period, have the ability to be at their designated Campus(es) within 30 minutes of being requested to provide continuous and proper supervision of patient care to their patients, and who assume all the functions and responsibilities of appointment to the Active Medical Staff including, where appropriate, service on Medical Staff and departmental committees, specialty care coverage for the emergency department and consultation assignments. If a Practitioner has fewer than 20 contacts within a two-year period, he/she shall automatically move to Courtesy Medical Staff status.

Members of the Active Medical Staff shall be appointed to a specific department, shall be required to pay Medical Staff dues, and shall be eligible to vote and to hold office. Members of the Active Medical Staff also shall promote the quality of medical care in their designated Campus(es) or Affiliated Location(s), offer sound counsel to the VPMA's and the Governing Body and participate in the internal governance of the Medical Staff according to these Bylaws. The Members of the Active Medical Staff shall, within their scope of Privileges, provide emergency care to patients without regard to source of payment or ability to pay.

Section 4. Courtesy Medical Staff.

The Courtesy Medical Staff shall consist of Practitioners qualified for staff appointment but who have no more than 20 patient Contacts or surgical procedures in any two-year period. If a Practitioner regularly admits patients and regularly provides services to more than 20 patient Contacts within a two-year period, the Practitioner shall automatically advance to Active Medical Staff status. Courtesy Medical Staff Members, except dentists and podiatrists, must be an active staff member in good standing of at least one other hospital where they actively participate in a patient care audit program or other quality assessment and improvement activities similar to those required of Active Medical Staff Members. This requirement may be waived for Practitioners practicing primarily in the clinic setting who wish to work cooperatively with hospital-based Practitioners in the care of their patients. It is the responsibility of the Medical Staff member to provide case logs from their primary hospital to verify their patient contacts or to provide a letter from their primary hospital's credentialing committee stating the Medical Staff member is in good standing and does not have any quality concerns at the facility. Courtesy Medical Staff Members shall be appointed to a specific department, accept the same responsibilities as an Active Staff Member unless deemed exempt by the MEC, and be required to pay Medical Staff dues. Courtesy Medical Staff shall not be eligible to vote or hold office. Courtesy Medical Staff Members who have had no patient Contacts may be deemed ineligible for reappointment, without right to hearing or appeal under the Fair Hearing Plan.

Section 5. Consulting Medical Staff.

The Consulting Medical Staff shall consist of Practitioners who are qualified for Medical Staff appointment but care for patients on a consultation basis only. Members of the Consulting Medical Staff shall not have admitting Privileges, but may participate in the care of a patient in conjunction with Active or Courtesy Member of the Medical Staff. Consulting Medical Staff Members, except dentists and podiatrists, must be Active Staff Members in good standing of at least one other hospital where they participate in a patient care audit program or other quality assessment and improvement activities similar to those required of Active Staff Members. This requirement may be waived for Practitioners practicing primarily in the clinic setting who wish to work cooperatively with hospital-based Practitioners in the care of their patients. Consulting Medical Staff Members shall be appointed to a specific department, accept the same responsibilities as an Active Staff Member upon request by the MEC and be required to pay Medical Staff dues. Consulting Staff Members shall not be eligible to vote or hold office. Consulting Medical Staff Members who have had no patient Contacts may be deemed ineligible for reappointment, without right to hearing or appeal under the Fair Hearing Plan.

Section 6. Honorary Medical Staff.

The Honorary Medical Staff shall consist of Practitioners who are not active at any Campus or Affiliated Location or who are honored by emeritus positions. They may be Medical Staff Members who have retired from active practice or who are of outstanding reputation, not necessarily residing in the community. Honorary Staff Members shall not be eligible to admit or attend to patients, to vote, or to hold office, and shall not be required to pay Medical Staff dues. Honorary Staff Members may serve on standing Medical Staff committees if requested by the MEC.

Section 7. Administrative Medical Staff.

The Administrative Medical Staff shall consist of Practitioners who are qualified for Medical Staff appointment but whose primary duties are medico-administrative in nature. Members of the Administrative Medical Staff shall devote no more than 25% of their time to patient care and shall automatically advance to Active Medical Staff status if patient care services rise above this threshold. Removal of Members of the administrative Medical Staff shall be pursuant to Article XIX of these Bylaws.

ARTICLE V. ALLIED HEALTH PROFESSIONALS

Section 1. General.

AHPs are those individuals who, although not eligible for Medical Staff membership, may be permitted to participate in patient care within defined limits as further established by Medical Staff policy. Only AHPs who document their background, training, experience, ability to work with others, and health status, with sufficient competence to demonstrate that any patient treated by them will receive high quality, safe, professional care, and that they are qualified to provide a needed service within Ascension NEWI Health System, shall be eligible to provide specified services.

Although AHPs may be employees of Ascension NEWI, they are not eligible for Medical Staff membership and have no recourse to the procedures provided in the Fair Hearing Plan. AHPs shall be subject to the review and appeal procedures of Section 4 of this Article. No AHP shall re-delegate a task delegated to him or her by a physician, and physicians shall have ultimate responsibility for patient care provided by the AHPs. All AHPs shall abide by all Campus or Affiliated Location and Medical Staff Bylaws, and policies, including those concerning the handling of confidential information and the ethical principles. The Governing Body retains the right, upon recommendation of the MEC, to suspend or terminate any or all of the Privileges or functions of any category of AHP.

AHPs shall be divided into two categories:

- A. Independent AHP.
- B. Dependent AHP.

Section 2. Independent AHPs.

- A. Independent AHPs shall consist of the following persons:
 - 1. Individuals with a doctorate degree in psychology from an accredited college or university and licensed by the Wisconsin Psychology Examining Board;
 - 2. Nurse-midwives licensed by the Wisconsin Board of Nursing;
 - 3. Advanced Practice Nurse Prescribers registered and licensed by the Wisconsin Board of Nursing;
 - 4. Registered Nurses who have graduated from an approved nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Education Program/Schools, or its predecessor, and have been certified as Certified Nurse Anesthetists (CRNAs) by the Council on Certification of Nurse Anesthetists, or its predecessor.
- B. Applications for clinical privileges as an independent AHP shall be processed in accordance with the procedures set forth in Article VI of these Bylaws, although approval shall not result in membership on the Medical Staff. Each independent AHP shall annually provide and maintain on file at all times evidence of professional liability insurance coverage. An individual applying for appointment as an independent AHP must be recommended to the MEC and continuously sponsored by a Member of the Medical Staff familiar with the AHP's field of expertise and the department chair of the department in which the independent AHP will serve.

- C. Independent AHPs shall exercise independent judgment in their areas of competence and participate directly in the management and care of patients within the scope of their license or certification, all applicable state and federal laws and Medical Staff policies.
- D. An independent AHP must work in collaboration with a Member of the Active Medical Staff in the same department and have been granted Privileges by that department.
- E. Independent AHPs may be required to attend meetings involving the clinical review of patient care in which they participated.
- F. Each independent AHP providing services shall undergo an annual performance review which will consist of competency evaluations completed by the collaborating physician. Biennial review of these evaluations will be performed in accordance with Medical Staff policy.

Section 3. Dependent AHPs.

- A. This category of AHP shall consist of (1) Physician Assistants, (2) Certified Nurse Practitioners (3) Certified Neurophysiologic InterOperative Monitoring Tech, (4) Neurophysiologist, (5) Optometrist, (6) Rehabilitation Psychologist, (7) Psychologists with less than Ph.D. degree status and/or without a clinical psychologist's license from the Wisconsin Department of Safety and Professional Services, Dependent AHPs shall practice solely within the scope of their license or certification and applicable state and federal laws. They may not independently admit or care for patients and must always be under the supervision of an appropriate Medical Staff department or a Practitioner who has been accorded Privileges to provide such care at the Campus or Affiliated Location designated by the dependent AHP. The employer of the individual who is seeking approval as a dependent AHP shall apply for specified services and clinical privileges in the manner determined by the MEC. The application must state the clinical duties and responsibilities requested for that individual. The employer of the dependent AHP shall assume full responsibility and be fully accountable for the conduct of that individual within a Campus or Affiliated Location. It is the further responsibility of the employer of the dependent AHP to acquaint said individual with the applicable policies of the Medical Staff and the Campus or Affiliated Location, as well as appropriate Medical Staff Members and Campus or Affiliated Location personnel with whom that individual shall have contact at the Campus or Affiliated Location. The employer shall furnish evidence of professional liability insurance coverage for such individuals.
- B. The clinical duties and responsibilities of the dependent AHP within a Campus or Affiliated Location shall terminate: (1) if the Medical Staff appointment of the employer is terminated for any reason; (2) if the employer's clinical privileges are curtailed to the extent that the professional services of the dependent AHP within the Campus or Affiliated Location are no longer necessary or permissible to assist

the employer; (3) if the employment relationship ceases; (4) if the employer's contract with the Campus or Affiliated Location is terminated; (5) at the discretion of the Hospital Presidents; or (6) by a majority vote of the MEC or the Governing Body.

- C. If the employer of the dependent AHP is not a Member of the Medical Staff, the clinical duties and responsibilities of the dependent AHP within the Campus or Affiliated Location shall terminate: (1) if there is no Member of the Medical Staff who is willing or able to provide the required supervision and direction to the dependent AHP; (2) if the Hospital Presidents do not approve the designation of one or more Members of the Medical Staff as supervising Practitioner; (3) if any agreements between the employer and Calumet Medical Center, Mercy Medical Center, St. Elizabeth Hospital Surgery Center, St. Elizabeth Hospital or Ascension NEWI Health System are amended or terminated so that the services of the dependent AHP are no longer needed or permitted; (4) at the discretion of the Hospital Presidents; or (5) by a majority vote of the MEC or the Governing Body.
- D. Each dependent AHP providing services shall undergo an annual performance review which will consist of competency evaluations completed by the supervising Practitioner. Biennial review of these evaluations will be performed in accordance with Medical Staff policy.

Section 4. Termination of AHP Status and/or Privileges.

An AHP whose application for clinical privileges is denied or terminated shall be entitled to have such action reviewed by an ad hoc committee duly appointed by the MEC. The AHP shall be given written notice of the date, time and place of such review along with the reasons for such action. At any review meeting, the AHP has the right to appear before the committee and present evidence refuting the action. Within a reasonable time after adjournment of the review, the committee will issue a written decision indicating whether it agrees with the privilege action. If the decision is in disagreement with the action, the matter will be referred to the MEC for its consideration and recommendation. The recommendation of the MEC shall be forwarded to the Governing Body for final action. If the decision is in agreement with the action, the AHP may appeal to the Governing Body or its designee, which shall have the sole authority to decide the status of the AHP's Privileges.

ARTICLE VI. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Application for Appointment and Reappointment.

- A. Practitioners desiring appointment or reappointment to the Medical Staff, except the honorary Medical Staff, Practitioners applying for any clinical privileges without Medical Staff membership (including Practitioners who provide care, treatment or services solely via telemedicine), and individuals applying as independent or dependent AHPs shall obtain the appropriate application and Privileges request forms from Medical Staff Services, which will supply Applicants with the forms along with a copy of these Bylaws and the Ethical and Religious Directives. A separate

credentials file shall be maintained for each Applicant requesting Medical Staff membership or clinical privileges.

- B. All applications for appointment or reappointment to the Medical Staff for clinical privileges only or as an independent AHP shall be presented in writing on a form approved by the MEC and shall be signed by the Applicant. The application shall include, but not be limited to, the following detailed information and certifications concerning the Applicant's professional qualifications and experience:
1. Personal Information. The Applicant's name, current home and office addresses and telephone numbers.
 2. Qualifications. Detailed information concerning the Applicant's qualifications including:
 - a. Copies of currently valid medical, dental, podiatric or other applicable licenses;
 - b. If the Applicant's practice will involve the prescription of controlled substances, a copy of his/her current unrestricted DEA registration to prescribe controlled substance in the State of Wisconsin (and in any other state where the Applicant prescribes controlled substances)²;
 - c. Information regarding ECFMG, Medicare and Medicaid and other certifications, as applicable;
 - d. Information concerning professional education and postgraduate training including the name of each institution, copies of degrees or certifications granted, program completed, and dates attended;
 - e. Copies of specialty and sub-specialty board certification and recertification;
 - f. Information and documentation pertaining to continuing education (as deemed necessary by the MEC); and
 - g. Information and documentation pertaining to all hospitals or other health care organizations where the Applicant has/had clinical privileges.
 3. Professional Liability Insurance. Information concerning the Applicant's professional liability insurance coverage including:
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- a. A statement that the Applicant carries at least the minimum amount of professional liability insurance as set forth in the Wisconsin Statutes or determined by the MEC;
 - b. Information as to whether any legal actions of any type, including Patients Compensation Panel Proceedings, have been initiated against the Applicant or are currently pending, whether any judgments have been entered against the Applicant or settlements made in cases involving the Applicant's care of patients;
 - c. The names and addresses of the Applicant's present and past professional liability insurance carriers (including any carrier who has denied, refused to renew, limited or canceled professional liability coverage or had coverage rated up because of unusual risk or notified Applicant of intent to do so); and
 - d. The Applicant's signature on any necessary consent forms to obtain the Applicant's professional liability claims record.
4. National Practitioner Data Bank. Information obtained through a query of the National Practitioner Data Bank/Proactive Disclosure Services (PDS) by the hospitals.
 5. Professional Sanctions. Information as to whether any of the following have at any time ever been, or are currently in the process of being, investigated, denied, revoked, suspended, reduced, not renewed, voluntarily or involuntarily³ relinquished, subjected to probationary conditions or subjected to any other disciplinary action:
 - a. Staff appointment, status or clinical privileges at any hospitals, clinic, or other health care entity;
 - b. Membership/fellowship in any local, state or national medical or dental professional organizations;
 - c. Specialty board certification/eligibility;
 - d. DEA registration or other controlled substances number;
 - e. License to practice any profession in any state;
 - f. Eligibility to participate in any federal or state health care program, including but not limited to, Medicare or Medicaid; or
 - g. Any state driver's license.
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If any of such actions ever occurred or are pending, an explanation thereof shall be included in the application.

6. **Work History and Experience.** Information regarding the Applicant's work history and experience including:
 - a. The names and addresses of all health care organizations/facilities that have practice information/work history for the Applicant and the dates of the Applicant's association; and
 - b. The names and addresses of all hospitals, clinics or other health entities where the Applicant provides or has provided clinical services, with the dates of all such affiliations.
7. **Peer Recommendations.** Upon initial appointment, the names of at least two professionals in the same discipline who have recently worked extensively with the Applicant and have directly observed his or her professional performance over a reasonable period of time and who can and will provide references. At least one such peer must be from the Applicant's most recent clinical appointment. Upon reappointment, the name of at least one professional in the same discipline who has recently worked extensively with the Applicant and has directly observed his or her professional performance over a reasonable period of time and will provide a reference. All peers providing references must be familiar with the Applicant's clinical performance in the last five years.
8. **Health Status.** A statement of the Applicant's ability to perform the essential functions of the Medical Staff or AHP staff, including a statement that no health_status problems exist that could affect his/her ability to perform the requested Privileges, including detailed information concerning the Applicant's physical and mental health status, as requested by the Credentialing policy and in accordance with all applicable laws, including, but not limited to the American with Disabilities Act.
9. **Criminal Charges and Convictions.** A fully completed Background Information Disclosure form, along with information as to any criminal convictions, current federal, state or municipal ordinance violations, pending criminal charges or any past criminal convictions, including their resolution, or any findings by a governmental agency that the Applicant has been found to have abused or neglected a child or patient has misappropriated the property of a patient. The Applicant also must cooperate in providing any additional information required to comply with the requirements of Chapter HFS 12 of the Wisconsin Administrative Code.
10. **Privilege Requests.** Requests stating the clinical privileges for which the Applicant wishes to be considered, designating each Campus or Affiliated Location where the Applicant seeks to exercise particular clinical privileges

(subject to the prior determination that the Campus or Affiliated Location allows the privilege to be performed on it pursuant to Article VII, Section 1.F) and identifying the primary Campus or Affiliated Location where the Applicant will practice.

- E. The application shall authorize Medical Staff Services to contact the Applicant's current and past professional liability carrier for information concerning the Applicant's type and extent of coverage, any change in the Applicant's professional liability coverage, and any actions entered, settled or pending against the Applicant.
- F. The Applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, ability to work with other health care professionals, character, health status (which may necessitate a medical evaluation performed by an internal or external source and may be requested by the MEC), ethics and other qualifications, and for resolving any doubts about such qualifications. Failure to provide information requested (or refusal to submit to a requested evaluation), in writing via special notice, by the Credentials Committee, MEC or Governing Body within 30 days of such a request shall be deemed a withdrawal of the application and a new application form must be completed and submitted to MSS if the Applicant wishes to apply for appointment or for clinical privileges.
- G. The Applicant shall attest to the correctness and completeness of all information contained in the application and acknowledge that a failure to adequately complete the application form, the withholding of requested information or a misrepresentation or misstatement in, or omission from the application, whether intentional or not, shall be a basis for automatic denial of appointment or re-appointment and clinical privileges or for summary dismissal from the Medical Staff, revocation of clinical privileges or denial of service or termination of service as an independent or dependent AHP.
- H. By applying for appointment to the Medical Staff or for clinical privileges, each Applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application, authorizes Ascension NEWI to consult with members of Medical Staffs of other hospitals and institutions with which the Applicant has been associated or with prior employers, professional review service organizations ("PRSO") and with others who may have information bearing on his/her competence, practice patterns and appropriate utilization of facility resources, character and ethical qualifications; consents to the inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, including, but not limited to Applicant-specific practice and morbidity and mortality data (when available) as well as of his/her moral and ethical qualifications for Medical Staff appointment; and consents to the verification of any and all information provided by the Applicant.

The Applicant shall release from any liability, to the fullest extent permitted by law, all representatives of Ascension NEWI and its Medical Staff for their acts performed in connection with evaluating the Applicant and his/her credentials and otherwise in connection with any review of, and disciplinary action related to, an Applicant's professional conduct or competence. The Applicant shall also release from any liability to the fullest extent permitted by law, all individuals and organizations who provide any information to Ascension NEWI concerning the Applicant's competence, ethics, character, professional conduct and other qualifications for Medical Staff appointment and clinical privileges, including otherwise privileged or confidential information.

The terms "Ascension NEWI" and "all representatives of Ascension NEWI and its Medical Staff" as used in this Section are intended to include the Governing Body, the Hospital Presidents, Chief Nursing Executive, the VPMAs, MSS and their authorized agents, employees and representatives, and all Members of the Medical Staff who have committee or other responsibility for collecting and/or evaluating the Applicant's credentials and/or acting upon his/her application. The term "character" is intended to include mental and emotional stability and capabilities.

- I. The application form shall include a statement that the Applicant has received and read the Bylaws of the Medical Staff and the Ethical and Religious Directives, and that he/she agrees to be bound by the terms of such Bylaws and ERDs, and any written Medical Staff policies, if he/she is granted appointment and/or clinical privileges and to be bound by the terms thereof without regard to whether or not he/she is granted appointment and/or clinical privileges in all matters relating to consideration of his/her application.
- J. The Applicant shall produce a current picture identification issued by a state or federal agency; so that Ascension NEWI may determine that the Applicant is the same as that identified in the credentialing documents.
- K. The application shall be submitted to MSS for processing as per Medical Staff policy. If MSS determines that the application is not complete, it shall notify the Applicant regarding the information required to complete the application. If the necessary information is not returned to MSS within 45 days of the initial request, the application shall be considered withdrawn and a new application form must be completed and submitted to MSS if the Applicant again wishes to apply for appointment to the Medical Staff or as an AHP. Within ten days after collecting the references and other materials deemed pertinent, and the information required under Section 425 of the Act and regulations, if any, MSS shall forward each application for appointment, together with all supporting materials, to the department chair or his/her designee for review.

Administrative Denial. Medical Staff Services may, upon the approval of the President of the Medical Staff, President-Elect, or VPMAs, deny an application for appointment or reappointment to the Medical Staff or for clinical privileges without further review, if it determines any of the following about the Applicant: (1) he/she does not hold a valid

Wisconsin license and no application is pending; (2) he/she does not have adequate professional liability insurance; (3) he/she is subject to current Medicare/Medicaid sanctions and/or is on the Office of the Inspector General's (OIG) list of excluded providers; is excluded from participation in any federally funded health care program (i.e. on the Office of the Inspector General's (OIG) list of excluded providers; subject to Medicare/Medicaid sanctions) (4) he/she is barred from providing services under Chapter HFS 12 of the Wisconsin Administrative Code; or (5) he/she has only requested clinical privileges that have been exclusively granted to another Practitioner, group of Practitioners or AHP, which contract has been reviewed by the MEC, who provided recommendation to the Governing Body for consideration and covers all the clinical privileges being requested by the Applicant. Applicants who are administratively denied under this Article VI, Section 2 do not have a right to hearing or appeal under the Fair Hearing Plan, but may submit evidence to MSS to refute the basis for the administrative denial.

Section 2. Expedited Appointment Process.

A. Track one applications:

1. Track one applications for initial appointment shall be processed consistent with Medical Staff policy.
2. The track one approval process shall be as follows:
 - a. MSS shall process the completed application and forward it to the appropriate department chair.
 - b. The department chair or vice chair and the Credentials Committee chair shall review the application and forward a recommendation to the MEC. The Credentials Committee will assess the Applicant's competence in six core areas:
 - i. Patient care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
 - ii. Medical/Clinical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
 - iii. Patient-based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
 - iv. Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication

skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

- v. Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and responsible attitude toward their patients, their profession, and society.
- vi. System-based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.
- c. The MEC shall forward its recommendation to the Governing Body's expedited credentialing subcommittee for approval.
- d. In any instance when the department chair, the Credentials Committee chair, the VPMA's and/or the MEC disagree or issue an unfavorable recommendation, the application shall become a track two application.
- e. The expedited credentialing subcommittee shall make a written report to the Governing Body at its next regularly scheduled meeting.
- f. After receipt of a recommendation, the Governing Body or its duly authorized committee shall act on the matter pursuant to Article VIII. If the Governing Body's decision is adverse to a Practitioner with respect to either appointment or clinical privileges, the Hospital President or VPMA shall promptly notify the Practitioner of such adverse decision by Special notice which shall include reason for denial and available due process, and such adverse decision shall be deferred until the Practitioner has exercised or has been deemed to have waived his/her rights under the Fair Hearing Plan. If the decision is adverse to an AHP, the process set forth in Article V, Section 4, will be followed. The fact that the adverse decision is deferred shall not be deemed to confer Privileges where none existed before.
- g. At its next regularly scheduled meeting after all the Practitioner's rights under the Fair Hearing Plan have been exhausted or waived, the Governing Body or its duly authorized committee shall act in the matter pursuant to Article VIII. The Governing Body's decision shall be final on all parties involved.

- h. When the Governing Body's decision is final, it shall send notice of such decision through the Hospital President, to the chair of the MEC, to the chair of the department concerned, to the VPMA, to MSS by special notice, to the Applicant.

B. Track two applications:

- 1. Track two applications for initial appointment are processed in the traditional manner pursuant to Section 4 of this Article VI.

Section 3. Appointment Process.

- A. Applications for appointment and for clinical privileges shall be processed consistent with Medical Staff policy. Every department chair or designee in whose department the Applicant seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for the clinical privileges requested.
- B. Applicants shall designate which Campus or Affiliated Location will be the primary site for the majority of his or her practice, as appropriate. This designation shall be made at the time of, and noted on applications for appointment or reappointment to the Medical Staff and, for AHPs and Practitioners not seeking Medical Staff membership, in connection with the application for clinical privileges.
- C. The Credentials Committee shall examine the evidence of the character, ability to work with other health care professionals, current professional competence, qualifications, practice patterns, health status, professional sanctions, and ethical standing of the Applicant and shall determine, through information contained in references given by the Applicant and from other sources available to the committee, including an appraisal from the clinical department chair in which Privileges are sought, whether the Applicant has established and meets all of the necessary qualifications for the category of staff appointment requested or as an independent AHP, and whether the Applicant meets all the necessary requirements for the clinical privileges requested. As part of its examination, the Credentials Committee shall assess the Applicant's competence in six core areas:
 - 1. Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
 - 2. Medical/Clinical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
 - 3. Patient-based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

4. **Interpersonal and Communication Skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
5. **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and responsible attitude toward their patients, their profession, and society.
6. **System-based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

The Credentials Committee shall make a recommendation that the Applicant be provisionally appointed and/or granted clinical privileges, that his/her application be denied, or that his/her application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may, where appropriate, be qualified by probationary conditions. The Credentials Committee's recommendations shall be forwarded to the MEC.

- D. At its next regular meeting after receipt of the application and recommendation of the Credentials Committee, the MEC shall consider whether to recommend to the Governing Body that the Applicant be provisionally appointed to the staff or granted the requested clinical privileges, that his/her application be denied, or that his/her application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.
1. When the recommendation of the MEC is to defer the application for further consideration, it must be followed up within 45 days with a subsequent recommendation for provisional appointment with specified clinical privileges or for granting of the requested clinical privileges, or for denial. A recommendation to defer an application need not be forwarded to the Governing Body until the subsequent recommendation has been received by the MEC.
 2. When the recommendation of the MEC is favorable to the Applicant, it shall be promptly forwarded to the Governing Body.
 3. When the recommendation of the MEC is adverse to a Practitioner either in respect to appointment or clinical privileges, the Hospital President or VPMA shall promptly so notify the Practitioner by special notice which shall include reason for denial and available due process. Such adverse recommendation may be forwarded to the Governing Body and MSS either

prior to and/or after the Practitioner has exercised or has been deemed to have waived his/her right to a hearing as provided in the Fair Hearing Plan.

4. An AHP Applicant shall not be entitled to appellate review by the Governing Body or any of the rights or procedures set forth in the Fair Hearing Plan, but shall be governed solely by the procedures of Section 4 of this Article VI.
- E. At its next regular meeting after receipt of a favorable recommendation that was not the result of a hearing as provided in the Fair Hearing Plan, the Governing Body or its duly authorized committee shall act on the matter pursuant to Article VIII. If the Governing Body's decision is adverse to a Practitioner with respect to either appointment or clinical privileges, the Hospital President or VPMA shall promptly notify the Practitioner of such adverse decision by special notice which shall include reason for denial and available due process. Such adverse decision shall be deferred until the Practitioner has exercised or has been deemed to have waived his/her right to a hearing and appellate review by the Governing Body under the Fair Hearing Plan. If the decision is adverse to an AHP, the process set forth in Article V, Section 4 will be followed. The fact that the adverse decision is deferred shall not be deemed to confer Privileges where none existed before.
- F. At its next regular meeting after all the Practitioner's rights under the Fair Hearing Plan have been exhausted or waived, the Governing Body or its duly authorized committee shall act in the matter pursuant to Article VIII. The Governing Body's decision shall be final on all parties involved.
- G. When the Governing Body's decision is final, it shall send notice of such decision through the Hospital President, to the chair of the MEC, to the chair of the department concerned, to the VPMA, to MSS, and by special notice, to the Applicant.
- H. Initial appointments shall in all cases be for a period not to exceed two (2) years.
- I. Ascension NEWI will provide an orientation for approved Applicants as per Medical Staff policy.

Section 4. Reappointment Process.

- A. Applications for reappointment shall be processed consistent with Medical Staff policy. The chair or vice chair of each clinical department shall review for each Practitioner and AHP scheduled for periodic appraisal for reappointment and/or continued clinical privileges all pertinent information available concerning the individual, including any application forms prescribed by the policy for this process, for the purpose of determining his/her recommendations for reappointments, and for the granting of clinical privileges for the ensuing period, and shall transmit his/her recommendations on Medical Staff Members and AHPs, in writing, to the Credentials Committee. MSS may establish a procedure by which the reappointment process is staggered so that groups of Practitioners are subject to

reappointment at regularly established intervals, provided however that in no event shall the period between reappointments for each Practitioner exceed two (2) years.) Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented. Thereafter, the procedures outlined in Section 4 of this Article VI relating to applications on initial appointments shall apply.

- B. Each recommendation concerning reappointment of Medical Staff Members and clinical privileges to be granted upon reappointment and for clinical privileges for independent AHPs and Practitioners who are not Members shall be based upon such individual's current professional competence and clinical performance, including his/her patterns of practice, based at least in part on the findings of quality assurance measures such as medical audits, utilization review, medical record review, peer review, infection control activities, tissue review, Practitioner specific data as compared to aggregate data, (when insufficient Practitioner-specific data are available, peer references shall be obtained and evaluated),⁴ morbidity and mortality data, and pharmacy and therapeutics activities; current Privileges and the basis for any requested modifications; core privilege or special privilege ongoing requirements; current health status; current liability insurance coverage and any filed, settled or pending professional liability claims or actions; current and past professional sanctions, participation in relevant continuing educational programs; timely completion of medical records; attendance at Medical Staff, department and committee meetings; participation in staff affairs; compliance with the Medical Staff Bylaws and policies; compliance with the Ethical and Religious Directives for Catholic Healthcare Services; use of the Campuses or Affiliated Locations for his/her patients; cooperation and relations with other Practitioners and Campus or Affiliated Location personnel; the information required under Section 425 of the Act, and regulations, if any, issued there under; and any other information the credentials or MEC deems necessary and appropriate for a proper evaluation of a Practitioner's or AHP's continued status and clinical privileges.
- C. If the reappointment process has not been fully completed by the end of the current two-year period, Applicants who have applied for reappointment or continued clinical privileges shall maintain their former status until the process is completed unless: (1) a recommendation is made to deny reappointment and/or continued clinical privileges, (2) corrective action is taken which alters such status, or (3) the delay is due to the Applicant's failure to timely submit a reappointment application form. In these instances, the Applicant's appointment and/or clinical privileges will end at the expiration of the current term. Where the appointment is temporarily extended to complete processing, such temporary extension of appointment and/or continued clinical privileges shall not create a right for automatic reappointment and/or continued clinical privileges for the subsequent term.

Section 5. Reapplication after Adverse Action.

- A. A Practitioner who has received a final adverse action regarding appointment or clinical privileges or both and who did not exercise any of the hearing rights provided in the Fair Hearing Plan shall not be eligible to reapply for the membership status or Privileges that were the subject of the adverse action for a period of six months from the date of final adverse action or until he/she completes training identified by the Medical Staff as a prerequisite for the Privileges, whichever is longer.
- B. A Practitioner who has received a final adverse action regarding appointment or clinical privileges or both and who exercised some or all of the hearing rights provided in the Fair Hearing Plan shall not be eligible to reapply for the membership status or clinical privileges that were the subject of the adverse action for a period of two years from the date of final adverse action.
- C. Any reapplication under this Section shall be processed as an initial application, but the Practitioner shall submit additional information as the Medical Staff or Governing Body may require in demonstration that the basis for the earlier adverse action no longer exists.
- D. If the recommendation of the Medical Staff or the action proposed by the Governing Body upon reapplication under this Section continues to be adverse, the scope of the hearing to which the Practitioner is entitled shall be limited to consideration of the sufficiency of the additional information submitted in demonstration that the basis for the earlier adverse action no longer exists.

ARTICLE VII. CLINICAL PRIVILEGES

Section 1. Clinical privileges In General.

- A. Every Practitioner or AHP shall be entitled to exercise only those clinical privileges specifically granted by the MEC and approved by the Governing Body except as provided in Sections 2, 3 and 6 of this Article VII. Clinical privileges shall be granted for a period not to exceed two years.
- B. Every application for staff appointment or reappointment or application for clinical privileges or continued clinical privileges shall contain a request for the specific clinical privileges desired by the Applicant. The evaluation of such requests shall be based upon the Applicant's education, licensure, training, experience, demonstrated and continuing competence, judgment, current health status and physical ability to perform the requested Privileges, references, other relevant information required in Article VI, Section 1.B such as, but not limited to, professional liability claims and actions, voluntary or

involuntary

limitation, reduction or loss of (1) any licensure or registration, (2) clinical privileges at any other hospital, and/or (3) Medical Staff status, and an appraisal by the clinical department in which such Privileges are sought. The Applicant shall have the burden of establishing his/her qualifications and continuing competence in the clinical privileges he/she requests. Information will be primary source verified as appropriate.

- C. Each Practitioner, excluding dentists, who applies for clinical privileges must be (1) currently Board certified, or (2) eligible or qualified for Board certification at the time of initial appointment and must become Board certified in his/her practice area within five years after completion of residency or specialized training. Certification required under this provision must be granted by a board recognized by the American Board of Medical Specialties, recognized by the American Osteopathic Association, or recognized by the American Board of Podiatric Medicine in the specialty that the Practitioner has chosen to primarily practice. Applicants must satisfy the minimum training and competency privileging requirements established by the appropriate clinical department and the Credentials Committee, and approved by the MEC. Applicants must maintain current board certification in their primary specialty or in their specialty of training most similar to the chosen specialty of practice.

This qualification for specialty board certification or being actively involved in seeking certification in the specialty that the Practitioner has chosen to primarily practice may in unusual circumstances involving a Practitioner who has extensive experience, qualifications and training, be waived by the Governing Body. Such waiver should be reserved only for Practitioners of unusual quality and experience, shall be premised upon a favorable recommendation from the department chair of the department in which the Practitioner shall serve, and three-fourths favorable recommendation from the MEC members present at the meeting where the Privileges are being recommended.

- D. Periodic re-determination of clinical privileges and the addition to or deletion from same shall

be based upon ongoing requirements for core Privileges or special Privileges, the direct observation of care provided, review of the records of patients treated in the facility or other

hospitals or facilities, and review of the records of the Medical Staff which document the

evaluation of the appointee's participation in the delivery of medical care. Applications for

additional clinical privileges must be in writing. To assure uniformity, applications shall

be submitted on a prescribed form on which the type of core clinical privileges or special Privileges desired are designated and the Applicant's relevant training and/or experience in

the two years prior must be stated. Such applications shall be processed in the same

manner

as applications for appointment or reappointment. Information regarding each Practitioner's

scope of Privileges shall be updated as changes in clinical privileges are made.

- E. Applications for Privileges or changes to existing Privileges will be acted upon in a timely manner and, except for good cause (including, but not limited to, delay on the part of the Applicant), each application is to be processed within 180 days from date of receipt by MSS of all information necessary to deem the application complete. This time period is deemed a guideline, not a requirement, and does not create any rights to have an application processed within this time period.⁵
- F. Privileges granted to dentists and podiatrists shall be based on their training, experience, ability to work with others, and demonstrated continuing competence and judgment. The scope and extent of surgical procedures that each dentist and podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical Privileges. Surgical procedures performed by podiatrists shall be under the overall supervision of the chair of the department of Surgery. Surgical procedures performed by dentists and oral surgeons shall be under the supervision of the chair of the department of Surgery. All patients admitted for inpatient dental or podiatric care shall receive the same admission physical examination and history as all other patients admitted to the facility. A physician appointee of the Medical Staff shall be responsible for the care of any medical/behavioral health/psychiatric problem that may be present at the time of such admission or presentation or that may arise during hospitalization.
- G. Standards for evaluating an Applicant's qualifications for the granting of clinical privileges shall be uniform among all Campuses or Affiliated Locations. However, subject to Governing Body approval, the MEC shall determine on a Campus-specific basis (not on an Applicant-specific basis) whether a particular clinical privilege is exercisable on the Campus or Affiliated Location due to differences in the physical setting. Factors to be considered in determining whether a clinical privilege can be exercised on a particular Campus or Affiliated Location include the physical facility, equipment, number and type of support staff and other resources at each Campus or Affiliated Location, as per Medical Staff policy.
- H. Information regarding each Practitioner's scope of Privileges shall be maintained by MSS and shall be updated upon the occurrence of any changes to the Practitioner's Privileges. Any decision to grant, deny, revise, or revoke a Practitioner's Privileges shall be disseminated and made available to all appropriate internal and external persons or entities. A copy of the scope of Privileges for each Practitioner granted Privileges shall be distributed to the appropriate Campus or Affiliated Location staff

through publication on the Ascension NEWI intranet system accessible to appropriate staff at the Campuses or Affiliated Locations.⁶

Section 2. Expedited Interim Privileges.

An Applicant for interim Privileges who is applying for appointment to the active, courtesy, consulting or administrative Medical Staff must have first submitted a complete application. The application will be submitted to the appropriate department chair or VPMA who will seek such recommendations from the department as are appropriate. If the application meets the requirements for a Track one application, interim clinical privileges may be granted by the President of the Medical Staff, the Hospital President or the VPMA with the recommendation of the chair or vice chair of the MEC and chair or vice chair of the department involved. Such Applicant shall be under the direct supervision of the relevant department chair. Interim Privileges shall be granted for a period not to exceed the earlier of 60 days or the date of the Governing Body's action on such Practitioner's application for appointment under Article VI, Section 2. A Practitioner granted interim Privileges will be assigned to the appropriate department as a provisional Member of the Active, Courtesy, or Consulting Medical Staff. Although interim Privileges may be granted, all applications for interim Privileges will be treated as an application for appointment under Article VI of these Bylaws. The fact that interim Privileges may have been granted will have no procedural effect on whether the application for appointment and full-term Privileges will be granted. Interim Privileges shall automatically terminate if the Applicant's application for Medical Staff appointment is withdrawn.

Section 3. Temporary/Locum Tenens Privileges.

- A. Temporary clinical privileges may be granted by the Hospital President (or his or her authorized designee) upon recommendation of the President of the Medical Staff after consultation with the VPMA, the President-elect of the Medical Staff and chair or vice chair of the department involved, for the care of a specific patient to a Practitioner who is not an Applicant for appointment when the specific patient's needs cannot be met by any Members of the Medical Staff. In urgent situations, evidence shall first be obtained and verified of current appropriate licensure, DEA certification, relevant training and experience, professional liability insurance, a peer reference, a report from the National Practitioner Data Bank, sanction screening, current or past professional sanctions, and his/her signed acknowledgment that he/she has received and read copies of the Medical Staff Bylaws and the Ethical and Religious Directives, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges and Medical Staff responsibilities. Temporary Privileges for new Applicants may be granted while awaiting review and approval by the organized Medical Staff upon verification of a track one application in accordance with Medical Staff policy. Such Practitioner shall be under the direct supervision of the relevant department chair. Temporary Privileges shall be granted for a period not to exceed 60 days. If all the

conditions for granting temporary Privileges are met, an initial grant of temporary Privileges may be extended for one additional period not to exceed 60 days.

- B. The President of the Medical Staff, the Hospital President or VPMA may permit a Practitioner serving as a locum tenens for a Member of the Medical Staff and thereby meeting an important patient care need to attend patients without applying for appointment to the Medical Staff for a period not to exceed 60 days, providing all of such Practitioner's credentials have been verified (including but not limited to a currently valid medical, dental, podiatric or other applicable license, a current DEA registration, information concerning professional liability insurance coverage, information regarding work history and experience, one professional reference, information concerning health status, criminal background information and sanction screening) and have first been approved by the departmental chair or vice chair concerned and the chair or vice chair of the MEC, and the Member engaging the locum tenens has filed a letter requesting temporary Privileges for the locum tenens, acknowledging responsibility for his/her actions and quality of practice. The locum tenens must sign an acknowledgment agreeing to be bound by these Medical Staff Bylaws and the Ethical and Religious Directives in all matters relating to his/her temporary Privileges.

Section 4. Termination of Interim/Temporary/Locum Tenens Privileges.

- A. Privileges granted pursuant to either Section 1, 2 or 3 of this Article VII may be subject to special requirements of supervision and reporting imposed by the Credentials Committee or relevant department chair. These Privileges may immediately be terminated by the President of the Medical Staff, the Hospital President or VPMA upon notice of any failure by the Practitioner to comply with such special conditions.
- B. The President of the Medical Staff, the Hospital President or VPMA may at any time, upon the recommendation of the chair or vice chair of either the MEC or of the relevant clinical department, terminate a Practitioner's interim or temporary Privileges effective as of the discharge from any facility of the Practitioner's patient(s) then under his/her care in the facility. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the Practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to the Fair Hearing Plan, and the same shall immediately be effective. The appropriate department chair or, in his/her absence, the chair of the MEC, shall assign a Member to the Medical Staff to assume responsibility for the care of such terminated Practitioner's patient(s) until they are discharged from the facility. The wishes of the patient(s) shall be considered where feasible in the selection of such substitute Practitioner.

- C. No Practitioner is entitled to interim or temporary Privileges as a matter of right. A Practitioner shall not be entitled to the procedural rights afforded by the Fair Hearing Plan because of his/her inability to obtain interim or temporary Privileges or because of any termination, modification or suspension of interim or temporary Privileges.

Section 5. Telemedicine Privileges.

The Medical Staff may utilize the privileging procedures set forth in this Section to review and act on the application for Medical Staff membership and Privileges received from an Applicant who wishes to provide patient care services from a distant site, on the condition that the services are to be provided pursuant to a written agreement between the Campus or Affiliated Location and the distant site, the Campus or Affiliated Location has made certain that the distant site's credentialing and privileging process at a minimum meet the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4), and the following requirements are met:

- A. Interpretive telemedicine Privileges: Practitioners based at distant sites whose practice at the facility will be limited to interpretive telemedicine only may apply for telemedicine Privileges, through one of the following mechanisms, as selected by the MEC either for the individual or for a designated class of Practitioners per policy decision of the MEC.

1. Submitting of the same application and information subject to the same credentialing and privileging process as is required of all other Practitioners applying for Medical Staff membership and clinical privileges; or
2. If the Practitioner will be providing the Interpretive Telemedicine services pursuant to a written contract where the services are under the control of a Joint Commission (JC)-accredited hospital or ambulatory care organization, the MEC and Governing Body may use the credentialing and privileging decision from the distant site to make a final privileging decision, if all of the following requirements are met:
 - a. the distant site is a JC accredited hospital or ambulatory care organization;
 - b. the Practitioner is in Good Standing on the distant site's Active Medical Staff and privileged at the distant site for those services to be provided at the Campus or Affiliated Location facility;
 - c. the distant site provides the Campus or Affiliated Location facility with a current list of the Practitioner's Privileges at the distant site;

- d. the Campus or Affiliated Location maintains documentation of, and undertakes, internal review of the Practitioner's performance of the Privileges granted at the Campus or Affiliated Location and sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement, at a minimum including information regarding all adverse outcomes related to sentinel events and complaints regarding the Practitioner received from patients, other Practitioners or staff at the Campus;
 - e. the Practitioner holds a license to practice independently that is issued or recognized by the State of Wisconsin; and
 - f. the Practitioner is not excluded or involved in a proceeding which may result in exclusion from any federally-funded health care program; or
3. If the Practitioner will be providing the interpretive telemedicine services pursuant to a written contract where the services are under the control of a Joint Commission (JC)-accredited organization, the MEC and Governing Body may use and rely on the credentialing information of the distant site for purposes of privileging the Practitioner, provided that the Practitioner holds a license to practice independently that is issued or recognized by the State of Wisconsin, is not excluded from any federally-funded Health Care Program, and provided that the Applicant submits a Medical Staff membership and Telemedicine Privileges application containing at least the following information (which shall be verified with either the distant JC-accredited site or a primary source):
- a. Medical staff status at distant site and scope of clinical privileges currently held;
 - b. Evidence of Wisconsin licensure;
 - c. Evidence of insurance meeting the requirements for Practitioners for Medical Staff membership;
 - d. Existence of any of the events or circumstances outlined in Article III, Section 3.G.;
 - e. Request for specific telemedicine Privileges desired; and
 - f. Acknowledgement that the Practitioner is subject to (i) Articles VI, VII and XVI of these Bylaws in all respects in connection with the application for or exercise of clinical privileges; and (ii) the conditions of appointment outlined in Article III, Section 3 of these Bylaws.

B. Interactive telemedicine Privileges: Practitioner based at distant sites requesting any form of interactive telemedicine Privileges may apply for Privileges through one of the following mechanisms as selected by the MEC either for the individual Practitioner or a designated class of Practitioners per policy decision of the MEC.

1. By Submitting of the same application and information, subject to the same credentialing and privileging process, as is required of all other Practitioners applying for Medical Staff membership and clinical privileges;

2. If the Practitioner will be providing the Interactive Telemedicine services pursuant to a written contract where the services are under the control of a Joint Commission (JC) - accredited hospital or ambulatory care organization, the MEC and Governing Body may use the credentialing and privileging decision from the distant site to make a final privileging decision, if all of the following requirements are met:

- a. the distant site is a JC accredited hospital or ambulatory care organization;
- b. the Practitioner is in Good Standing on the distant site's Active Medical Staff and privileged at the distant site for those services to be provided at the Campus or Affiliated Location facility;
- c. the distant site provides the Campus or Affiliated Location facility with a current list of the Practitioner's Privileges at the distant site;
- d. the Campus or Affiliated Location maintains documentation of, and undertakes, internal review of the Practitioner's performance of the Privileges granted at the Campus or Affiliated Location and sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement, at a minimum including information regarding all adverse outcomes related to sentinel events and complaints regarding the Practitioner received from patients, other Practitioners or staff at the Campus;
- e. the Practitioner holds a license to practice independently that is issued or recognized by the State of Wisconsin; and
- f. is not excluded or proposed to be excluded from any federally-funded health care program; or

3. If the Practitioner will be providing the Interactive Telemedicine services pursuant to a written contract where the services are under the control of a Joint Commission (JC)-accredited organization, the MEC and Governing Body may use and rely on the credentialing information of the distant site for purposes of privileging the Practitioner; provided that the Practitioner holds a license to practice independently that is issued or recognized by the State of Wisconsin, is not excluded or proposed to be excluded from any federally-funded health care program, and that the Applicant submits a Medical Staff membership and telemedicine Privileges application containing at least the following information (which information shall be verified with either the distant JC-accredited site), or a primary source):

- a. Medical staff status at distant site and scope of clinical privileges currently held;
 - b. Evidence of Wisconsin licensure;
 - c. Evidence of insurance meeting the requirements for Practitioners for Medical Staff membership;
 - d. Existence of any of the events or circumstances outlined in Article III, Section 3.G.;
 - e. Request for specific telemedicine Privileges desired; and
 - f. Acknowledgement that the Practitioner is subject to (i) Articles VI, VII and XVI of these Bylaws in all respects in connection with the application for or exercise of clinical privileges; and (ii) the conditions of appointment outlined in Article III, Section 3 of these Bylaws.
- C. In processing requests for clinical privileges, MSS may rely upon credentialing information obtained and verified in accord with JC standards by a JC-accredited distant site where the Practitioner currently holds Medical Staff membership or clinical privileges rather than directly obtaining primary source verification of the information supplied by the Practitioner.
- D. Practitioners with only telemedicine Privileges who also elect to apply for Medical Staff membership will be assigned to the consulting Medical Staff category.

Section 6. Emergency and Disaster Privileges.

A. Emergency Privileges.

1. In the case of emergency, any Practitioner, to the degree permitted by his/her license and regardless of staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, including calling for any consultation considered necessary or desirable, if no other Practitioner who is a Member of the Medical Staff is immediately available. When an emergency situation no longer exists, such Practitioner must request the Privileges necessary to continue to treat the patient. In the event such Privileges are denied or not requested, the patient shall be assigned to an appropriate Member of the Medical Staff. For the purposes of this Section, an “emergency” is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

B. Disaster Privileges (Non-Members/Volunteer Practitioners).

1. For the purpose of this Section, a “disaster” exists when a Campus or Affiliated Location implements its disaster plan and the Campus or Affiliated Location is unable to handle the immediate patient needs.
2. During a disaster and in the best interest of immediate patient care the “Personnel Tracking Manager, Planning Section,” under the AHS Incident Command system (which will generally be the Hospital President, VPMA, CMO, President of the Medical Staff or their designee) may, at their discretion, grant disaster Privileges on a case-by-case basis to volunteer Practitioners upon presentation of the following:
 - a. valid government-issued photo identification (i.e., drivers license or passport); and
 - b. At least one of the following:
 - i. A current picture hospital ID card/badge (a photocopy will be made when possible); or
 - ii. A current license to practice (a photocopy will be made when possible); or
 - iii. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (“DMAT”) (a photocopy will be made when possible); or

- iv. Presentation by current Campus or Affiliated Location or Medical Staff Member(s) with personal knowledge regarding the Practitioner's ability to act as a volunteer during a disaster.
3. The "Incident Commander" and "the Medical Care Branch Director, Operations Section," under the AHS Incident Command system will have the overall responsibility for assignment of duties to any volunteer Practitioners that are granted disaster Privileges.
4. As soon as possible, additional information will be gathered from the volunteer Practitioner(s) on a "Disaster Privileges" form. Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at a Campus or Affiliated Location. In extraordinary circumstances where primary source verification cannot be completed within 72 hours, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
5. When possible, all Practitioners granted Privileges during a disaster will be identified by a "Voluntary Practitioner: Disaster Privileges Granted" ID badge. The badges shall be maintained in the "Disaster Cart" in the Emergency Department.
6. When a facility deems a "disaster or emergency situation to no longer exist or to be under control":
 - a. The disaster Privileges shall expire.
 - b. The Practitioner(s) that was granted disaster Privileges must request Medical Staff membership and the clinical privileges necessary to continue to treat patients.
 - c. In the event such Privileges are denied or the voluntary Practitioner does not desire such Privileges, any patients still receiving care on-Campus or Affiliated Location shall be assigned to an appropriate Medical Staff Member.
 - d. After-the-fact/retroactive credentialing for temporary Privileges will occur as soon as possible if feasible to cover the time period of the disaster.

Section 7. Withdrawal of Privileges.

Any Member of the Medical Staff may voluntarily withdraw any clinical privilege at any time upon written notice to the MEC. Such action, unless as a result of disciplinary action or investigation or in lieu thereof, shall not create a right of hearing under the Fair Hearing Plan nor generate any reporting requirements under Wisconsin Statutes Section 50.36.

Section 8. Orders from Individuals Without Clinical privileges or Medical Staff Membership.

Campuses or Affiliated Locations may accept and execute orders per policy for outpatients from Practitioners, AHPs and individuals licensed to practice medicine, podiatry or dentistry in any state who are not Members of the Medical Staff and who have not been granted any clinical privileges only if all the following conditions are met:

1. The order is within the scope of practice, as established by state law, of the ordering professional.
2. The ordering professional is currently licensed, certified or registered in any state in a field of practice recognized by Wisconsin law and, upon the Campus's request, provides satisfactory evidence of such current licensure, certification or registration.
3. The ordering professional is not excluded from any federally-funded health program (such as Medicare or Medicaid).
4. The order can be executed within the standards of the applicable disciplines under which the order is to be performed without the presence or supervision of the ordering professional.
5. The ordering professional does not hold himself/herself out to be associated or affiliated with a Campus or Affiliated Location or its Medical Staff.

Section 9. Focused Professional Practice Evaluation.

1. A period of focused professional practice evaluation shall be implemented:
 - a. for all initially requested Privileges; and
 - b. in response to concerns regarding the provision of safe, high quality patient care. Triggering events for such evaluation may consist of single incidents or evidence of a clinical practice trend.
2. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of the Practitioner's current clinical competence, practice behavior and ability to perform the requested privilege.
3. Information for focused professional practice evaluation includes, as appropriate, chart review, monitoring clinical practice patterns, simulation,

proctoring, external peer review, and discussion with other individuals involved in the care of each patient.

Section 10. Ongoing Professional Practice Evaluation.

1. A process of ongoing professional practice evaluation exists to continuously review Medical Staff Members' care and to identify professional practice trends that impact on quality of care and patient safety.
2. The criteria used in the ongoing professional practice evaluation may include such factors as:
 - a. The review of operative and other clinical procedures performed and their outcomes;
 - b. Patterns of blood and pharmaceutical usage;
 - c. Requests for tests and procedures;
 - d. Length of stay patterns;
 - e. Morbidity and mortality data;
 - f. Practitioner's use of consultants; and
 - g. Other relevant factors as determined by the Medical Staff.
3. The information used to review the ongoing professional practice evaluation factors shall include, as appropriate, periodic chart reviews, direct observations, monitoring of diagnostic and treatment techniques and discussions with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nursing, and administrative personnel.
4. Relevant information obtained from the ongoing professional practice evaluation shall be integrated into Medical Staff performance improvement activities. Such information shall help determine whether existing Privileges should be maintained, revised or revoked.

ARTICLE IX. CORRECTIVE ACTION

Section 1. Corrective Action.

- A. Corrective action against any Practitioner may be requested by the chair of a department in which the individual has Privileges, the President of the Medical Staff, the Hospital President of the Campus or Affiliated Location where the activities or conduct primarily occurred, the VPMA of the Campus or Affiliated Location where the activities or conduct primarily occurred, the chair of any

standing Medical Staff committee or the Governing Body of the Campus or Affiliated Location where the activities occurred.

- B. Grounds for corrective action shall include the following: (1) the Practitioner's activities or professional conduct which are considered to lower the standards or aims of the Medical Staff, which reflect negatively upon the reputation of the Medical Staff as a whole in the community, are disruptive to the operations of the Campus or Affiliated Location, so as to adversely affect patient care; (2) unethical practice; (3) criminal charges (i.e. pending) or conviction; (4) substandard quality of care; (5) failure to keep adequate records; (6) violation of the bylaws, rules and regulations or the policies of the Medical Staff or of the Campus; (7) violation of the Ethical and Religious Directives of Catholic Health Care Facilities; (8) violation of the principles of ethics of the American Medical, Osteopathic, Dental or Podiatric Association, as appropriate; (9) violation of state or federal law; (10) exercising Privileges while the Practitioner's professional ability is impaired, whether through illness, accident, addiction or from any other source; (11) significant misstatement in or omission from any application for membership or Privileges or any misrepresentation in presenting the Practitioner's credentials; (12) harassment, mistreatment or otherwise degrading any patient, employee of the Campus or Affiliated Location, Member of the Medical Staff or member of the Governing Body; (13) breach of confidentiality; and (14) conduct qualifying for administrative automatic suspension pursuant to Section 3 of this Article IX.
- C. Except for suspensions under Sections 2, 3, 4 or 5 of this Article IX, all requests for corrective action shall be made in writing to the MEC and shall set forth in general terms the acts or omissions or the reason for the request.
- D. The chair of the MEC shall promptly notify the Hospital President of the Campus or Affiliated Location where the activities or conduct primarily occurred, in writing, of all requests for corrective action received by the MEC and shall continue to keep the Hospital Presidents of all Campuses or Affiliated Locations fully informed of all action taken in connection therewith.
- E. Except for suspensions under Sections 2, 3, 4 or 5 of this Article IX, upon receipt of a request submitted pursuant to Paragraph C above, the MEC chair shall appoint a subcommittee of at least three members of the MEC to determine whether, and to what extent, an investigation is necessary. If the subcommittee determines that no investigation is required it shall so report to the MEC and the MEC shall proceed in accordance with Paragraph F below. If it determines that an investigation is necessary, the subcommittee shall immediately undertake a careful and detailed investigation of the complaint, unless an investigation that meets the requirements of this subsection has already been completed. A report of the findings of the subcommittee shall be made to the MEC within 30 days after the receipt of the request for corrective action. Prior to making such report, the subcommittee shall inform the Practitioner against whom corrective action has been requested of the general nature of the charges against him/her, give him/her an opportunity to appear before the subcommittee, and permit him/her to make a statement on his/her own

behalf at such meeting. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules related to hearings or appellate review shall apply to such an appearance. The investigating body shall make a record of the interview.

- F. In the event the recommended corrective action is to suspend or terminate a Practitioner's clinical privileges or expel the Practitioner from the staff, the Practitioner shall be permitted to make an appearance before the MEC prior to its action on such request for corrective action. This appearance shall not be a substitute for a hearing, shall be preliminary in nature, and none of the procedural rules related to hearings or appellate review shall apply. The investigating body shall make a record of the interview.
- G. Action by the MEC could include, but not be limited to: (1) denial or modification of the request for corrective action, (2) a warning letter, (3) a letter of admonition, (4) a letter of reprimand, (5) probation that does not limit clinical privileges, (6) consultation without limiting clinical privileges, or (7) a requirement that the Practitioner undergo a physical or mental examination and report by a physician or psychologist chosen by and acceptable to the MEC and compliance with restrictions as recommended as a result of such examination. The MEC may also recommend that the Governing Body: (a) suspend, limit or terminate the Practitioner's clinical privileges, (b) suspend or revoke staff membership, (c) require consultation which limits clinical privileges, or (d) impose probation that limits clinical privileges, for a specified term. If the MEC makes a recommendation to the Governing Body under this Paragraph, it shall also recommend the interval status of the Practitioner during the fair hearing process, if invoked.
- H. No corrective action shall be taken against a Practitioner for advocating medically appropriate treatment for patients.

Section 2. Summary Suspension.

- A. The President of the Medical Staff, the VPMA of the Campus or Affiliated Location where the activities or conduct primarily occurred, a majority of the MEC, a majority of the Governing Body, or the chair of the Practitioner's department, or the Hospital President in consultation with the President of the Medical Staff, department chair, or VPMA, when available, shall each have the right, upon a determination that action must be taken due to a Practitioner posing an imminent danger to patients, staff, other persons or property, to temporarily suspend all or a portion of the Privileges of a Practitioner, such suspension to be effective immediately. Immediately upon the imposition of the suspension, the President of the staff, the VPMA, or the department chair shall provide for alternative medical coverage for the patient(s) of the suspended Practitioner remaining at the Campus or Affiliated Location at the time of suspension. The wishes of the patient(s) shall be considered in the selection of other medical coverage.

- B. Notice of the suspension shall be delivered to the Practitioner by special notice. A written report stating the reasons for the suspension shall be made to the MEC within two business days of such suspension.
- C. A Practitioner whose clinical privileges have been summarily suspended shall be entitled to an informal hearing before the MEC on the matter within such reasonable time period as the MEC shall determine, not to exceed ten business days after submission of the written report required under Paragraph B above. The informal hearing shall include at least (1) a review of the written report stating the reasons for the summary suspension, and (2) an opportunity for the Practitioner to have an interview and discuss this matter with the MEC. At such interview, the Practitioner shall be invited to discuss, explain or refute the charges against him or her. A record of the interview shall be made by the MEC. The MEC can request further material and information as required to make its determination. This informal hearing shall be preliminary in nature, and none of the procedural rules relating to hearings or appellate review shall apply.
- D. The MEC may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such informal hearing, the MEC does not recommend immediate termination of the summary suspension, the affected Practitioner shall be entitled to the hearing available under Article X of these Bylaws. Also, if the MEC does not recommend immediate termination of the summary suspension of the affected Practitioner, and the summary suspension lasts longer than 30 days, the adverse action shall be reportable to the National Practitioner Data Bank/PDS. If the recommendation of the MEC following such hearing continues to be adverse to the Practitioner, such Practitioner shall be entitled to request an appellate review of the Governing Body, but the terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision thereon by the Governing Body.

Section 3. Administrative Automatic Suspension.

- A. The President of the Medical Staff, the Hospital President of the Campus or Affiliated Location where the activities or conduct primarily occurred, the VPMA of the Campus or Affiliated Location where the activities or conduct primarily occurred, a majority of the MEC, or a majority of the Governing Body of any Campus or Affiliated Location, shall each have the right to automatically suspend all or a portion of the Privileges of a Practitioner or AHP, effective immediately, under the following conditions:
 - 1. Licensure. Action by the State Board of Medical Examiners or the State Board of Dental Examiners or analogous agency of the State of Wisconsin revoking or suspending a Practitioner's or AHP's license (or placing him or her on probation or limiting his or her practice), shall automatically suspend all of the Practitioner's or AHP's Privileges. Suspension shall occur whether the action of the licensing board is unilateral or agreed to by the licensee. A Practitioner or AHP who is placed on probation by a State

agency or whose practice is limited by a State agency shall, within 15 days of the action, have his or her Privileges reviewed by the credentials committee, which shall submit a recommendation to the MEC regarding the continued Medical Staff status and/or Privileges of the Practitioner or AHP. The Practitioner or AHP shall promptly provide written notice to the credentials committee of such revocation, suspension, limitation or probation of his/her professional license.

2. **DEA Registration.** Whenever a Practitioner's or AHP's DEA or other controlled substances number is revoked, suspended or voluntarily relinquished, all Privileges to prescribe controlled substances of that Practitioner or AHP shall be automatically suspended. The credentials committee shall review the matter and submit a recommendation to the MEC regarding the Medical Staff status and/or Privileges of the Practitioner or AHP. The Practitioner or AHP shall promptly provide written notice to the credentials committee of such revocation, suspension or voluntary relinquishment of his/her DEA number.
3. **Professional Liability Insurance.** In the event that the policy of professional liability insurance of a Practitioner or AHP is canceled, terminated without renewal, or reduced in coverage, limits, or extension of financial guarantees to below limits required of Medical Staff Members or otherwise required by law, all Privileges of that Practitioner or AHP shall be automatically suspended. The Practitioner or AHP shall promptly provide written notice to the credentials committee of such cancellation, termination, or reduction in insurance coverage. The credentials committee shall review the matter and submit a recommendation to the MEC regarding the Medical Staff status and/or Privileges of the Practitioner or AHP.
4. **Criminal Matters.** (a) An automatic suspension of all Privileges of a Practitioner or AHP shall be imposed upon notification received by the credentials committee of a criminal felony conviction of the Practitioner or AHP. Upon such suspension, the credentials committee shall review the matter and submit a recommendation to the MEC regarding the continuation of the Medical Staff status and/or Privileges of the Practitioner or AHP. (b) An automatic suspension of all Privileges of a Practitioner may be imposed for Practitioners or AHPs who have had criminal felony charges filed against them. Upon such suspension, the credentials committee may, or if requested by the Practitioner shall, convene to conduct a review of the matter and submit a recommendation to the MEC regarding the continuation of the Medical Staff status and/or Privileges of the Practitioner or AHP. The Practitioner or AHP shall promptly provide written notice to the credentials committee of such filing of criminal felony charges or criminal felony conviction against him/her by any law enforcement agency or health care regulatory agency of the United States, the State of Wisconsin or any other state or political subdivision.

5. Patient Abuse and Neglect. Unless proof of rehabilitation review approval is submitted, an automatic suspension of all Privileges shall occur upon notification received by the credentials committee of the existence of (a) pending criminal felony charges; (b) a criminal felony conviction; (c) pending investigations into or a final administrative finding of patient abuse, neglect or misappropriation of patient property or similar offenses as addressed in the Wisconsin Caregiver Criminal Background Check Law; or (d) a determination under the Children's Code to have abused or neglected a child against a Practitioner or AHP. The Practitioner or AHP shall promptly provide written notice to the credentials committee of such pending criminal felony charges or investigation, criminal felony conviction, or final administrative finding of patient abuse, neglect, misappropriation of patient property or similar offenses addressed in the Wisconsin Caregiver Criminal Background Check law or a determination under the Children's Code of child neglect against the Practitioner or AHP. The credentials committee shall review the matter and submit a recommendation to the MEC regarding the Medical Staff status and/or Privileges of the Practitioner or AHP. If the Practitioner provides evidence that rehabilitation review approval has been received, the MEC must determine whether the rehabilitation review approval has placed any limits on the Practitioner's or AHP's ability to practice the Privileges granted, whether the MEC wishes to retain the Practitioner on the Medical Staff and whether it can accommodate any restrictions imposed as a condition of rehabilitation review approval. The MEC may then take further action as is appropriate under the circumstances.
6. Sanctions. An automatic suspension of all Privileges may be imposed upon a Practitioner's or AHP's failure to provide written notification to the credentials committee within five calendar days of receipt by the Practitioner or AHP of an initial sanction notice of a gross and flagrant violation, or of the commencement of a formal investigation, or the filing of charges, or a final determination by a Medicare quality improvement organization, the Department of Health and Human Services, the Wisconsin Department of Health Services, the Office of the Inspector General or any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin. The credentials committee shall promptly review the matter and submit a recommendation to the MEC regarding the continued affiliation status and/or Privileges of the Practitioner or AHP.
7. Failure to provide information. An automatic suspension may be imposed upon a Practitioner's or AHP's failure without good cause to supply information or documentation requested by any of the following: the President of the Medical Staff, the Hospital President, the VPMA, the credentials committee, or the MEC. A suspension shall be imposed only if (a) the request for information or documentation was in writing, (b) the request was related to evaluation of the Practitioner's or AHP's qualifications for membership or Privileges, (c) the Practitioner or AHP

failed to either comply with the request or to satisfactorily explain his/her inability to comply, and (d) the Practitioner or AHP was notified in writing that failure to supply the requested information or documentation within 15 days from receipt of the notice would result in automatic suspension. Any automatic suspension imposed pursuant to this Paragraph may be a suspension of any portion or all of the Practitioner's or AHP's Privileges and shall remain in effect until the Practitioner or AHP supplies the information or documentation sought or satisfactorily explains his/her failure to supply it.

8. Exclusion from Federally-Funded Health Care Program. An automatic suspension may be imposed upon a Practitioner's or AHP's exclusion, in whole or in part, from any federally-funded health care program. If the Practitioner or AHP notifies the President of the Medical Staff of any proposed or actual exclusion from any federally-funded health care program as required by this Fair Hearing Plan within two days of the Practitioner's or AHP's receipt of notice of such, a simultaneous request in writing by the Practitioner or AHP for a meeting with the Hospital President and the President of the Medical Staff, or their designees, to contest the fact of the exclusion and present relevant information will be granted. This meeting will be held as soon as practicable but not later than five business days from the date of the written request. The Hospital President and the President of the Medical Staff or their designees shall determine within ten business days following the meeting, and after such follow-up investigation as they deem appropriate, whether exclusion has occurred and whether staff status and Privileges will be immediately terminated. The Practitioner or AHP will be notified of any termination decision under this Paragraph, as soon as practicable. A Practitioner or AHP who does not notify the President of the Medical Staff of any proposed or actual exclusion from any federally-funded health care program as required by this Fair Hearing Plan will have his/her membership and/or Privileges immediately terminated, upon the President of the Medical Staff or his/her designee's receipt of reliable information of the exclusion.
- B. Each Practitioner and AHP shall have the duty to provide written notification to the Hospital President or the VPMA of any action which may constitute a cause for automatic suspension. Failure to report such action as required in Paragraph A of this Section 3 will result in automatic suspension.
- C. Notice of the suspension shall be delivered to the Practitioner or AHP by special notice. A written report stating the reasons for the suspension shall be made to the MEC within two business days of such suspension.
- D. Administrative automatic suspension activated pursuant to this Section shall not give rise to any right of hearing or appellate review under Article X of these bylaws.

- E. Immediately upon the imposition of an administrative automatic suspension, the President of the staff, the VPMA or the department chair shall have the authority to provide for alternative medical coverage for the suspended Practitioner's or AHP's patients who are being treated at the time of the suspension. The wishes of the patient(s) shall be considered in the selection of alternative medical coverage.

Section 4. Suspension for Misconduct.

- A. In circumstances where an incident of misconduct is of sufficient severity and urgency that it cannot be safely addressed by the corrective action procedure as outlined in Section 1 of this Article, a suspension of all Privileges under this Section may be imposed by two (i.e. one clinical and one administrative) of the following: the President of the Medical Staff, the Hospital President of the Campus or Affiliated Location where the activities or conduct primarily occurred, the VPMA of the Campus or Affiliated Location where the activities or conduct primarily occurred, the chair of the department to which the Practitioner or AHP is assigned, a majority of the MEC or a majority of the Governing Body of any Campus or Affiliated Location. Misconduct not involving clinical issues can consist of, but is not limited to: sexual harassment; or abuse of other Practitioners or facility staff. Immediately upon the imposition of the suspension, the President of the staff, the VPMA, or the department chair shall provide for alternative medical coverage for the patient(s) of the suspended Practitioner or AHP remaining at the Campus or Affiliated Location at the time of suspension. The wishes of the patient(s) shall be considered in the selection of alternative medical coverage. Any Practitioner or AHP suspended pursuant to this Section 4.A shall remain available to confer with the alternative Practitioner to the extent necessary to safeguard the patient(s).
- B. Notice of the suspension shall be delivered to the Practitioner or AHP by special notice. A written report stating the reasons for the suspension shall be made to the MEC within two business days of such suspension.
- C. A Practitioner or AHP whose clinical privileges have been suspended shall be entitled to request an informal hearing before the MEC on the matter within such reasonable time period as the MEC shall determine after receiving a written request. The request for such an informal hearing must be filed with the MEC within five days of the actual notice to the Practitioner or AHP of imposition of the suspension.
- D. The informal hearing shall be scheduled as soon as practicable after receipt of the request for a hearing and in no event later than ten business days after that date except for good cause. Notice of the date, time and place of the hearing shall be given to the Practitioner or AHP by telephone, in writing or in person. The informal hearing shall include at least (1) a review of the written report stating the reasons for the summary suspension, and (2) an opportunity for the Practitioner or AHP to have an interview and discuss this matter with the MEC. At such interview, the Practitioner or AHP shall be invited to discuss, explain or refute the charges against him/her. A record of the interview shall be made by the MEC. The MEC can

request further material and information as required to make its determination. This informal hearing shall be preliminary in nature and none of the procedural rules relating to hearings or appellate review shall apply.

- E. The MEC may recommend modification, continuance or termination of the terms of the suspension of a Practitioner. If, as a result of such informal hearing, the MEC does not recommend immediate termination of the suspension, and the suspension remains in effect for more than 14 days, an affected Practitioner shall be entitled to the hearing available under Article X of these bylaws. If the recommendation of the MEC following such hearing continues to be adverse to the Practitioner, the Practitioner shall be entitled to request an appellate review of the Governing Body pursuant to this Fair Hearing Plan, but the terms of the suspension as sustained or as modified by the MEC shall remain in effect pending a final decision thereon by the Governing Body.
- F. The MEC may recommend modification, continuance or termination of the terms of the suspension of an AHP. If, as a result of such informal hearing, the MEC does not recommend immediate termination of the suspension, and the suspension remains in effect for more than 14 days, the affected AHP shall be entitled to the review available under Article V, Section 4 of the Medical Staff bylaws.

Section 5. Medical Record Automatic Suspension.

- A. The President of the Medical Staff, the Hospital President, the VPMA, a majority of the MEC or a majority of the Governing Body of any Campus or Affiliated Location shall be authorized to automatically suspend the Privileges of any Practitioner or AHP for incomplete medical records.
- B. Automatic suspension pursuant to this Section 5 shall not give rise to any right to hearing or appellate review under Article X of these bylaws.
- C. Immediately upon the imposition of an automatic suspension, the President of the staff, the VPMA or the department chair shall have the authority to provide for alternative medical coverage for the suspended Practitioner's or AHP's patients who are being treated at the time of the suspension. The wishes of the patient(s) shall be considered in the selection of other medical coverage.

Section 6. Time Periods for Processing.

Requests for corrective action shall be considered in a timely and good faith manner by all individuals and groups required by the Fair Hearing Plan to act on such requests and, except for good cause, be processed within the time periods specified. The time periods specified for corrective action are to guide the acting parties in accomplishing their tasks and shall not be deemed to create any right for the Practitioner or AHP to have a suspension lifted or to have a request for corrective action dismissed within those time periods.

ARTICLE X. FAIR HEARING AND APPELLATE REVIEW PLAN AND PROCEDURE

Section 1. Right to Hearing and to Appellate Review.

A. The following are adverse recommendations and shall constitute grounds for a hearing when taken against a Practitioner except as otherwise provided in the Medical Staff Bylaws or this Fair Hearing Plan:

1. Denial of initial staff appointment, except an administrative denial as provided in Article V, Section 2 of the Medical Staff Bylaws;
2. Limitation of admitting Privileges, except for temporary suspension due to medical record delinquency;
3. Denial of staff reappointment;
4. Suspension of Medical Staff appointment, except for suspensions under Section 3 or 5 of Article IX;
5. Expulsion from the Medical Staff, except expulsions under Section 3.A.8 of Article IX;
6. Denial of requested Privileges, except an administrative denial as provided in Article VI, Section 2 of the Medical Staff Bylaws;
7. Reduction of Privileges;
8. Denial of additional Privileges;
9. Continuation of a suspension of Privileges pursuant to Section 2 or 4 of Article IX following informal hearing before the MEC;
10. Termination of some or all Privileges, except terminations under Section 3.A.8. of Article IX;
11. Terms of probation or preceptorship which limit clinical privileges;
12. Requirement of consultation which limits clinical privileges.

In forming such recommendations, the recommending body should conclude that:
(a) there is a reasonable belief that the action is in furtherance of quality health care;
(b) reasonable efforts have been taken to obtain the pertinent facts; and (c) a reasonable belief exists that the action is warranted by the facts.

F. When any Practitioner receives notice of a recommendation of the MEC that, if ratified by decision of the Governing Body, will adversely affect his/her appointment to or status as a Practitioner or his/her exercise of clinical privileges, he/she may request a hearing before a hearing committee appointed by the MEC.

If the recommendation of the hearing committee following such hearing is still adverse to the affected Practitioner, he/she may request an appellate review by the Governing Body pursuant to the procedures outlined in Section 6.A. of this Article X before the Governing Body makes a final decision on the matter.

- F. When any Practitioner receives notice of a decision by the Governing Body or the MEC that will adversely affect his/her appointment to or status as a Practitioner or his/her exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the MEC of the Medical Staff with respect to which he/she was entitled to a hearing and appellate review, he/she may request a hearing by a committee appointed by the Governing Body, and if such hearing does not result in a favorable recommendation, to an appellate review by the Governing Body, before the Governing Body makes a final decision on the matter.
- F. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article X.

Section 2. Procedure for Requesting Hearing.

- A. The Hospital President of the Campus or Affiliated Location where the activities or conduct primarily occurred shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected Practitioner who is entitled to a hearing, by special notice. The notice shall:
 - 1. Advise him/her of the recommendation, action or proposed action and the basis therefore;
 - 2. Advise him of his/her right to a hearing in accordance with this Article X, and specify that he/she shall have 30 days within which to request a hearing in writing, with receipt by the Hospital President who provided written notice of the right to hearing within that 30 day period;
 - 3. State that failure to request a hearing within the specified time, to submit a statement of the case if required by the hearing committee, or to personally appear at the scheduled hearing, shall constitute a waiver of the Practitioner's right to the hearing and subsequent appellate review;
 - 4. State that upon receipt of his/her request, the Practitioner shall be notified of the date, time and place of the hearing, which date shall not be less than 30 days following receipt of the request by the Hospital President unless the Practitioner requests an earlier date in his/her request for a hearing;
 - 5. Advise the Practitioner of his/her right to be represented at the hearing by an appointee of in good standing, by an attorney, or by any other individual chosen by the Practitioner. The Practitioner shall be advised that if he/she fails to notify the Hospital President in the request for a hearing that he/she desires to be represented by an attorney, he/she shall be deemed to have waived the right to be so represented;

6. Advise the Practitioner that a record of the hearing, and, if he/she so requests, of the appellate review, shall be made, and of his/her right to receive a copy upon payment of reasonable charges for the preparation thereof;
 7. Advise the Practitioner of his/her right to call, examine and cross-examine witnesses, to present relevant evidence, and to submit a written statement at the close of the hearing; and
 8. State that upon completion of the hearing procedure the Practitioner shall receive a copy of the written recommendation of the hearing committee, including a statement of the basis of the recommendation.
- B. The failure of a Practitioner to request any hearing to which he/she is entitled by this Fair Hearing Plan within 30 days and in the manner herein provided, or failure to personally appear at the scheduled hearing, shall be deemed a waiver of his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled on the matter. The failure of a Practitioner to request any appellate review to which he/she is entitled by this Fair Hearing Plan within the time and in the manner herein provided shall be deemed a waiver of his/her right to such appellate review on the matter.
- C. When the waived hearing or appellate review relates to an adverse recommendation of the MEC or of a committee appointed by the Governing Body, the same shall thereupon become and remain effective against the Practitioner pending the Governing Body's decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Governing Body, the same shall thereupon become and remain effective against the Practitioner in the same manner as a final decision of the Governing Body provided for in Section 7 of this Article X. In either of such events, the Hospital President shall promptly notify the affected Practitioner of his/her status by special notice.

Section 3. Scheduling and Notice of Hearing.

- A. Within 15 days after receipt of a request for a hearing from a Practitioner entitled to one, the MEC or the Governing Body, whichever is appropriate, shall schedule and arrange for a hearing and notify the Practitioner of its time and place. The hearing date shall be not less than 30 days, and not more than 60, from the date of notice of hearing is provided to the Practitioner, unless the Practitioner, in writing, agrees to an earlier or later date.
- B. The notice of hearing shall state the time, place and date of the hearing, a list by number of the specific or representative patient records in question (if any), a preliminary list of witnesses who may testify on behalf of the MEC or the Governing Body (depending on which body's action prompted the request for a hearing), and shall contain a short and plain statement of

the basis for the adverse action which identifies acts, omissions or transactions with which the Practitioner is charged and, when appropriate, identifies other reasons or subject matter which justify the adverse recommendation or decision. The Practitioner shall be notified in writing of any subsequent modifications to the grounds for the adverse recommendation or action, or the list of expected witnesses, within a reasonable period prior to the hearing date.

- C. At least ten business days prior to the hearing, the Practitioner shall furnish to the MEC or Governing Body, as appropriate, a written list of the names and addresses of the individuals the Practitioner intends to call as witnesses at the hearing and the name of the Medical Staff Member or counsel chosen as his/her representative under Section 5.E. of this Article X, if any. Each party shall update its witness list if and when additional witnesses are identified prior to hearing, and neither party shall call witnesses not named in advance, except in rebuttal.

Section 4. Composition of Hearing Committee.

- A. When a hearing relates to an adverse recommendation of the MEC, such hearing shall be conducted by a designated subcommittee consisting of five Medical Staff Members, one of whom shall be designated as chair; provided, however, that no appointee who is in direct economic competition with the Practitioner (i.e. a Practitioner who is in the same practice specialty area and directly competes for business) shall serve on any hearing committee. The hearing committee may use, on a consulting basis, members of the same medical specialty as Practitioner. The Hospital President with the Medical Staff President will select the hearing committee.
- B. When a hearing relates to an adverse decision of the Governing Body or its MEC that is not based on a prior adverse recommendation of the MEC of the Medical Staff, the Governing Body shall appoint a hearing committee composed of at least three members to conduct such hearing and shall designate one of the members of this committee as chair. At least one representative from the Medical Staff who is not in direct economic competition with the Practitioner shall be included on this committee. The hearing committee may use, on a consulting basis, members of the same medical specialty as Practitioner.
- C. A Medical Staff Member or a Governing Body member shall not be disqualified from
serving on a hearing committee because he or she has heard of the case or has knowledge of the facts involved, or what he or she supposes the facts to be, or has
participated in the review or investigation of the matter at issue. No Medical Staff
Member or Governing Body member who requests corrective action shall serve

as a voting member of the hearing committee. However, the individual may appear before the committee if requested by either of the parties concerned. In any event, all members of the hearing committee shall be required to consider and decide the case with good faith objectivity.

- D. In any instance in which the MEC determines that an impartial hearing committee cannot be appointed under Paragraph A of this Section 4, the MEC may appoint qualified Practitioners who are not Members of the Medical Staff, but who are active or consulting staff appointees on the Medical Staff of any other hospital. Alternatively, at the discretion of the MEC, the hearing may be held before a hearing officer acceptable to both the affected Practitioner and the MEC. Such hearing officer would function in a manner similar to an administrative law judge and appropriately could be a retired judge or an attorney with no other connections to the facility.

Section 5. Conduct of Hearing.

- A. At least a majority of the members of the hearing committee must be present when the hearing takes place, and no member may vote by proxy.
- B. An accurate record of the hearing must be kept. The mechanism shall be established by the hearing committee and may be accomplished by use of a court reporter, detailed transcription, by the taking of adequate minutes, or a combination of these. A Practitioner desiring an alternate method of recording the hearing shall bear the primary cost thereof.
- C. The personal presence of the Practitioner for whom the hearing has been scheduled shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 2 of this Article X and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 2.
- D. Postponement of hearings beyond the scheduled date shall be made only with the approval of the hearing committee. The granting of such postponements shall only be for good cause shown and is in the sole discretion of the hearing committee. A hearing shall be postponed no more than two times, whether at the request of the Practitioner or the other party.
- E. If the affected Practitioner desires to be represented by an attorney at a hearing pursuant to this Section, his or her request for hearing must so state. The request for hearing must also include the name, address and phone number of the attorney. The hearing committee may preclude participation by legal counsel in the hearing or adjourn the hearing for a period not to exceed 20 days if the

Practitioner fails to notify the hearing committee in accord with this Section. The MEC or Governing Body may also be represented by an attorney. While legal counsel may attend and assist the respective parties, hearing proceedings are not judicial in form but a forum for professional evaluation and discussion. Accordingly, the hearing committee retains the right to limit the role of counsel's active participation in the hearing. Any Practitioner who incurs legal fees in his or her behalf shall be solely responsible for payment of those fees.

- F. Either a hearing officer, if one is appointed, or the chair of the hearing committee or his/her designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.
- G. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The Practitioner for whom the hearing is being held or his/her representative, and the representative of the MEC or Governing Body, whichever is relevant, shall be entitled to submit either prior to or during the hearing, memoranda concerning any issue of procedure or of fact or at the close of the hearing may submit a written statement,⁷ Such memoranda and statement(s) shall become a part of the hearing record. The hearing officer may, but is not required to, order that oral evidence be taken only on oath or affirmation. In reaching a decision, official notice may be taken by the hearing committee, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration at the hearing and of any facts which may be judicially noticed by the courts of this state. Participants present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the record of the hearing. The Practitioner for whom the hearing is being held shall be given the opportunity, on request, to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing committee. The committee shall also be entitled to consider any pertinent material contained in the facility's files, and all other information which can and may be considered in connection with applications for appointment and reappointment to the Medical Staff and for clinical privileges pursuant to this Fair Hearing Plan.
- H. The MEC, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff appointee, and/or an attorney, to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Governing Body or its MEC,

when its action has prompted the hearing, shall appoint one of its members and/or an attorney to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses.

- I. The affected Practitioner and the MEC and/or Governing Body or its executive committee, shall have the following rights: to call and examine witnesses; to introduce written evidence; to cross-examine any witness on any matter relevant to the issue of the hearing; to challenge any witness; and to rebut any evidence. If the Practitioner does not testify on his/her own behalf, he/she may be called and examined as if under cross-examination.
- J. The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.
- K. The hearing committee may require that the parties submit written, detailed statements of the case to the committee and to each other. If so, the hearing can consist of clarification and explanation of the written statements of the case. If a party is ordered by the hearing committee to supply a detailed statement of the case and fails to do so, the hearing committee may conclude that this constitutes a waiver of the party's case.
- L. If the hearing committee determines to require the parties to submit written statements of the case, notice to that effect shall be provided to each party at least ten business days prior to the hearing. The written statements of the case shall be supplied both to the committee and to the other party at least two business days prior to the commencement of the hearing.
- M. Statements from Medical Staff Members, nursing or other Campus or Affiliated Location staff, other professional personnel, patients or others may be distributed to the hearing committee and the parties in advance of or at the hearing. The statements shall be made a part of the record of the hearing and given such evidence as may be appropriate. These statements must be available to all parties. When time and distance allow, the authors of the statements should be available at the hearing for questioning by either party, if so requested.
- N. The body whose action occasioned the hearing shall have the initial burden of going forward to present evidence in support of its action. The Practitioner shall then be responsible for supporting his or her challenge to the action by clear and convincing evidence that no substantial basis exists for the action or the conclusions drawn from the facts are arbitrary, unreasonable or capricious. The other party shall then have an opportunity to rebut the evidence provided by the Practitioner. The burden of proof shall at all times remain with the Practitioner.

- O. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened.
- P. Within 30 days after close of the hearing, the hearing committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the MEC or to the Governing Body, whichever appointed it. The written report should include an explanation for the hearing committee's findings and recommendation that makes a rational connection between the issues to be decided, the evidence presented or considered, and the conclusion reached. The hearing committee shall also transmit a copy of its report and recommendations to the affected Practitioner, delivered through the Hospital President, by special notice. The report may recommend confirmation, modification, or denial of the original adverse recommendation of the MEC or decision of the Governing Body or its executive committee.
- Q. If, after the MEC has considered the report and recommendation of the hearing committee and the hearing record, its reconsidered recommendation is favorable to the Practitioner, it shall be forwarded to the Governing Body for action at its next regularly scheduled meeting and the procedure shall thereafter follow that set forth in Article VIII of these Medical Staff Bylaws. If such MEC recommendation continues to be adverse, the Hospital President of the Campus or Affiliated Location where the activities or conduct primarily occurred shall promptly notify the Practitioner by special notice. The Hospital President shall also forward such recommendation and documentation to the Governing Body, but the Governing Body shall not take any action on the matter until after the Practitioner has exercised or has been deemed to have waived his/her rights to an appellate review as provided in Section 6 of this Article X.
- R. A favorable reconsidered decision of the Governing Body shall be final and effective immediately upon transmittal of such reconsidered decision to the Practitioner. If the Governing Body's decision following a hearing is adverse to the Practitioner in either respect to appointment or clinical privileges, the Hospital President of the Campus or Affiliated Location where the activities or conduct primarily occurred shall promptly send him or her a copy of such adverse decision by special notice via Certified Mail. This notice shall also state that he or she has a right to an appellate review, that he or she has ten days following receipt of the notice to file a written request for appellate review and that failure to properly request review shall constitute a waiver of the right to review, and a summary of the appellate review procedures. The adverse decision shall then be held in abeyance until the Practitioner has exercised or been deemed to have waived his/her rights to appellate review under Section 6 of this Article X. The fact that the adverse decision is held in abeyance shall not be deemed to confer Privileges where none existed before.

Section 6. Appeal to the Governing Body.

- A. Within ten days after receipt of notice of an adverse recommendation or decision made or adhered to after a hearing as above provided, the affected Practitioner may, by written notice to the Governing Body delivered through the Hospital President of the Campus or Affiliated Location where the activities or conduct primarily occurred by special notice, request an appellate review by the Governing Body, outlining the Practitioner's reasons for contesting the recommendation or decision and the findings of fact that are disputed. Unless the opportunity for oral argument is specifically requested in such notice, the appellate review shall be held only on the record on which the adverse recommendation or decision is based, supplemented by a written statement by the Practitioner if he/she so desires. Failure to specify the reasons for contesting the recommendation or decision and to identify the facts that are disputed constitutes a waiver of appellate review.

- B. If such appellate review is not requested by the affected Practitioner in writing with the detail required by Paragraph A above, and received by the Hospital President within ten days of the Practitioner's receipt of the notice of the adverse decision, the affected Practitioner shall be deemed to have waived his/her right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 2 of this Article X.

- C. Within ten days after receipt of such request for an appellate review, the Governing Body shall schedule a date for such review, including a time and place for oral argument if such has been requested and is to be permitted, and shall, through the Hospital President of the Campus or Affiliated Location where the activities or conduct primarily occurred, by special notice, notify the affected Practitioner of the same. The date of the appellate review shall not be less than 20 days, nor more than 45 days, from the date of receipt of the affected Practitioner's request for appellate review, except that the Practitioner may, in writing, agree to an earlier date. The time for appellate review may be extended by the appellate review body for good cause. The appellate review can occur at a regular meeting of the Governing Body.

- D. The appellate review shall be conducted by the Governing Body or by a duly appointed appellate review committee of the Governing Body of not fewer than five members. If a committee is appointed, the chair of the Governing Body shall designate one of its members as chair. The chair of the appellate review committee shall be the presiding officer. He or she shall determine the order of the procedure during the review, make all required rulings and maintain decorum.

- E. The appellate review committee shall have all the powers granted to the hearing committee, and those additional powers as are reasonably appropriate to the discharge of its responsibilities.

- F. The affected Practitioner shall have access to the report and record (and transcript, if any) of the hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision. He/she may submit a written statement on his/her own behalf by sending it to the Governing Body through the Hospital President by special notice, at least five working days prior to the scheduled date for the appellate review. A similar statement may be submitted by the MEC, the chair of the Medical Staff hearing committee, or by the chair of the hearing committee appointed by the Governing Body, whichever is appropriate, and if submitted, the Hospital President shall mail a copy thereof to the Practitioner at least three working days prior to the date of such appellate review by special notice.
- G. The Governing Body or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to Paragraphs A and E of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the affected Practitioner was justified and was not arbitrary or capricious. If oral argument is requested and permitted as part of the review procedure, the affected Practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him by any member of the appellate review body. The hearing committee of the MEC or Governing Body, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him by any member of the appellate review body.
- H. New or additional matters not raised during the original hearing or in the hearing committee report and not otherwise reflected in the record shall only be introduced at the appellate review under unusual circumstances, and the Governing Body or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.
- I. The appellate review committee may recess the review proceedings and reconvene the same without additional notice for the convenience of participants.
- J. If the appellate review is conducted by the Governing Body, it may affirm, modify or reverse its prior decision, or, in its discretion, it may refer the matter back to the MEC for further review and recommendation, which further recommendation must be submitted to the Governing Body within ten days. Such referral may include a request that the MEC arrange for a further hearing to resolve specified disputed issues.
- K. If the appellate review is conducted by a committee of the Governing Body, the appellate committee shall, within five days after the date the appellate review is adjourned or closed, either make a written report recommending that the Governing Body affirm, modify or reverse the prior decision, or it may refer the matter back to the MEC for further review and recommendation which review and further

recommendation must be completed and submitted to the appellate committee within ten days of the referral. Such referral may include a request that the MEC arrange for a further hearing to resolve disputed issues. Within five days after receipt of recommendations from the MEC after referral, the committee shall make its recommendation to the Governing Body as above provided.

- L. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. All action required of the Governing Body may be taken by a committee of the Governing Body duly authorized to act.

Section 7. Final Decision by the Governing Body.

- A. Within 30 days after the conclusion of the appellate review, the Governing Body shall make its final decision in the matter, in accordance with Article VIII of these Medical Staff Bylaws and shall send notice thereof to the MEC and, through the Hospital President of the Campus or Affiliated Location where the activities or conduct primarily occurred, to the affected Practitioner by special notice. The Governing Body's decision shall be final on all parties involved.
- B. Notwithstanding any other provision of the Medical Staff Bylaws or this Fair Hearing Plan, no Practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the MEC, or by the Governing Body, or by a duly authorized committee of the Governing Body, or by both.
- C. Failure by the Governing Body or MEC or any hearing committee operating under this Article X to comply with a time limit specified herein shall not be deemed to invalidate their actions.

If the final decision of the Governing Body adversely affects a Practitioner's Medical Staff status or clinical privileges for more than 30 days, or if the Governing Body accepts the surrender of clinical privileges or Medical Staff status of a Practitioner under investigation for possible incompetence or improper professional conduct or in exchange for not conducting such an investigation or proceeding, the Ascension NEWI Medical Staff Services shall make such reports as required by Sections 423 and 424 of the Act, and by Wisconsin law.

ARTICLE XI. OFFICERS

Section 1. Officers of the Medical Staff.

- A. The officers of the Medical Staff shall be:
 - 1. President
 - 2. President-Elect

3. Immediate Past President

Section 2. Qualifications of Officers.

Any non-provisional Member of the Active Medical Staff is eligible to be nominated as an officer. There shall not be a time requirement above and beyond that to become an Active Staff appointee to hold an office on the Medical Staff. Officers must remain Members of the Active Medical Staff in good standing during their term of office. If any officer fails to maintain such status, the VPMA and Hospital President shall promptly review the change in Medical Staff status and make a recommendation to the MEC regarding the officer continuing to hold an office on the Medical Staff.

Section 3. Election of Officers.

- A. Officers shall be elected at the annual meeting of the Medical Staff. Only non-provisional Practitioners who are on the Active Medical Staff shall be eligible to vote.
- B. The nominating committee shall offer a slate of nominees for office. Such slate shall include at least one nominee for each vacancy. The nominating committee shall not recommend nominees for office until it approves an entire slate of nominees, and then shall recommend approval of the entire slate by the Medical Staff. Such slate shall be posted or communicated to the Active Medical Staff at least 14 days prior to the annual meeting.
- C. Election for President-elect shall be by simple majority of ballots returned. If a simple majority does not vote for the entire slate of nominees, the nominating committee shall then offer a new slate of nominees in accordance with this Section.
- D. The officers of the Medical Staff shall be: President, President-elect and Immediate Past President. The President-elect shall automatically succeed to the presidency for the two years following his/her term as President-elect without further vote.

Section 4. Term of Office.

All officers shall serve a two-year term commencing on the first day of the Medical Staff year.

Section 5. Vacancies in Office.

Vacancy in the office of President-elect during the Medical Staff year shall be filled by the MEC. If there is a vacancy in the office of the President, the President-elect shall serve out the remaining term.

Section 6. Duties of Officers.

- A. President. The President shall serve as the chief administrative officer of the Medical Staff to:

1. Act in coordination with the Hospital Presidents and the VPMA's in all matters of mutual concern on the four Campuses or Affiliated Locations within Ascension NEWI;
 2. Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff;
 3. Serve as chair of the MEC;
 4. Serve as a member of the Quality and Patient Safety Committee;
 5. Serve as ex officio member of all other Medical Staff committees;
 6. Be responsible for the enforcement of Medical Staff Bylaws, policies, and Ethical and Religious Directives, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner – all policies to be reviewed at least every three years;
 7. Appoint committee chairs in consultation with the respective Hospital President and VPMA and all committee members in consultation with the committee chair to all standing, special, and multidisciplinary Medical Staff committees except the MEC;
 8. Represent the views, policies, needs and grievances of the Medical Staff to the Governing Body;
 9. Receive and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care; and
 10. Be responsible for the educational activities of the Medical Staff.
 11. Perform any of the duties of any department chair or chair of any Medical Staff committee, if such individual is unavailable or otherwise fails to perform the necessary duties.
- B. President-Elect. In the absence of the President, the President-elect shall assume all duties and have the authority of the President. He/she shall be a member of the MEC. He/she shall automatically serve in place of the President if the latter fails to serve for any reason.
- C. Immediate Past-President. The immediate Past-President shall advise the other Medical Staff officers and shall serve as a member of the MEC.

Section 7. Removal from Office.

A. Reasons for Removal.

1. The MEC shall automatically remove from office any officer upon verification of revocation or suspension of such officer's license to practice medicine, dentistry, or podiatry. There shall be no right of appeal or hearing in connection with such action. In addition, an officer may be removed from office for valid cause, including gross neglect or malfeasance in office, acting in violation of these Bylaws or other rules of the Medical Staff, or unethical activities. The officer shall be informed of any allegations or concerns precipitating removal from office, and shall be afforded the opportunity to respond to the allegations before final action is taken by the MEC. The decision of the MEC shall be final.
2. Upon loss or suspension of Medical Staff appointment, an officer shall automatically be removed from office by the MEC pending the results of the hearing and appellate review procedures provided in the Fair Hearing Plan.
3. By written request of 20% of the Active Medical Staff directed to the President of the Medical Staff, or by the CMO, or by the VPMA or a Hospital President, with final approval of such removal to be granted by the MEC, or by certification by two physicians with special qualification in the appropriate medical field(s) that the officer cannot be expected to perform the duties of the office because of illness for a minimum of three months, an officer shall be considered for removal from office by the MEC. Such request shall include a list of the allegations or concerns precipitating the request for removal.

B. Procedures.

1. The CMO, all Hospital Presidents and all VPMA shall be kept fully informed of the progress on the issue by the MEC.
2. An officer removed from office pursuant to Paragraph A.3. above shall be so notified in writing by the President of the Medical Staff, and advised of his/her rights to a review by the MEC, if any. When the President of the Medical Staff is the officer in question, the immediate Past-President of the Medical Staff shall carry out the duties of the President during the removal process until the issue is resolved, at which time the President (if not removed) will resume his/her duties or the President-Elect will take over the remaining term of the removed President.
3. The officer in question will be relieved of the duties of the office until the question is resolved.

4. Suspension or removal from office shall not affect the Medical Staff appointment or clinical privileges of the officer in question.
- C. Review Procedures.
1. A meeting of the MEC shall be called within seven days to consider the matter. A quorum of the MEC must be present to act on the matter. The officer in question shall have no vote in the matter and may be excluded from the meeting except as in Paragraph C.2 below.
 2. The officer in question shall be permitted to make an appearance before the MEC prior to its taking final action on the request.
 3. An officer may be removed by an affirmative vote of two-thirds of the MEC members present at a meeting at which there is a quorum.
 4. The final decision of the MEC shall be given promptly to the officer in question in writing by the President of the Medical Staff.

ARTICLE XII. CLINICAL DEPARTMENTS

Section 1. Organization of Clinical Departments.

There shall be one department of the Medical Staff for each of the following clinical areas: (1) medicine (including hospital service, occupational medicine, and physiatry), (2) pediatrics, (3) OB-GYN, (4) surgery (including pathology and podiatry), (5) anesthesia, (6) family medicine, (7) radiology (including radiation oncology), (8) emergency medicine, and (9) behavioral health.

Each department shall have a chair and vice chair that shall be responsible for the overall supervision of the clinical work within the department. The chair and the vice chair when possible should conduct the majority of their patient care activity at different Campuses or Affiliated Locations from each other

Section 2. Qualifications, Selection and Tenure of Department Chair and Vice Chair.

- A. Each chair and vice chair shall be an appointee to the Medical Staff assigned to the applicable Ascension NEWI department and shall be Board certified, or deemed equivalently qualified, as demonstrated by training, experience, and leadership ability for the position. Candidates for the chair and vice chair shall be nominated by the department consistent with Medical Staff Bylaws. The chair and vice chair shall be elected by a majority of the Active Staff Members of their department and ratified by the then current MEC.
- B. Each chair and vice chair shall serve a two-year term. Each vice chair shall succeed the chair upon completion of the chair's term.

- C. Removal of a chair or vice chair during his/her term of office may be recommended by a two-thirds majority vote of all Active Staff that voted or by written request of the CMO or VPMA at the Campus or Affiliated Location where the practitioner primarily practices. Removal of the chair or vice chair shall be approved by an affirmative vote of two-thirds of the MEC present at a meeting at which there is a quorum.

Vacancies in the office of chair during the Medical Staff year shall be filled by the vice-chair. Vacancies in the office of vice-chair shall be filled through election by the respective department and ratified by the then current MEC.

Section 3. Functions of Department Chair and Vice Chair.

Each chair and vice chair shall:

- A. Be accountable for the professional, clinical and administrative activities within the department, including continuous assessment and improvement of the quality of patient care, treatment and services, patient safety and patient satisfaction;
- B. Give guidance to the MEC on the overall Medical Staff policies and make specific recommendations and suggestions regarding the department in order to assure quality patient care, treatment and services, patient safety and patient satisfaction. The chair shall be a member of the MEC;
- C. Maintain continuing surveillance of the professional performance of all Practitioners and AHPs with clinical privileges in the department and shall report to the MEC on a regular basis;
- D. Develop and recommend to the MEC specific Medical Staff policies and procedures regarding the overall provision of professional care, treatment and services and administrative activities and criteria within the department, with all policies to be reviewed at least every three years;
- E. Be responsible for enforcement of the Medical Staff Bylaws, rules and Medical Staff and department policies;
- F. Be responsible for compliance with and enforcement of the Ascension Health Mission, Vision and Values and the Ethical and Religious Directives among the members of the department in their relationships with each other, other professional and support staff, Campus or Affiliated Location administration, the Governing Body and the community the Campus or Affiliated Location serves;
- G. Be responsible for implementation within the department of actions taken by the MEC;
- H. Be responsible for implementation within the department of the Ascension NEWI quality and utilization review plans;

- I. Transmit to the MEC recommendations concerning the staff classification, and the reappointment and the delineation of clinical privileges for all Practitioners in the department and as appropriate, AHPs;
- J. Make recommendations to the credentials committee on the criteria for the granting of clinical privileges that are relevant to the care provided in the department, consistent with the policies of the Medical Staff and of the Governing Body;
- K. Make recommendations to the MEC on the minimum guidelines for specialty training and competence for procedures undertaken by Practitioners in the department;
- L. Be responsible for orientation, teaching, continuing education, and research programs in the department;
- M. Participate in every phase of administration of the department through cooperation with the nursing service and the Campus or Affiliated Location administration in matters affecting patient care including personnel, supplies, space, special regulations, standing orders, techniques and the coordination and integration of interdepartmental and intradepartmental services;
- N. Assess and make recommendations regarding space, resources and off-site sources for needed patient care, treatment and services; and
- O. Assist in the preparation of departmental annual reports which include patient care information such as quality of care, patient safety and patient satisfaction, and information on budgetary planning pertaining to the department as may be required by the MEC, the Hospital President, the CMO, the VPMA or the Governing Body.
- P. Recommend a sufficient number of qualified and competent persons to provide care, treatment and services.
- Q. Determine the qualifications and competence of department personnel who are not Medical Staff Members and who provide care, treatment and services.
- R. Assess and make recommendations regarding the maintenance of quality medical records.⁸

Section 4. General Functions of Department.

- A. Each department shall maintain written policies concerning the operation of the department, consistent with Medical Staff policies.
- B. Each department shall assist in the review of pertinent department sources of medical information relating to patient care for the purposes of monitoring the quality and appropriateness of care in the department relative to MEC's established

standards. Departments shall identify and make recommendations for actions to improve patient care.

- C. Each department shall meet separately on an ongoing basis to conduct peer review and analyze the clinical work of the department. Peer review shall be conducted consistent with Medical Staff policies and state law.
- D. To serve as the primary means for providing assurances to the Governing Body as to the appropriateness of professional performance and ethical conduct of its members and to strive toward assuring that the pattern of patient care in the Campuses or Affiliated Locations is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available.

Section 5. Specific Department Functions.

In addition to the general functions set forth in Section 4 above, the following departments shall have the specific functions shown below:

- A. Surgery, Pathology, OB/GYN, Internal Medicine and Family Medicine Departments. Review all surgical procedures whether or not tissue is removed in which there is a major discrepancy between preoperative and postoperative, including pathologic, diagnoses. Cases shall be selected for consideration and study based on Medical Staff approved screening indicators and/or quality plan focus.

Section 6. Assignment to Departments.

The MEC shall, after consideration of the recommendations of the clinical departments as transmitted through the credentials committee, recommend initial departmental assignments for all appointees. Independent AHPs shall be assigned to the department that their collaborative Active Medical Staff Practitioner is assigned. Dependent AHPs shall be assigned to the department that their supervising Practitioner is assigned.

Section 7. Departmental Sections.

In addition to the Medical Staff departments listed in Article XII, Section 1, the departments may create sections of subspecialties as the need arises. These department sections may be added after approved by the MEC based on a recommendation from the department affected. Clinical sections of departments shall not be established unless approved by the MEC.

Section 8. Department of Quality Improvement Role.

Medical staff departments are a major component of Ascension NEWI's program organized and operated to help improve the quality of health care and to avoid the improper utilization of services. The activities of the departments will be conducted in a manner consistent with the provisions of sec. 146.37 and 146.38 of the Wisconsin Statutes. The peer review protections of these statutes, including the confidentiality of department records and proceedings, are intended to apply to all activities of the departments relating

to improving the quality of health care or the improper utilization of services and include activities of individual department members, as well as other individuals designated by the department to assist in carrying out the duties of the departments.

ARTICLE XIII. MEDICAL STAFF COMMITTEES

Section 1. Standing Committees.

The standing committees of the Medical Staff shall be:

1. Medical Executive Committee
2. Credentials Committee
3. Nominating Committee
4. Peer Review Committee
5. Pharmacy and Therapeutics Committee
6. Infection Prevention Committee
7. Intensive and Critical Care Committee
8. Practitioner and Allied Health Professional Health and Wellness Advisory Committee
9. Bylaws Committee
10. Cancer Committee
11. Medical Record Committee
12. Utilization Review Committee
 - A. Composition. The utilization review committee shall consist of appointees from the Active Staff and VPMA selected on a basis that will ensure representation of the clinical departments, hospital-based specialties, the Medical Staff at large, and each Campus or Affiliated Location of the Medical Staff.
 - B. Duties. The duties of the utilization review committee shall be:
 1. Review admissions or continued stays not meeting Interqual/Milliman Criteria in the acute care setting based on assessment of Interqual/Milliman criteria, Medicare or insurance specific guidelines and physician medical judgment.
 2. Appropriateness and efficacy of duration of stay
 3. Appropriateness and efficacy of diagnostic and therapeutic services

4. Review of outlier cases related to admission status and/or extended length of stay
5. Readmission review
6. Insurance/patient appeal denial process
7. Non-coverage and denial letter notifications
8. Metastar/QIO denials/appeals/changes or technical billing issues
9. Compliance with CMS conditions of participation and requirements associated with Utilization Management
10. Concurrent and retrospective review of cases as deemed necessary and appropriate

The composition, duties and meeting requirements of all committees not specifically set forth in this article shall be determined by Medical Staff policy.

Section 2. Medical Executive Committee (MEC)

- A. Composition. The MEC shall be a standing committee and shall consist of the officers of the Medical Staff, and the chair of each clinical department. The chair of the MEC shall be the President of the Medical Staff. The Critical Access Hospital Medical Director of Calumet Medical Center shall be an ex officio member. The VPMA of the hospitals and all the Hospital Presidents and/or their designees shall attend the meetings of the MEC and shall be non-voting members of the committee. The majority of the MEC members must be fully licensed physicians who are Members of the Active Medical Staff.
- B. Duties. The duties of the MEC shall be:
 1. To act on behalf of the Medical Staff between meetings of the Medical Staff, within the scope of its responsibilities as described in these Bylaws. The authority delegated to the Medical Executive Committee by the Medical Staff may be limited or removed by the Medical Staff by amending these Medical Staff Bylaws in accordance with Article XXI;⁹
 2. To coordinate the activities of the various departments;
 3. To receive and act upon committee and departmental reports;
 4. To adopt Medical Staff policies and procedures on the behalf of the Medical Staff and make recommendations to the Governing Body for approval and implementation of such Medical Staff policies and procedures;

5. To provide liaison between the Medical Staff, the Hospital Presidents, the CMO, the VPMA's, and the Governing Body;
6. To recommend action to the Hospital Presidents and VPMA's on matters of a medico-administrative nature;
7. To make recommendations on Campus or Affiliated Location management matters (for example, long range planning) to the Governing Body through the Hospital Presidents and VPMA's;
8. To identify and isolate problems which, if resolved, could result in improved patient care, treatment and services, patient safety and patient satisfaction and take appropriate corrective action;
9. To provide oversight for all clinical protocols, clinical guidelines and case management for the medical care rendered to patients at the Campus;
10. To fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to patients at the Campus;
11. To maintain proper accreditation with The Joint Commission and any applicable state and federal programs and ensure that the Medical Staff is kept abreast of such accreditation programs and informed of the accreditation status of the Campus;
12. To make recommendations to the Governing Body regarding the process used to review the credentials of, and delineate Privileges to, the Medical Staff.¹⁰
13. To review the credentials of all Applicants and to make recommendations to the Governing Body for staff appointment, assignments to departments and delineation of clinical privileges;
14. To establish and enforce criteria and standards for Medical Staff membership.
15. To review periodically all available information regarding the performance and clinical competence of Practitioners and AHPs with clinical privileges and, as a result of such reviews, to make recommendations for reappointments and renewal or changes in clinical privileges to the Governing Body as outlined in Medical Staff policy;
16. To review the competency of any Practitioner or AHP with clinical privileges at any time it deems necessary or as requested by the CMO, a VPMA, a Hospital President or the Governing Body and take such action, including corrective action or summary suspension as it considers necessary in the interest of maintaining quality patient care, treatment and services and patient safety;

17. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all Practitioners and AHPs including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;
 18. To collaborate with the Ascension NEWI Ethics Committee in dealing with ethical questions pertaining to medical practice within Ascension NEWI and to respond and act on grievances submitted by Campus or Affiliated Location personnel;
 19. To report at each general staff meeting;
 20. To provide input to the Hospital Presidents on the selection and removal of the VPMA's
 21. To approve, and to recommend approval to the Governing Body of the Campus's utilization review plan annually, and to review and report findings of the utilization review process to the Medical Staff;
 22. To request and review a monthly financial report covering Medical Staff funds from Ascension Finance Department;
 23. To make recommendations to the Governing Body regarding the structure of the Medical Staff and;¹¹
 25. To provide for the consideration of differing points of view when conflicts arise between the Medical Executive Committee and Medical Staff on issues including, but not limited to, proposals to adopt a rule, regulation, or policy (or an amendment thereto), and report on such consideration and the Medical Executive Committee's determination relating thereto to the Medical Staff, as appropriate.¹²
- C. Subcommittees. The chair of the MEC may appoint such subcommittees as deemed appropriate to fulfill specific functions of the committee.
- D. Meetings. The MEC shall meet at least once a month and maintain a permanent record of its proceedings and actions. The presence of 50% of the voting MEC members shall constitute a quorum
- E. The MEC shall implement a program of regular communication with the Active Staff Members. This can include, but is not limited to, scheduled periodic meetings of all Active Staff Members, e-mail communications, distribution of reports, and meetings of the department sections.
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- F. When outside federal or state agencies or governing law define activities and responsibilities as functions which are to be provided or performed by a Medical Staff as a whole or as a MEC, Medical Staff department, or other committee of a Medical Staff of a hospital, absent action by the Governing Body assigning such functions to another committee or entity, the MEC shall be authorized to perform, and will undertake to perform or arrange for the performance of, all such functions.
- G. Removal of MEC Members.
1. Reasons for Removal.
 - a. Removal from current office or chair position.
 - b. Loss or suspension of Medical Staff appointment.
 - c. An MEC member shall be considered for removal from service by the MEC upon written request of 20% of the Active Medical Staff directed to the chair of the MEC, or by the CMO or Hospital President, or by certification by two physicians with special qualification in the appropriate medical field(s) that the member cannot be expected to perform his/her duties because of illness for a minimum of three months. Such request shall include a list of the allegations or concerns precipitating the request for removal.
 2. Procedures.
 - a. A member removed from service pursuant to Paragraph 1.(c) above shall be so notified in writing by the chair of the MEC and advised of his/her rights to a review by the MEC, if any. When the chair of the MEC is the member in question, the immediate Past-President of the Medical Staff shall carry out the duties of the chair during the removal process until the issue is resolved, at which time the chair (if not removed) will resume his/her duties or the resident-Elect will take over the remaining term of the removed chair.
 - b. The member in question will be relieved of his/her MEC duties until the question is resolved.
 3. Review Procedures.
 - a. A meeting of the MEC shall be called within seven working days to consider the matter. A quorum of the MEC must be present to act on the matter. The member in question shall have no vote in the matter and

may be excluded from the meeting except as in Paragraph 3.(b) below.

- b. The member in question shall be permitted to make an appearance before the MEC prior to its taking final action on the request.
 - c. A member may be removed by an affirmative vote of two-thirds of the MEC members present at a meeting at which there is a quorum.
 - d. The final decision of the MEC shall be given promptly to the member in question in writing by the chair of the MEC.
- H. **Override of the MEC.** The Active Medical Staff may submit a matter to the Governing Body based upon a petition signed by 20% of the Active Medical Staff, opposing an action or inaction of the MEC. The Active Medical Staff may submit a proposal regarding Medical Staff Policies to the Governing Body in accordance with Article XXI of these Medical Staff Bylaws. The Active Medical Staff may change, reduce or remove the authority of the MEC by amending these Medical Staff Bylaws in accordance with Article XXI.

Section 3. Credentials Committee.

- A. **Composition.** The credentials committee shall consist of ten appointees from the Active Staff, and the VPMAs, selected on a basis that will ensure representation of the clinical departments, hospital-based specialties, the Medical Staff at large, and each Campus or Affiliated Location of the Medical Staff. Independent AHP's may be appointed as ex-officio members and vote on AHP applications. The Chair shall be an ex-officio member. The Hospital Presidents shall attend the meetings of the credentials committee and shall be non-voting members of the committee.
- B. **Duties.** The duties of the credentials committee shall be:
- 1. To review the credentials of all Applicants and to make a report and recommendations for appointment and/or delineation of clinical privileges including specific consideration of the recommendations from the departments in which such Applicant requests Privileges, and assignments of Applicants to the various departments or services in compliance with Articles V, VI and VII of these Bylaws and any applicable state laws.
 - 2. To review periodically all information available regarding the competence of Practitioners and AHPs and, as a result of such reviews, to make recommendations for the granting of continued clinical privileges, reappointments, and the assignment of Practitioners and AHPs to the various departments or services as provided in Articles VI and VII of these Bylaws and to review the competency of any Practitioner or AHP at any other time as requested by the MEC or Governing Body.

3. To review reports that are referred by the executive, medical record and quality and utilization review committees and by the President of the Medical Staff.
4. To review recommendations regarding categories of AHPs who may provide services within a Campus or Affiliated Location either as independent or dependent AHPs, and the qualifications and prerogatives of each category.

Section 4. Nominating Committee.

- A. The nominating committee shall be composed of the two immediate Past Presidents of the Medical Staff, two members who are currently serving on the medical MEC, one at-large member appointed by the MEC, and two VPMAs in an advisory capacity. At least one member of the committee shall be a non-AMG physician. The chair of the nominating committee shall be the current President. In case of any immediate Past-President's inability to serve, the next Past President will serve on the nominating committee.
- B. The nominating committee shall offer a slate of candidates for vacancies in the officers of the Medical Staff. The committee shall consider primarily the ability, performance and availability of nominees when presenting its slate of candidates.

Section 5. Medical Records Committee

- A. The medical records committee shall be chaired by a physician liaison who is a Member in good standing of the Medical Staff.
- B. Duties of the medical records committee include:
 1. Development and maintenance of policies and procedures outlining
 - a. specification of the minimal content of medical histories and physical examinations;
 - b. requirements for a patient's medical history and physical examination and required updates, timeframes for validation and countersignature;
 - c. definition of the scope of the medical history and physical examination when required for non-inpatient services.
 2. Monitoring the quality of medical histories and physical examinations.
 3. Monitoring delinquencies in medical recordkeeping.

Section 6. Committee Quality Improvement Role.

The following committees are a major component of Ascension NEWI's program organized and operated to help improve the quality of health care and to promote the proper utilization of health care services.

1. Medical Executive Committee
2. Credentials Committee
3. Quality and Patient Safety Committee
4. Peer Review Committee
5. Pharmacy and Therapeutics Committee
6. Infection Prevention Committee
7. Intensive and Critical Care Committee
8. Practitioner and Allied Health Professional Health and Wellness Advisory Committee
9. Cancer Committee
10. Medical Records Committee
11. Utilization Review Committee

The activities of these committees will be conducted in a manner consistent with the provisions of Sections 146.37 and 146.38 of the Wisconsin Statutes. The peer review protections of those statutes, including the protection of the confidentiality of committee records and proceedings, as well as immunity for actions taken in good faith by members of such committees, are intended to apply to all activities of the committees relating to improving the quality of health care or improper utilization of services and include activities of the individual committee members, as well as other individuals designated by the committees to assist in carrying out the duties of the committees, including but not limited to overseeing monitoring plans.

ARTICLE XIV. MEDICAL STAFF MEETINGS

Section 1. Regular Meetings.

The Medical Staff shall meet once annually. The agenda for the annual staff meeting shall include reports of review and evaluation of the work done in the clinical departments and the performance of the required Medical Staff functions over the past year.

By resolution, the MEC may provide for the holding of additional regular meetings of the Medical Staff for the purpose of transacting such business as may come before the meeting.

All regular meetings shall be held at such day and hour as the President of the Medical Staff shall designate in the call and notice of the meeting.

Section 2. Special Meetings.

- A. The President, President-Elect or Designee or the MEC may call a special meeting of the Medical Staff at any time. The President/President-Elect or Designee shall call a special meeting within seven days after receipt by him/her of a written request for same signed by not less than one-fourth of the Active Staff and stating the purpose for such meeting. The MEC shall designate the time and place of any special meeting.
- B. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail/electronic format, i.e., fax, PDF, e-mail, to each appointee to the Active Staff not fewer than five nor more than seven days before the date of such meeting, by or at the direction of the President. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each staff appointee at his/her address as it appears on the records of the facility. Notice shall also be sent to appointees of other Medical Staff groups who have so requested. The attendance of an appointee of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 3. Agenda.

The agenda for regular and special meetings of the Medical Staff shall be written, and the agenda for regular meetings shall be distributed not less than five days before the time of such meeting.

Section 4. Quorum and Voting.

The presence of 33% of the Active Medical Staff who are present in person, or by proxy as provided below, shall constitute a quorum at any regular or special meeting. In the event that an item of business fails for the lack of a quorum, a vote by signed mail-in/electronic format, i.e., fax, PDF, e-mail, ballot shall be allowed as provided below. A quorum is necessary in order to conduct business at a meeting. Except for actions to amend the Bylaws, a simple majority of those present in person is required for an action to be approved; for Bylaws amendment, see Article XXI.

Section 5. Attendance Requirements.

Attendance at general Medical Staff meetings is encouraged.

Section 6. Proxy Votes.

An appointee to the Active Medical Staff, if unable to attend a regular or special meeting of the Medical Staff or of a regular or special meeting of a clinical department, may give his/her written, signed and dated proxy to another appointee to the Medical Staff, such proxy vote to be cast and counted in the same manner as if it were a vote of the appointee if he/she were present, and such proxy to cast a definite yes or no vote on specific questions listed on the written agenda for such meeting. Oral proxies, general proxies not giving specific votes on specific items on such agenda, proxies for items not on such agenda, and any other proxy not as constituted above shall be prohibited. In the matter of proxies for staff officers and departmental chair elections, the same rules shall apply. An appointee to the Active Staff may give a written proxy in support of the name of a candidate for a Medical Staff or departmental office in the same manner as for any other questions. He/she may vote only on candidates published in advance by the nominating committee of the Medical Staff or the given clinical department.

Section 7. Minutes.

Minutes of each regular and special meeting of the Medical Staff shall be prepared and shall include a record of the attendance of Medical Staff appointees and the vote taken on each matter. The minutes shall be signed by the President, President-elect or designee presiding at the meeting, and a permanent file of the minutes of each meeting shall be maintained.

Section 8. Mail-in/Electronic Voting for Designated Items.

Upon the approval of the President of the Medical Staff, a vote by mail-in/electronic voting may occur after a regular or special meeting where a quorum did not occur at the meeting or at the decision of the President. Mail-in/electronic voting shall occur in the form and format as designated by the President, e.g. fax, PDF, e-mail. A written ballot for the vote shall be distributed to all Members of the Active Medical Staff not less than five days before the voting period, and the written ballot shall state the voting period. The voting period shall be not less than five nor more than seven days. Items subject to this section shall be approved if they receive the affirmative vote of at least fifty percent (50%) of the Active Medical Staff Members who vote on the matter, except that items that include amendments to the Bylaws are approved if they receive the affirmative vote of two-thirds of the Active Medical Staff Members who vote on the matter, provided at least fifty percent (50%) of the Active Medical Staff Members vote on the matter.

ARTICLE XV. COMMITTEE AND DEPARTMENT MEETINGS

Section 1. Regular Meetings.

Committees and departments may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall hold regular meetings at least quarterly to review and evaluate the clinical work of Practitioners and AHPs with Privileges in the department. Meetings may be cancelled by the Department

Chair if no department business is scheduled. The agenda for such meetings shall be distributed or posted as provided in Campus or Affiliated Location policies. At the departmental meetings, emphasis should be placed on quality assurance, quality improvement and educational issues.

Section 2. Special Meetings.

A special meeting of any department or committee may be called by or at the request of the chair or vice chair thereof, by the President/President-Elect or Designee of the Medical Staff, or by one-third of the group's then members, but not fewer than two members.

Section 3. Notice of Meetings.

Written or oral notice stating the place, day, hour and agenda of any special meeting or of any regular meeting not held pursuant to resolution shall be given not fewer than five days before the time of such meeting, by the person or persons calling the meeting. If sent by electronic format, i.e., fax, PDF, e-mail, the notice of the meeting shall be deemed delivered. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail, addressed to the appointee at his/her address as it appears on the records of the facility with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Section 4. Quorum.

Fifty percent of the voting membership shall constitute a quorum for meetings of the MEC and credentials committee. Other standing committees and each department shall set their own meeting quorum requirements. In the event that an item of business fails for lack of a quorum, a vote by mail/electronic format, i.e., fax, PDF, e-mail, shall be allowed.

Section 5. Manner of Action.

The action of a majority of the department or committee members present at a meeting at which a quorum is present shall be the action of a committee or department. Action may be taken without a meeting by unanimous consent in writing/electronic format, i.e., fax PDF, e-mail, (setting forth the action so taken), signed by each department or committee member entitled to vote there at.

Section 6. Rights of Ex Officio Members.

Persons serving under these Bylaws as ex officio members of a committee shall have all rights and Privileges of regular members.

Section 7. Minutes.

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of department or committee members and the vote taken on each matter. The minutes shall be signed by the presiding officer and

promptly forwarded to the MEC. Minutes shall be approved at the next meeting of the department or committee. Each committee and department shall maintain a permanent file of the minutes of each meeting.

Section 8. Attendance Requirements.

- A. Each department shall have the autonomy to set their own meeting frequency but not less than quarterly, and quorum requirements. Attendance at committee meetings is encouraged.
- B. A Practitioner whose patient's clinical course is scheduled for discussion at a root cause analysis or peer review committee meeting shall be so notified and expected to attend the meeting. If such Practitioner is not otherwise required to attend the regular department meeting, the President of the staff shall, through the Hospital President, give the Practitioner advance written notice of the time and place of the meeting at which his/her attendance is required. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the Practitioner shall so state, shall be given by special notice, and shall include a statement that his/her attendance at the meeting at which the alleged deviation is to be discussed is mandatory.
- C. Failure by a Practitioner to attend any meeting with respect to which he/she was given notice that attendance was mandatory, without submission of a written request for postponement as described below, shall result in an automatic suspension of all or such portion of the Practitioner's clinical privileges as the MEC may direct, and such suspension shall remain in effect without recourse to hearing or appeal pursuant to the Fair Hearing Plan until the MEC makes a recommendation as to further follow up, if any, or at the end of ten business days if the MEC fails to make any recommendation within that period. In all other cases, if the Practitioner shall make a timely written request for postponement supported by an adequate showing that his/her absence will be unavoidable, such presentation shall be postponed by the chair of his/her department, or by the MEC if the chair is the Practitioner involved, until not later than the next regular departmental meeting; otherwise the pertinent clinical information shall be presented and discussed as scheduled.

ARTICLE XVI. IMMUNITY FROM LIABILITY

Section 1. Purpose.

Because the Governing Body has the ultimate responsibility for the conduct of all facilities in a manner consistent with each facility's objective of making available high quality safe patient care, and because the organized Medical Staff has the responsibility for the quality of all medical care provided to patients and for the ethical conduct and professional

practices of its Practitioners and AHPs, as well as for accounting therefore to the Governing Body, it is of the greatest importance that the most careful consideration be given to appointments and reappointments to the Medical Staff and to the granting of clinical privileges. In these matters, complete candor is required. Also, every facility, through its Medical Staff and management, owes a duty to other Ascension NEWI facilities and health care institutions to respond candidly to requests for references and evaluations of Practitioners and AHPs and of other health care providers practicing, employed, or trained at each Campus or Affiliated Location.

Section 2. Immunity.

The following shall be express conditions to any Practitioner's or AHP's application for appointment or reappointment or application for, or exercise of, clinical privileges or continued clinical privileges at any Campus or Affiliated Location.

- A. Any act, communication, report, recommendation, or disclosure, with respect to any such Applicant, performed or made and at the request of an authorized representative of an Ascension NEWI or any other health care facility, for the purpose of achieving and maintaining high quality safe patient care in an Ascension NEWI or any other health care facility, shall be privileged to the fullest extent permitted by law.
- B. Such Privileges shall extend to Members of the Medical Staff and of its Governing Body, its AHPs or other health care providers, the CMO, the Hospital Presidents and his/her representatives, the VPMA, authorized representatives of Ascension NEWI and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XVI, the term, "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Governing Body, of the Medical Staff or of Ascension NEWI.
- C. There shall, to the fullest extent permitted by law, be immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure made in good faith and without malice, even where the information involved would otherwise be deemed privileged.
- D. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with an Ascension NEWI or any other health care institution's activities related, but not limited to:
 - 1. Applications for appointment or clinical privileges.
 - 2. Periodic reappraisals for reappointment or continued clinical privileges.

3. Corrective action, including summary suspension.
 4. Hearings and appellate reviews.
 5. Medical care evaluations.
 6. Utilization reviews.
 7. Practitioner and AHP evaluations requested by the Ascension NEWI Practitioner and AHP Health and Wellness Advisory Committee.
 8. Other Campus or Affiliated Location, departmental, or committee activities related to quality patient care and inter-professional conduct.
- E. The acts, communications, reports, recommendations, and disclosures referred to in this Article XVI may relate to a Practitioner's or AHP's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care or patient safety.
- F. In furtherance of the foregoing, each Practitioner or AHP shall, upon request of a Campus or Affiliated Location, execute releases in accordance with the tenor and import of this Article XVI, in favor of the individuals and organizations specified in Paragraph B of this Section 2, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.
- G. The consents, authorizations, releases, rights, Privileges and immunities provided by Article VI of these Bylaws for the protection of the Campus's Practitioners, other Campus or Affiliated Location officials and personnel and their parties, in connection with applications for initial appointments and reappointments, shall be fully applicable to the activities and procedures covered by this Article XVI. All provisions in these Bylaws and in other forms used in the credentials process relating to authorizations, confidentiality of information and immunity from liability are in addition to and not in limitation to other immunities provided by law.

Section 3. Immunity for Liability.

Agent Status of Medical Staff Members. Members of the Medical Staff serving as officers, serving or assisting any hospital or Medical Staff committee, or assisting on peer review or quality management activities involving care provided at CMC, MMC and SEH, as authorized by the Medical Staff, shall have the status of "agents" as defined in the respective "Corporate Bylaws of the Corporation" of the applicable Governing Body, and

pursuant to such status, shall have the right of indemnification by the respective Corporation as provided in the Corporate Bylaws. Indemnification of Medical Staff Members serving or assisting LSSC shall be as provided in the LSSC operating documents.

ARTICLE XVII. CONTINUING EDUCATION

All Practitioners shall participate in a program of continuing education designed to keep them informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care and to refresh them in various aspects of their basic medical education. .

ARTICLE XVIII. RESIDENTS AND MEDICAL STUDENTS

The Medical Staff recognizes that Practitioners may train fellows, residents and/or medical students at a facility. Such residents and medical students are not Medical Staff Members and are not AHPs. Such residents and medical students shall be granted clinical privileges consistent with Medical Staff policies. Such residents and medical students may not take any actions at a Campus or Affiliated Location except under the direct supervision of a Practitioner. The MEC, the credentials committee, the President/President-Elect or Designee of the Medical Staff and or the VPMA may, at any time and for any reason, restrict access to a Campus or Affiliated Location from any particular resident or medical student or from all residents or medical students. Residents and medical students are not granted any hearing rights under these Bylaws.

ARTICLE XIX. TERMINATION OF PRACTITIONERS IN MEDICO-ADMINISTRATIVE POSITIONS

The Governing Body may terminate the administrative functions of any Practitioner serving in a medico-administrative capacity by giving prompt written notice to such Practitioner and to the MEC. Such termination shall not affect his/her appointment to the Medical Staff or clinical privileges except as provided in these Bylaws or any contract with the Practitioner. If the termination of a Practitioner's administrative functions directly affects his/her Medical Staff appointment or clinical privileges then such Practitioner shall be entitled to the hearing procedures provided in the Fair Hearing Plan, except as provided otherwise in any contract between the Campus or Affiliated Location and such Practitioner.

ARTICLE XX. DUES

The amount of dues of the Medical Staff shall be determined annually on the recommendation of the MEC. All categories of the Medical Staff, except for Honorary Medical Staff, shall be assessed dues, although dues may differ between categories, per Medical Staff policy. Dues will be designated for use by the MEC, consistent with the purposes of and responsibilities of the Medical Staff. If the total amount of dues collected from the Medical Staff is insufficient to cover annual Medical Staff expenses, expenditures or other costs, the MEC shall be solely responsible for any and all outstanding expenses, expenditures or other costs and shall not approve any additional expenses, expenditures or other costs until additional dues payments are received for all outstanding amounts. The MEC shall prepare an annual Medical Staff budget and make the budget available to all Members of the Medical Staff. The MEC shall also prepare budgetary reports and provide

updates to the Medical Staff on a regular basis. Failure to pay the annual dues assessment shall constitute automatic resignation and reinstatement shall require submission of an application for initial appointment to the Medical Staff.

ARTICLE XXI. MEDICAL STAFF BYLAWS & POLICIES

Section 1. Medical Staff Bylaws.

- A. Associated Details. These Medical Staff Bylaws contain the basic steps of the processes listed below. Supplementary procedural details associated with these basic processes (“Associated Details”) may be placed in these Bylaws, a Medical Staff Policy, or a Campus or Affiliated Location Policy approved by the Medical Executive Committee. Such Associated Details may be adopted or amended by the Medical Executive Committee as provided in Article XXI, Section 2 of these Bylaws, but cannot substantively conflict with the processes described in these Medical Staff Bylaws.
1. Privileging/Credentialing/Appointment
 - a. Medical Staff appointment and reappointment.
 - b. Credentialing and re-credentialing of Staff Members.
 - c. Privileging and re-privileging of Staff Members.
 2. Adverse Actions
 - a. Automatic suspension of Staff Membership and/or clinical privileges.
 - b. Summary suspension of Staff Membership or clinical privileges.
 - c. Recommending termination or suspension of Staff Membership and/or termination, suspension, or reduction of clinical privileges.
 - d. Fair hearing and appeal process, including the process for scheduling and conducting hearings and appeals.
 3. Medical Staff / Medical Executive Committee
 - a. Selection and removal of Medical Staff Officers.
 - b. How the Medical Executive Committee’s authority is delegated or removed.
 - c. Selection and removal of Medical Executive Committee members.
 4. Documents
 - a. Adopting and amending these Medical Staff Bylaws.
 - b. Adopting and amending Medical Staff Policies.

- B. Review. These Bylaws shall be reviewed at least biennially by the Bylaws Committee, which shall make a recommendation regarding the need for any amendments to the MEC.
- C. These Bylaws may be reviewed or amended by a majority vote of votes cast by the Active Staff members eligible to vote who are present at any Medical Staff meeting called for such purposes, or by a majority of the votes cast by the Active Medical Staff members eligible to vote in an electronic mail ballot, provided that ten (10) calendar days prior written notice accompanied by the proposed alterations (or electronic access to the proposed alterations) has been given to the voting members of the Medical Staff by the Medical Executive Committee. Once approval by the Active Staff members eligible to vote, the amendments shall be forwarded to the Governing Body for approval.
- D. Amendments may be proposed by written petition to the President of the Medical Staff by ten percent (10%) of the eligible voting Active Staff members, by a Medical Executive Committee member, or by any standing Medical Staff committee. The President of the Medical Staff shall present the petition for discussion to the Medical Executive Committee within sixty (60) calendar days. Following its review and comment, the Medical Executive Committee shall present the proposed Amendment in writing to the Active Medical Staff members eligible to vote as herein required.
- E. The Medical Executive Committee has the power to adopt such amendments to the Bylaws as are, in the Committee's judgment, technical modifications or clarification; reorganizing or renumbering; or amendments necessary because of spelling, punctuation, or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or Governing Body within ninety (90) calendar days of adoption by the Medical Executive Committee. The action to amend, in such circumstances may be taken by motion acted upon in the same manner as any other motion before the Medical Executive Committee.
- F. Amendments to Medical Staff Bylaws are accomplished through a cooperative process involving both the Medical Staff and Governing Body and are effective upon approval by the Governing Body. The Governing Body gives full consideration to the recommendations and views of the Medical Staff before taking final action.
- G. All Medical Staff members shall be advised in writing of Medical Staff Bylaws changes that are implemented pursuant to the procedure described above, and they will be provided with revised texts or electronic copies of the revised affected pages, as appropriate.
- H. Adoption

These Bylaws shall be effective when adopted by a majority vote of the Active Staff voting and have been approved by the Governing Body and shall replace any previous Bylaws. All members of the Medical Staff shall receive written notification of any amendments to these Bylaws once approved. They shall be equally binding to the Governing Board and the Medical Staff.

I. Unified Medical Staff and Opt Out

Section 1. A majority of Medical Staff members who hold privileges at an individual respective Hospital (the “Eligible Members”), voting in the affirmative at the meeting described below, is required to opt out of the unified medical staff created by these Bylaws. To hold a vote to opt out, a petition, signed by one third (1/3) of the Eligible Members must first be presented to the Medical Executive Committee and the Governing Body. Within sixty (60) days following the Governing Body’s receipt of the written petition and its verification that the requisite number of bona fide signatures are present, the Governing Body shall direct the Medical Executive Committee to hold an opt out vote at a meeting held for that purpose. The Medical Executive Committee shall provide thirty (30) days’ advance written notice to each of the Eligible Members of the Hospital subject to the petition, and the opt out vote shall occur by written ballot of those Eligible Members present at the meeting. If the Eligible Members present at the meeting and voting in the affirmative to opt out represent a majority of all of the Eligible Members, then the Governing Body will establish a separate medical staff at the Hospital under Bylaws substantially in the form as set forth in these Bylaws, but for the provisions that created the unified medical staff.

J. Conflict Resolution

1. When there is a conflict between Medical Staff members, the Medical Executive Committee, and the Governing Body with regard to new and/or amended Medical Staff policies and procedures, including Division-specific policies and procedures:
2. A special meeting to discuss the conflict may be called by a petition signed by at least 25% of the voting members of the Medical Staff (or 25% of the voting members of the involved Division for a Division-specific policy and procedure). The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.
3. If the differences cannot be resolved, the Medical Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting members of the Medical Staff, to the Governing Body for final action.

Section 2. Medical Staff Policies.

- A. Generally. The Medical Executive Committee may adopt Medical Staff Policies as may be necessary to implement more specifically the general principles found within these Medical Staff Bylaws and guide and support the provision of care, treatment and services at the Medical Center, subject to the approval of the Governing Body. Medical Staff Policies must be consistent with these Medical Staff Bylaws, Campus or Affiliated Location Policies, and applicable statutes and regulations. The Medical Executive Committee will ensure that all approved Medical Staff Policies and amendments to such Policies are communicated to the Medical Staff.
- B. Adoption Process. Any Medical Staff Member, the MEC, other Medical Staff Committee, or a Medical Staff Department, may submit a proposal to adopt a new Medical Staff Policy to the Medical Staff President. The Medical Staff President (or his/her designee) shall notify current Active Medical Staff Members of the proposed Policy via email at least seven (7) days before the Medical Executive Committee will vote on the proposed Policy. The Medical Staff President may submit the proposed Policy to the Medical Executive Committee for approval at the next regular Medical Executive Committee meeting, or at a special Medical Executive Committee meeting called for such purpose. Prior to voting on the proposed Policy, the Medical Executive Committee may make changes to the proposed Policy without providing additional notice to the Medical Staff. To be approved by the Medical Executive Committee, a new Policy must be approved by a majority (51%) vote of the Medical Executive Committee. A Policy approved by the Medical Executive Committee shall be forwarded to the Governing Body for its approval and shall become effective if and when it is approved by the Governing Body. If a proposed Policy is not submitted to or approved by the Medical Executive Committee, the Medical Staff may submit the proposed Policy directly to the Governing Body if two-thirds (2/3) of the Active Medical Staff Members vote to submit such proposed Policy directly to the Governing Body. A proposed Policy shall become effective if and when it is approved by the Governing Body. At a minimum, the Governing Body will provide a preliminary response to a proposed Policy within sixty (60) days.
- C. Amendment. Medical Staff Policies may be amended or repealed upon recommendation of the Medical Executive Committee and approval of the Governing Body. The Medical Executive Committee will ensure amendments to Medical Staff Policies which are approved by the Medical Executive Committee and the Governing Board are communicated to the Medical Staff.
1. Policy Amendments Proposed by the Medical Executive Committee. The Medical Executive Committee may develop a proposal to amend a Medical Staff Policy at any time. To be approved by the Medical Executive

Committee, the proposed amendment must be approved by a majority (51%) vote of the Medical Executive Committee. An amendment approved by the Medical Executive Committee shall be forwarded to the Governing Body for its approval and shall become effective if and when such amendment is approved by the Governing Body. At a minimum, the Governing Body will provide a preliminary response to a proposed amendment within sixty (60) days. The foregoing notwithstanding, in cases of a documented need for an urgent amendment to Medical Staff Policies necessary to comply with law or regulation, the Medical Executive Committee may provisionally approve such amendment without prior notification to the Medical Staff. In such cases, the Medical Staff shall immediately be notified of the provisional approval by the Medical Executive Committee, and the Medical Staff shall have the opportunity for retrospective review and comment on the provisionally approved amendment. If there is no conflict over the provisional amendment, the provisional amendment shall stand. If there is conflict between the Medical Executive Committee and Medical Staff regarding the provisional amendment, the conflict will be addressed by the Medical Executive Committee in accordance with the terms of Article XIII.2.B.35.¹³

2. Policy Amendments Proposed by a Medical Staff Member, Committee, or Department. Any Medical Staff Member, committee, or Department may submit a proposed amendment to a Medical Staff Policy to the Medical Staff President. The Medical Staff President may submit the proposed amendment to the Medical Executive Committee at the next regular Medical Executive Committee meeting, or at a special Medical Executive Committee meeting called for such purpose. To be approved by the Medical Executive Committee, the proposed amendment must be approved by a majority (51%) vote of the Medical Executive Committee. An amendment approved by the Medical Executive Committee shall be forwarded to the Governing Body for its approval and shall become effective if and when it is approved by the Governing Body. If a proposed Policy is not submitted to or approved by the Medical Executive Committee, the Medical Staff may submit the proposed Policy directly to the Governing Body if two-thirds (2/3) of the Active Medical Staff Members vote to submit such proposed Policy directly to the Governing Body. Such a proposed Policy shall become effective if and when it is approved by the Governing Body. At a minimum, the Governing Body will provide a preliminary response to a proposed amendment within sixty (60) days.
3. Policy Amendments Proposed by the Governing Body. An amendment to the Medical Staff Medical Staff Policies proposed by the Governing Body shall be submitted to the Medical Staff President for consideration by the Medical Executive Committee at the next regular Medical Executive Committee meeting, or at a special Medical Executive Committee meeting

called for such purpose. To be approved by the Medical Executive Committee, the proposed amendment shall require a majority (51%) vote of the Medical Executive Committee. At a minimum, the Medical Executive Committee will provide a preliminary response a proposed amendment within sixty (60) days. An amendment approved by the Medical Executive Committee shall be returned to the Governing Body for its final approval and shall become effective if and when it is approved by the Governing Body. At a minimum, the Governing Body will provide a preliminary response an amendment approved by the Medical Executive Committee within sixty (60) days.

- D. Technical Modifications. Modifications that do not materially change any Medical Staff Policy provision, such as reorganization, reformatting, renumbering, correction of grammatical, spelling, or punctuation errors, or correction of statutory, regulatory, or accreditation standard citations contained in a footnote reference, shall not be considered an amendment of the Medical Staff Policies and shall not require approval as described above.
- E. Status of Medical Staff Policies. In the event of any conflict or inconsistency between these Bylaws and Medical Staff Policies, these Bylaws shall supersede and prevail. In the event of any conflict or inconsistency between Medical Staff Policies and Department policies, Medical Staff Policies shall supersede and prevail.
- F. History and Physicals. History and Physical Examinations. A medical history and physical examination (H&P) must be performed and documented by a Physician, Oral Surgeon, Doctor of Medicine or Osteopathy, or other qualified licensed individual (as identified in applicable Medical Staff Policies), no more than thirty (30) days before or twenty-four (24) hours after admission or registration (inpatient or outpatient), but in all cases prior to surgery or a procedure requiring anesthesia services (as described in the Medical Staff Policies). If the H&P is performed within thirty (30) days prior to the patient's admission or registration, a Physician, Oral Surgeon, or other qualified licensed individual (as identified in the Medical Staff Policies) must complete and document an updated examination of the patient, including any changes in the patient's condition, within 24 hours after the patient's admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia services (as described in Medical Staff Policies). H&P's require specific co-signature requirements as specified in hospital policy. These requirements also apply to outpatient requirements as outlined in hospital policy. Refer to the Medical Staff Policies for more information regarding H&P documentation requirements.

ARTICLE XXII ADOPTION

These Bylaws may be adopted at any regular or special meeting of the Medical Staff, shall replace any previous Bylaws and shall become effective when approved by the Governing Body. Errors, alterations, or additions to these Bylaws shall be effected through the due

process outlined in Article XXI of these Bylaws. These changes, if correction of error, shall be added as errata or, if additions or changes, as supplemental to these Bylaws as an appendage, or by issuance of a revision of the page in question.

All Medical Staff Members shall be informed of updates to these Bylaws as they occur.

ARTICLE XXIII IDENTIFICATION PROCEDURE

Any words contained in these Bylaws which import one gender may be applied to any gender and words which import the singular or plural may be applied to the plural or the singular, all as a sensible construction of the language so requires.

Roberts Rules of Order shall apply when no other provision has been made in these Bylaws as to procedures.

November 4, 2013: AMENDED by the Active Medical Staff of Ascension NEWI Health System.

November 20, 2013: AMENDMENT APPROVED by the Governing Body of Ascension
NEWI Health System

September 25, 2014: AMENDMENT APPROVED by the Governing Body of Ascension
NEWI Health System

July 19, 2017 AMENDMENT APPROVED by the Governing Body of Ascension NEWI
Health System