

**FLAMBEAU HOSPITAL INC.**

**Medical Staff  
Bylaws  
&  
Rules and Regulations**

Revised September 7, 2000  
Revised July 5, 2001  
Revised March 6, 2003  
Revised March 2004  
Revised August 2005  
Revised May 2006  
Revised April 2007  
Revised April 2008  
Revised August 2008  
Revised April 2009  
Revised June 2010  
Revised August 2011  
Revised August 2013  
Revised August 2015

**FLAMBEAU HOSPITAL INC.**  
**MEDICAL STAFF BYLAWS**  
**Table of Contents**

**Preamble.....4**

**Definitions.....5**

**I. Name.....6**

**II. Purposes .....6**

**III. Medical Staff Membership.....6**

    A. Nature of Medical Staff Membership.....6

    B. Qualifications for Membership .....6

    C. Conditions and Duration of Appointment.....9

**IV. Procedure for Appointment and Reappointment.....10**

    A. Application for Appointment.....10

    B. Administrative Denial.....13

    C. Appointment Process.....13

    D. Reappointment Process .....15

    E. Reapplication After Adverse Action.....16

    F. Time Periods for Processing.....17

**V. Categories of the Medical Staff.....17**

    A. The Medical Staff.....17

    B. Honorary Medical Staff .....17

    C. Active Medical Staff.....17

    D. Associate Medical Staff .....18

    E. Courtesy Medical Staff.....19

    F. Consulting Medical Staff .....19

    G. Contract Physicians Staff.....20

    H. Dental Staff Functions .....21

    I. Podiatry Staff Functions.....21

**VI. Allied Health Affiliates .....22**

    A. General Provisions .....22

    B. Independent Allied Health Affiliates .....23

    C. Independent Allied Health Affiliates/Chiropractors .....24

    D. Dependent Allied Health Affiliates.....24

    E. Removal Procedures and Status .....25

**VII. Clinical Privileges .....26**

    A. Regular Privileges .....26

    B. Temporary Privileges for Medical Staff Applicants or for Locum Tenens Only ....27

    C. Temporary Privileges to Meet an Important Patient Care Need .....28

    D. Emergency Privileges.....29

    E. Telemedicine Privileges.....30

    F. Leave of Absence and Reappointment.....32

    G. Orders from Individuals w/o Clinical Privileges/ Medical Staff Membership...34

**VIII. Corrective Action.....34**

    A. Procedure.....34

    B. Summary Suspension.....36

C.	Temporary Suspension.....	37
D.	Automatic Suspension.....	37
<b>IX.</b>	<b>Hearing and Appellate Review Procedure.....</b>	<b>40</b>
A.	Right to Hearing and to Appellate Review.....	40
B.	Request for Hearing.....	42
C.	Notice of Hearing.....	43
D.	Pre-Hearing Procedure.....	43
E.	Composition of Hearing Committee.....	44
F.	Conduct of Hearing.....	45
G.	Hearing Committee Report and Further Action.....	47
H.	Appeal to Governing Body.....	48
I.	Final Decision by Governing Body.....	50
J.	Substantial Compliance.....	51
K.	Waiver of Time Limits.....	51
<b>X.</b>	<b>Officers.....</b>	<b>51</b>
A.	Officers of the Medical Staff.....	51
B.	Qualifications of Officers.....	51
C.	Election of Officers.....	51
D.	Term of Office.....	51
E.	Vacancies in Office.....	52
F.	Duties of Officers.....	52
G.	Removal of Officers.....	53
<b>XI.</b>	<b>Services.....</b>	<b>53</b>
A.	Organization of Services.....	53
B.	Qualifications, Section and Tenure of Service Chiefs.....	53
C.	Functions of Service Chiefs.....	53
D.	Functions of Services.....	55
<b>XII.</b>	<b>Committees.....</b>	<b>55</b>
A.	Standing Committee.....	55
B.	Multidisciplinary Committees Involving Medical Staff.....	58
C.	Joint Conference Committee.....	64
D.	Additional Committees.....	65
<b>XIII.</b>	<b>Meetings.....</b>	<b>65</b>
A.	Annual Meeting.....	65
B.	Regular Meetings.....	65
C.	Special Meetings.....	66
D.	Attendance at Meetings.....	66
E.	Quorum.....	66
F.	Board of Director Representation.....	67
G.	Minutes.....	67
H.	Rights of Ex-Officio Members.....	67
I.	Insurance Protection.....	67
<b>XIV.</b>	<b>Immunity from Liability.....</b>	<b>67</b>
<b>XV.</b>	<b>Rules and Regulations.....</b>	<b>68</b>
<b>XVI.</b>	<b>Parliamentary Authority.....</b>	<b>69</b>
<b>XVII.</b>	<b>General Provisions.....</b>	<b>69</b>
<b>XVIII.</b>	<b>Amendments.....</b>	<b>69</b>
<b>XIX.</b>	<b>Adoption.....</b>	<b>69</b>

# FLAMBEAU HOSPITAL INC.

Park Falls, Wisconsin

## MEDICAL STAFF BYLAWS

### *PREAMBLE*

**WHEREAS**, Flambeau Hospital Inc. is a nonprofit corporation organized under the laws of the State of Wisconsin; and

**WHEREAS**, its purpose is to serve as a general hospital providing patient care, education and research; and

**WHEREAS**, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Body, and that the cooperative efforts of the Medical Staff, the Administrator and the Governing Body are necessary to fulfill the Hospital's obligations to its patients;

**THEREFORE**, the Practitioners practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws. Because of the small size of this institution and Medical Staff, it is not deemed appropriate or necessary to departmentalize. Therefore, the Medical Staff as a whole will conduct the business of the specialty services.

## DEFINITIONS

1. The term "Medical Staff" means the Hospital's organized component of physicians, dentists and podiatrists appointed by the Governing Body of Flambeau Hospital, Inc., and granted specific medical privileges for the purpose of providing appropriate medical, dental and podiatric care to patients in the Hospital.
2. The term "Governing Body" means the Board of Directors of the Flambeau Hospital, Inc.
3. The term "Medical Executive Committee" means the Medical Executive Committee of the Medical Staff.
4. The term "Chief of Staff" means the individual elected at the annual meeting of the Medical Staff to act in their behalf in the overall management of Hospital.
5. The term "Practitioner" means an appropriately licensed physician (M.D. or D.O.), dentist, or podiatrist applying for or exercising clinical privileges at the Hospital.
6. The term "Service" means that group of Practitioners who have clinical privileges in one of the general areas of medicine, surgery, obstetrics and gynecology, pediatrics, family practice, pathology, radiology, psychiatry, ancillary services, social services, cardiopulmonary therapy, occupational therapy, physical therapy, laboratory services, or dietary services.
7. The term "Chief of Service" means the Medical Staff member fully appointed in accordance with these Bylaws to serve as the head of a Service.
8. The term "Hospital" is used to refer to the Flambeau Hospital, Inc.
9. The terms "he," "his," or "him" will be used to refer equally to both female and male gender.
10. The term "Medical Staff year" shall be a twelve (12) month period commencing with the third Wednesday of April of each year.
11. The term "Administrator" means the individual appointed by the Governing Body to act in its behalf in the management of the Hospital.
12. The term "special notice" means written notification sent by certified or registered mail, return receipt requested, or hand delivered to the addressee.
13. The term "health status" means an individual's mental, physical and emotional health and stability.
14. The term "in good standing" means an individual who at the time the issue is raised is current in the payment of dues, has not been suspended in the previous twelve (12) months for any purpose excluding medical records completion, and is not on leave of absence.
15. The term "Code of Ethics" means the Code of Ethics or Principles of Ethics of the American Medical, Dental, Osteopathic or Podiatry Association, whichever is applicable.

# BYLAWS

## **I. NAME.**

The name of this organization shall be the Medical Staff of Flambeau Hospital, Inc.

## **II. PURPOSES.**

The purposes of this organization are:

- A. To ensure that all patients admitted to the Hospital or treated in the outpatient department receive quality care;
- B. To promote development, administration and compliance with the Medical Staff Bylaws and Rules and Regulations of the Medical Staff;
- C. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Body and administration;
- D. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;
- E. To ensure a high level of professional performance of all Practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges and through an ongoing review and evaluation of each Practitioner's performance in the Hospital;
- F. To provide a utilization review program;
- G. To provide for continuous monitoring of patient care practices;
- H. To provide retrospective review and evaluation of the quality of patient care provided by the Medical Staff;
- I. To provide recommendations to the Governing Body relative to appointments, reappointments, staff category and corrective action; and
- J. To approve sources of patient care provided outside the Hospital.

## **III. MEDICAL STAFF MEMBERSHIP.**

### **A. NATURE OF MEDICAL STAFF MEMBERSHIP.**

Membership on the Medical Staff of Flambeau Hospital is a privilege that shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, requirements and ethical directives set forth in these Bylaws.

### **B. QUALIFICATIONS FOR MEMBERSHIP.**

- 1. Only Practitioners licensed to practice in the State of Wisconsin, who can provide documentation of continued DEA registration, if applicable, who can document their background, experience, training and demonstrated competence, their adherence to the ethics of their

profession, their good reputation, and their ability to work with others, with sufficient adequacy to assure the Medical Staff and the Governing Body that any patient treated by them in the Hospital will be given quality medical care, shall be qualified for membership on the Medical Staff.

- a. Continued DEA registration requirements do not apply to the following practitioners:
  - i. Radiologists who will be providing remote image interpretation services only and are not prescribing, ordering or administering controlled substances; and
  - ii. Pathologists and other practitioners whose clinical practice is such that there is no need to prescribe, administer, or order controlled substances.
2. No applicant shall be denied membership on the basis of sex, race, age, creed, color, or national origin or handicap, disability or any other category of person protected under state or federal laws if otherwise qualified. No applicant shall be granted or denied membership or privileges based upon any physical or mental condition unrelated to continuously meeting all of the qualifications for Medical Staff membership and clinical privileges and discharging in an acceptable manner the essential responsibilities of clinical privileges and Medical Staff membership.
3. Acceptance of membership on the Medical Staff shall constitute the staff member's agreement that he will strictly abide by the applicable code of Ethics, the Statement of Medical Staff Conduct, Hospital policy, Hospital Bylaws, Medical Staff Bylaws and Rules and Regulations, both current and additional that may be promulgated from time to time.
4. Applicants must provide evidence of graduation from a medical school meeting the standards of the Accreditation Council of Graduate Medical Education, a dental school meeting the standards of the Council on Dental Education of the American Dental Association, or a school of podiatry meeting the standards of the Council on Education of the American Podiatry Association.
5. As a part of their appointment and reappointment to the Medical Staff, or at any other time upon the request of the Governing Body or Medical Executive Committee, Practitioners must certify that their current health status does not in any way impair their ability to safely exercise the clinical privileges requested or to care for patients, and the Governing Body may precondition appointment, reappointment, or the continuing exercise of any or all clinical privileges upon the Practitioner undergoing a health examination by a physician or psychologist acceptable to the Governing Body or upon submission of any other reasonable evidence of current health status that may be requested by the Medical Executive Committee or the Governing Body. The Medical Executive Committee may require that a member of the Medical Staff submit to a physical examination by an appropriate physician or psychologist at such other times as the committee determines to be appropriate. The presence of a physical or mental condition that can reasonably be accommodated

shall not constitute a bar to the granting of Medical Staff membership or clinical privileges.

6. No Practitioner shall be entitled to membership on the Medical Staff or to the enjoyment of particular privileges merely by virtue of the fact that he is duly licensed to practice medicine, osteopathy, dentistry or podiatry in this or in any other state or by virtue of the membership in any professional organization or past or present privileges at another hospital.
7. The acceptable number of continuing education hours shall be the same as those required for licensure in the state of Wisconsin.
8. As a condition of membership or the grant of any clinical privileges, an individual who is granted membership on the Medical Staff or granted any clinical privileges shall maintain and document the minimum amount of professional liability insurance coverage required by the State of Wisconsin, and if applicable, the staff member shall participate in the Wisconsin Injured Patients and Families Compensation Fund. Those staff appointees who do not qualify for the Wisconsin Injured Patients and Families Compensation Fund shall maintain and document minimum professional liability insurance coverage in an amount no less than \$1,000,000 per occurrence and \$3,000,000 for all occurrences. Professional liability insurance must be maintained at all times as a condition of Medical Staff membership or the grant of any clinical privileges, and each Practitioner must maintain a current copy of the face sheet of his professional liability insurance policy on file in Medical Staff Services. Should a Practitioner change insurance coverage due to a change in the type of practice covered, the Practitioner shall notify the Hospital within twenty-four (24) hours.
9. As a condition of membership or the grant of any clinical privileges, an individual who is granted membership on the Medical Staff or is granted any clinical privileges shall document his full compliance with state, federal and accreditation requirements, including but not limited to rubella, bloodborne pathogens, tuberculosis, immunizations, and any other testing or training requirements that may be required by the Centers for Disease Control, OSHA, Wisconsin Department of Health, and Flambeau Hospital policies.
10. As a condition of membership or the grant of any clinical privilege, an individual who is granted membership on the Medical Staff or any clinical privileges shall abide by state, federal and Hospital security and privacy rules, regulations and policies relating to protected health information
11. The Governing Body solely shall determine whether to select or reject Medical Staff based on the limitations of facilities, services, staff, support capabilities or any combination thereof. Decisions not to appoint or reappoint or grant privileges to an otherwise qualified Practitioner in accord with criteria of a Medical Staff development plan or due to the existence of any contracts for exclusive provision of clinical services, shall be made by the Governing Body.



12. No applicant who is currently excluded from any health care program funded in whole or in part by the federal government or who is barred from providing services in Flambeau Hospital under Chapter DHS 12 of the Wisconsin Administrative Code is eligible or qualified for medical staff membership, the grant of clinical privileges, or allied health affiliate status.

C. CONDITIONS AND DURATION OF APPOINTMENT.

1. Initial appointments and reappointments shall be made by the Governing Body after recommendation of the Medical Staff. Initial appointments shall be to the Associate Staff and shall be at a minimum for a period extending to the Medical Staff's routine reappointment schedule following the first twelve (12) months of the initial appointment. Initial appointment will be on a six (6) month probationary status. Reappointments shall be for a period of no more than two (2) years. Each member of the Medical Staff shall receive notification of his appointment, renewal, or cancellation by means of a letter from the Governing Body.
2. If a member of the Medical Staff has not performed admissions, procedures, history and physical examinations, consultations, or assisting on surgery of Hospital patients for the two (2) year period immediately preceding the renewal date for reapplication of privileges, that Practitioner's status on the Medical Staff will be assumed to be an automatic resignation of privileges. It should be noted that this Section does not apply to nonmembers of the Medical Staff who only conduct off-premise ordering of outpatient tests at the Hospital; such Practitioners need not apply for privileges to provide only off-premise ordering of ancillary testing.
3. In no case shall the Governing Body take action on any application, refuse to renew any appointment, or cancel any appointment previously made, without a recommendation from the Medical Staff, unless the Medical Staff fails or refuses to issue a recommendation after being given a reasonable opportunity to do so.
4. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Body, in accordance with these Bylaws.
5. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continuous care and supervision of his patients; to not receive from or pay to another Practitioner, either directly or indirectly, any part of his fee for professional services; to abide by the Medical Staff Bylaws, rules and regulations; to accept committee assignments; to accept consultation assignments; and to accept participation in quality assurance activity to ensure that patients are receiving quality care.
6. As part of their appointment and reappointment to the Medical Staff or the grant of their clinical privileges, Practitioners have a continuing

obligation to promptly notify the Administrator of, and to provide such additional information as may be requested regarding each of the following:

- a. The revocation, limitation, or suspension of his professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal governmental agency related to his professional license, or the imposition of terms of probation or limitation by any state;
- b. Previously successful or currently pending challenges to any licensure or registration or voluntary relinquishment of such licensure or registration;
- c. Loss of staff membership or privileges at any hospital or other health care institution, whether temporary or permanent, including all suspensions;
- d. Cancellation or change of professional liability insurance coverage;
- e. Receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or notice of the commencement of a formal investigation, or the filing of charges regarding health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin;
- f. Receipt of notice of the filing of any suit against the Practitioner alleging professional liability or the final disposition of any suit against the Practitioner for professional liability in connection with the treatment of any patient in or at the Hospital;
- g. Any criminal conviction or pending criminal charge, and any findings by a governmental agency that the Practitioner has been found to have abused or neglected a child or patient, or has misappropriated a patient's property; and
- h. Any proposed or actual exclusion from any federally funded health care program, any notice to the individual or his representative of proposed or actual exclusion or any pending investigation of the individual in connection with any health care program funded in whole or in part by the federal government, including Medicare and Medicaid.

#### **IV. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT.**

##### **A. APPLICATION FOR APPOINTMENT.**

1. Practitioners desiring appointment to the Medical Staff shall obtain an application and privilege request form from the Administrator who will, in addition to the forms, supply the applicant with a copy of the Medical Staff Bylaws, Rules and Regulations, the applicable Code of Ethics, the Hospital philosophy and objectives and the Medicare notice to

physicians regarding penalties for misrepresenting or falsifying information required for payment of federal funds.

2. All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Body after consultation with the Medical Executive Committee. The application shall require detailed information concerning the applicant's professional qualifications and experience; shall include a request for specific clinical privileges; shall include the names of at least two (2) persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and ethical character; shall include information as to whether the applicant's membership status, licensure, certification and/or clinical privileges have ever been either voluntarily or involuntarily limited, revoked, suspended, reduced, not renewed, denied, canceled, investigated (other than standard credentialing), voluntarily relinquished or subjected to probationary conditions or reprimand, or had proceedings towards these ends instituted or recommended, or been subjected to any other disciplinary action or sanction by any other hospital or health care institution, local or state medical organization or professional society, health plan (including but not limited to Medicare or Medicaid), licensing board, specialty board, employer who employed the applicant in a clinical or practice setting, or the Drug Enforcement Administration. The application shall include: any criminal convictions; findings of abuse, neglect or misappropriation; exclusion or sanction by a federally funded health program; information as to the applicant's ability to perform the privileges requested; information as to withdrawal of requests for medical staff membership or clinical privileges; any malpractice claims, suits, final judgments or settlements whether pending or finally determined as a result of professional liability actions and information on changes in professional liability insurance coverage initiated by the carrier (other than standard price increases); shall include an authorization to consult with others outside the Hospital to verify the applicant's credentials; and shall include a release of liability for such consultation.
3. The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.
4. The application shall be submitted to the Administrator. After collecting the references and other materials deemed pertinent, he shall transmit the completed application and all supporting materials to the Medical Executive Committee for evaluation.
5. A completed application shall consist of, but not be limited to, verification of the following areas if applicable to each Practitioner: current State of Wisconsin licensure (with evidence of current licensure in file), current Drug Enforcement Agency number/certificate (with evidence of current registration in file), education, graduate medical training, board certification, academic appointments, all Hospital affiliations, other institutional affiliations, all professional practice

affiliations, current professional liability coverage (with evidence of current professional liability coverage in file) as well as information regarding any malpractice claims, suits, settlements or arbitration proceedings in the past or currently pending, disciplinary actions, health status, references, delineation of privileges being requested, criminal record, caregiver database and National Practitioner Data Bank reports.

6. By applying for appointment to the Medical Staff, each applicant thereby signifies his willingness to appear for interviews in regard to his application, authorizes the Hospital to consult with appointees of the Medical Staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his competence, character, ethical qualifications and health status; consents to the Hospital's inspection of all records and documents that may be material to an evaluation of the applicant's professional qualifications and competence to carry out the clinical privileges he requests as well as of his moral and ethical qualifications for staff appointment; releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his credentials; and releases from any liability all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.
7. The application form shall include a statement that the applicant has received and read the Bylaws, Rules and Regulations of the Medical Staff, the applicable Code of Ethics, and that he agrees to be bound by the terms of those documents without regard to whether or not the applicant is granted appointment and/or clinical privileges in all matters relating to consideration of his application.
8. All applicants shall provide to the Hospital a certificate of insurance evidencing current professional liability coverage with a carrier licensed or approved by the State of Wisconsin.
9. Staff members not covered under the Wisconsin Injured Patients and Families Compensation Fund shall provide to the Hospital upon application and annually thereafter a certificate of insurance verifying the required minimum limits of coverage per claim. Liability coverage must be provided through a carrier licensed or approved by the State of Wisconsin.
10. All applicants shall provide a copy of their license renewal card.
11. All applicants shall provide a copy of their Drug Enforcement Agency number or certificate.
12. Evidence of current licensure, DEA registration, and insurance must be submitted upon request and maintained on file in the Medical Staff Office.

13. All foreign school graduate applicants must provide documentation that they are certified by the Educational Council for Foreign Medical School Graduates.
14. All physician applicants shall provide a signed acknowledgment that the applicant has received notice that misrepresenting information required for payment of federal funds may be subject to penalty under federal law.
15. Failure to adequately complete the application form, the withholding of requested information or the providing of false or misleading information or omitting material information necessary for a full picture of the applicant's professional history, whether the omission or misrepresentation is deliberate or unintentional, shall be a basis for denial of membership on or removal from the Medical Staff.

B. ADMINISTRATIVE DENIAL.

The Administrator may, with the approval of the Chief of Staff, deny an application for appointment or reappointment to the Medical Staff or for clinical privileges without further review, if he determines any of the following apply: the applicant: (1) does not hold a valid Wisconsin license and no application is pending; (2) does not have adequate professional liability insurance; (3) is not eligible to receive payment from the Medicare or Medical Assistance program or is currently excluded from any health care program funded in whole or in part by the federal government; (4) is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code; (5) has been denied medical staff membership (or denial has been or is being recommended at the Medical Executive Committee level or higher) at any other facility within the Ministry Health Care, Inc., system; or (6) has requested clinical privileges that have been exclusively granted to another Medical Staff member pursuant to a written contract currently in effect without notice of intent to terminate by either party, which contract covers all the privileges requested by the applicant. Applicants who are administratively denied under this Section do not have a right to a fair hearing under Article IX of these Bylaws but may submit evidence to the Administrator to refute the basis for the administrative denial.

C. APPOINTMENT PROCESS.

1. Upon receipt of a completed application and all pertinent references, the Medical Executive Committee shall investigate the character, qualifications and professional competence of the Practitioner. The Medical Executive Committee shall determine through information contained in references given by the Practitioner and from other sources available to the committee, including an appraisal from the clinical service in which privileges are sought, whether the Practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by the Practitioner. The National Practitioner Data Bank shall be queried as required by Title IV of Public Law 99-660 (The Health Care Quality Improvement act of 1986.) While the recommendation and the appointment to the Medical Staff shall be based primarily on professional competence of applicants, the ability of the Hospital to provide adequate facilities and supportive services for the applicant and

his patients; patient care needs for additional staff members with the applicant's skill and training shall also be considerations of the Governing Body in determining Medical Staff membership. To the extent the geographic location of the applicant and his practice affects the ability of the applicant to provide effective continuity of care for Hospital patients, it shall also be a consideration.

2. Within two months from receipt of the completed application, the Medical Executive Committee shall determine whether to recommend to the Governing Body that the Practitioner be provisionally appointed to the Medical Staff, that he be rejected for Medical Staff appointment, or that his 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. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within a month with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection for staff appointment.
3. Any favorable recommendation for appointment will be conditioned upon applicant's completing documentation of the applicant's health status, including the applicant's ability to safely perform the clinical privileges requested, with or without accommodation. Such documentation will be completed by the applicant and assessed by the Medical Executive Committee after the Medical Executive Committee makes a favorable determination on appointment but prior to any referral of the recommendation to the Governing Body. The Medical Executive Committee may require the Practitioner submit to a physical examination by an appropriate physician or psychologist for the purpose of determining the Practitioner's ability to competently and safely exercise the privileges requested, with or without reasonable accommodation. Unless the health information obtained requires further evaluation and reconsideration, when the recommendation of the Medical Executive Committee continues to be favorable, the Administrator shall promptly forward recommendation, together with all supporting documentation, to the Governing Body. If the health information obtained reveals a condition that warrants further investigation or evaluation, the Medical Executive Committee shall defer the application for further investigation and shall determine whether to change its recommendation on appointment or privileges within sixty (60) days. The Medical Executive Committee shall then affirm or revise its previous recommendations.
4. When the recommendation of the Medical Executive Committee is adverse to the Practitioner, either in respect to appointment or clinical privileges, as defined in Article IX of these Bylaws, the Administrator shall promptly notify the Practitioner by special notice. The adverse recommendation shall be passed on to the governing Body, but the Governing Body shall not take any action thereon until after the Practitioner has exercised or been deemed to have waived his right to a hearing as provided in Article IX of these Bylaws.

5. At its next regular meeting after receipt of a favorable recommendation from the Medical Executive Committee, after a Practitioner has waived his appeal rights, or after receiving a recommendation from the Medical Executive Committee based on a hearing, the Governing Body shall act on the matter in accordance with Article IX of these Bylaws. All decisions to appoint shall include a delineation of the clinical privileges that the Practitioner may exercise.
6. Whenever the Governing Body's decision will be contrary to the recommendation of the Medical Executive Committee, the governing Body shall submit the matter to the Joint Conference Committee for review and recommendation and shall consider such recommendation before making its decision final.
7. When the Governing Body's decision is final, it shall send notice of such decision through the Administrator to the Chief of Staff, to the Chief of Service concerned, and, by special notice, to the Practitioner.

D. REAPPOINTMENT PROCESS.

1. The Medical Executive Committee shall review all pertinent information available on each Practitioner for the purpose of determining its recommendations for reappointment to the Medical Staff and for the granting of clinical privileges and shall transmit its recommendations, in writing, to the Medical Staff. Reappointment shall be for a period of up to two (2) years.
2. The subject staff appointee shall supply in writing the information to be used in the appraisal for staff reappointment and privilege delineation, including all information necessary to update the information contained in the initial application for appointment since the time the last update was supplied. Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment, with any basis for change, shall be based upon such member's professional competence, clinical judgment and, when appropriate, technical skill in the treatment of patients, previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration), or the voluntary relinquishment of such licensure or registration, voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, denial or loss of clinical privileges at another hospital or institution, any refusal or cancellation of professional liability insurance, any malpractice claims, suits, final judgments or settlements whether pending or finally determined as a result of professional liability action and shall include consideration of the staff appointee's health status as it relates to the member's ability to competently and safely exercise his clinical privileges with or without reasonable accommodation. The presence of a physical or mental condition that can reasonably be accommodated shall not constitute a bar to the grant of Medical Staff membership or clinical privileges. Other reappraisal parameters may include the individual's maintenance of timely, accurate and complete medical records; patterns of care as demonstrated by reviews and evaluations conducted by committees; his ethics and conduct, his attendance at Medical Staff meetings and

participation in Staff affairs, his compliance with the Hospital Bylaws and Medical Staff Bylaws, Rules and Regulations, his cooperation with Hospital personnel, his use of the Hospital's facilities for his patients, his relations with other Practitioners, and his general attitude toward patients, the Hospital and the public, quality assurance findings related to his practice, and his compliance with requirements by the Department of Regulation and Licensing in regard to continuing medical education. The National Practitioner Data Bank shall be queried as required by Title IV of Public Law 99-660 (The Health Care Quality Improvement Act of 1986.)

3. Thereafter, the procedure provided in Section IV.C relating to recommendations on the applications for initial appointment shall be followed.
4. If the reappointment process has not been fully completed by the end of the current appointment, applicants who have applied for reappointment shall maintain their former appointment status until the process is completed unless: 1) a recommendation is made to deny reappointment consistent with due process, (2) corrective action after completed due process 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 will end at the expiration of the current appointment. Where the appointment is temporarily extended to complete processing, such temporary extension of appointment shall not create a right for automatic reappointment for the subsequent term.

E. REAPPLICATION AFTER ADVERSE ACTION.

1. An applicant who has received a final adverse professional review action regarding appointment or clinical privileges or both and who did not exercise any of the hearing rights provided in these Bylaws 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 (6) months from the date of final adverse action or until he completes training identified by the Medical Staff as a prerequisite for the privileges, whichever is shorter.
2. An applicant who has received a final adverse professional review action regarding appointment and who exercised some or all of the hearing rights provided under Article IX shall not be eligible to reapply for the membership status or privileges that were the subject of the adverse action for a period of two (2) years from the date of final adverse action.
3. Any reapplication under this Section shall be processed as an initial application, but the applicant 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.
4. If the recommendation of the Medical Staff or the action proposed by the Governing Body upon reapplication under Section IV.E.2 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.

5. Notwithstanding any other provision of this section, an applicant who was rejected or a practitioner who lost Medical Staff membership due to any of the following reasons shall not be eligible to reapply, regardless of any lapse of time:
  - a. Providing false or misleading information in connection with an application for membership or clinical privileges;
  - b. Falsifying patient records;
  - c. Engaging in patient abuse; or
  - d. Engaging in sexual assault

F. TIME PERIODS FOR PROCESSING.

Applications for appointment or reappointment shall be considered in a timely and good faith manner by all individuals and groups who are required by these Bylaws to act on such applications and, except for good cause, shall be processed within the time periods specified. However, the time periods specified are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the Practitioner to have his application processed within those periods nor to create a right for a Medical Staff member to be automatically reappointed for the coming term.

V. **CATEGORIES OF THE MEDICAL STAFF.**

A. THE MEDICAL STAFF.

The Medical Staff shall be divided into Honorary, Active, Associate, Courtesy, Consulting, and Contract Staff.

B. THE HONORARY MEDICAL STAFF.

1. The Honorary Medical Staff shall consist of Practitioners who are not active in the Hospital and who are honored by emeritus positions. These may be: (1) Practitioners who have retired from active Hospital service, or (2) Practitioners who have outstanding qualifications, not necessarily residents in the community.
2. The Honorary Staff is not eligible to vote or hold office, to admit or treat patients at the Hospital, and shall have no assigned duties.

C. THE ACTIVE MEDICAL STAFF.

1. The Active Medical Staff shall consist of those Practitioners who regularly admit patients to, or are otherwise regularly involved in, the care of patients in the Hospital, who are located close enough to the Hospital to provide continuous care to their patients, and who assume all the functions and responsibilities of membership on the Active Medical Staff.
2. Members of the Active Medical Staff must have been members of the Associate Medical Staff for a period of at least six (6) months, which requirement may be waived in unusual circumstances by the Medical

Executive Committee and the Governing Body. They must have attained acceptable qualifications in their field of practice according to current national standards and have an active interest in the operation of the Hospital.

3. Members of the Active Medical Staff shall promote the quality of medical care in the Hospital, offer sound counsel to the Administrator and the Governing Body and participate in the internal governance of the Medical Staff according to these Bylaws. The members of the Active Staff shall, within the scope of their privileges, provide emergency care and attend to charity patients as assigned by the Chief of their Service.
4. The Active Medical Staff should deliver the preponderance of the medical service within the Hospital and should perform all significant organizational and administrative duties pertaining to the Medical Staff. Members of the Active Staff shall be eligible to vote and hold office. They shall pay dues as established by the Medical Staff.
5. Members of the Active Medical Staff shall be required to attend Medical Staff meetings as provided in Article XIII of these Bylaws.
6. Members of the Active Medical Staff over sixty (60) years of age may at their discretion be exempt from certain duties such as rotation call in the emergency room.

D. THE ASSOCIATE MEDICAL STAFF.

1. The Associate Medical Staff shall consist of newly appointed Practitioners (except to the Honorary Medical Staff) and those who have been reappointed to the Associate Medical Staff for an additional period after completion of their initial term. The staff category to which the Practitioner will be seeking to advance must be specified at the time of application.
2. The Associate Medical Staff member will be expected to fulfill the responsibilities and abide by the restrictions applicable to the staff category designated for advancement, as a condition of advancement upon completion of the Associate Medical Staff term. However, Associate Medical Staff members shall not be eligible to (1) vote in the election of officers or the amendment or adoption of Bylaws, (2) serve on the Medical Executive Committee, or (3) hold office.
3. Associate Medical Staff members shall be appointed and assigned to services in the same manner as provided for the Active Medical Staff. The appropriate Service Chief to which the Associate Medical Staff member is assigned shall observe the member's activities during this Associate Staff membership and will recommend appropriate staff category and clinical privileges following their initial term.
4. A member of the Associate Medical Staff who does not qualify at the end of his initial term of appointment for advancement to the staff category designated should be scheduled for a personal interview with the Medical Executive Committee at the time of reappointment to

discuss the status of his continued interest in membership on the Medical Staff of the Hospital. The Medical Executive Committee, after consultation with the Chair of the Service(s) involved, will recommend continuation of the Associate Medical Staff for an additional period not to exceed one year, appointment to the Active, Courtesy, or Consulting Medical Staff, or non-reappointment to the Medical Staff. In the case of non-reappointment or revocation of specific clinical privileges, the Practitioner shall be entitled to the procedural rights set forth in these Bylaws.

5. If the Practitioner fails to meet the requirements or responsibilities of the staff category to which he was initially designated to advance, the Practitioner may be advanced to any other staff category for which he qualifies, if approved by the Governing Body.

E. THE COURTESY MEDICAL STAFF.

1. New members of the Courtesy Medical Staff must have been members of the Associate Medical Staff, the Active Medical Staff or the Consulting Medical Staff for a period of at least six (6) months before being eligible for the Courtesy Medical Staff.
2. Members of the Courtesy Medical Staff must be a member of the Active or Associate Medical Staff of another hospital where he actively participates in a peer review process and other quality assessment and improvement activities similar to those required of the Active Medical Staff of this Hospital.

If the Courtesy Medical Staff member is not on the Active or Associate Staff of another hospital, the Staff member may be required to provide access to his outpatient records for purposes of quality assurance and reassessment at time of reappointment.

3. The Courtesy Medical Staff shall consist of those Practitioners eligible for Medical Staff membership who wish to attend a limited number of patients in the Hospital. They shall be appointed to this category at their own request in the same manner as other members of the Medical Staff and they shall have such privileges as may be determined by the Medical Executive Committee in conformity with Article VII of these Bylaws. They shall not be eligible to vote or hold office. They may service on standing or special committees, but not on the Medical Executive or Joint Conference Committees.
4. Members of the Courtesy Medical Staff may admit patients to Hospital only when sufficient beds are available and when such admission does not interfere with the admission of patients by members of the Active and Associate Medical Staffs.

F. THE CONSULTING MEDICAL STAFF.

1. New members of the Consulting Medical Staff must have been members of the Associate Medical Staff, the Courtesy Medical Staff or the Active Medical Staff for a period of at least six (6) months before being eligible for the Consulting Medical Staff.

2. The Consulting Medical Staff shall consist of Practitioners of recognized professional ability who are active in their specialties and have signified a willingness to accept such appointment to the Medical Staff. Members of the Consulting Medical Staff shall be members of specialty boards, diplomats of one of the national boards of medical specialties, or other Practitioners who, in the opinion of the Medical Executive Committee, are qualified for consultation work in their specialty.
3. Members of the Consulting Medical Staff shall have such non-surgical privileges as may be granted by the Governing Body in accordance with these Bylaws. All surgical privileges require Active, Courtesy or Associate staff membership with advancement to these Medical Staff categories designated.
4. The Consulting Medical Staff is not ordinarily eligible to vote or hold office and shall have no assigned duties. However, the radiologist and pathologist shall ordinarily be eligible to vote and hold office at the discretion of the Active Medical Staff.

G. CONTRACT PHYSICIANS STAFF.

1. Definitions.
  - a. Contract physicians are graduates of a recognized medical school, fully and legally licensed to practice medicine in the State of Wisconsin, who contract with the Hospital on an hourly or salaried basis to render medical care to patients in the Hospital. They shall be divided into full-time contract physicians and part-time contract physicians.
2. Full-time Contract Physicians.
  - a. Full-time Contract Physicians, defined as physicians with contracts for extended timeframes versus individual occurrences, shall be members of the Medical Staff and subject to all provisions of the Bylaws, Rules and Regulations. Such a physician shall not have his Medical Staff privileges terminated or restricted without the same due process provisions provided to other Medical Staff members, unless agreed to otherwise in the contract of employment.
3. Part-time Contract Physicians.
  - a. Part-time contract physicians shall be members of the Medical Staff, but need not serve on committees. Their professional activities shall be limited to the Hospital's emergency room and to the procedures customarily performed therein and such other privileges as may be extended to them by the Governing Body, upon recommendation of the Medical Executive Committee. They may not admit patients to the Hospital except through members of the Active, Associate, or Courtesy Medical Staffs. Except as otherwise provided herein, they shall be subject to the Bylaws and Rules and Regulations of the Medical Staff.

- b. The procedure for appointment for part-time contract physicians shall be the same as that contained in Article IV, for Medical Staff Members.
  - c. The employment or privileges of part-time contract physicians may be terminated or restricted at any time in accordance with the terms of their individual contracts, by the Administrator after consultation with the Chief of the Medical Staff. Such actions shall be reviewed by the Medical Executive Committee, which shall make recommendations to the Governing Body. Unless their contracts provide for it, at no time during this process shall the part-time contract physicians be accorded any of the hearing and appeal rights set forth in Article IX of these Bylaws.
4. Right to Vote.
- a. Contract physicians may be given the right to vote. This right will be written into the contract and approved by the Governing Body on the recommendation of the Medical Staff.

H. DENTAL STAFF FUNCTIONS.

- 1. Dental staff privileges will be determined in the same manner as those of the Medical Staff.
- 2. The Medical Executive Committee shall have the responsibility for reviewing the qualification of dentists, upon consultation with Dental Staff members.
- 3. Dentists granted membership on the Medical Staff in accordance with the procedures set forth in Article IV may be members of any category of the Medical Staff for which they qualify and shall be assigned to the Surgery Service.
- 4. Except as provided in Section VII.A.4, dentists shall conform to the Bylaws, Rules and Regulations of the Medical Staff with the following additions:
  - a. Patients may be admitted for dental services by a dentist after obtaining the concurrence of the admitting physician.
  - b. At the time of admission, the name of the medical consultant must appear on the appropriate forms. This consultant shall be responsible for pre- and post-operative medical evaluation and care of the patient, except as provided below.
  - c. The dentist may discharge the patient after obtaining the concurrence of the attending physician.
  - d. Complete records, both dental and medical, shall be required on each patient and shall be part of the Hospital record.

I. PODIATRY STAFF FUNCTIONS.

- 1. Podiatry staff privileges will be determined in the same manner as those of the Medical Staff.

2. The Medical Executive Committee shall have the responsibility for reviewing the qualification of podiatrists, upon consultation with Podiatry Staff members.
3. Podiatrists granted membership on the Medical Staff in accordance with the procedures set forth in Article IV may be members of any category of the Medical Staff for which they qualify and shall be assigned to the Surgery Service.
4. Except as provided in Section VII.A.7, podiatrists shall conform to the Bylaws, Rules and Regulations of the Medical Staff with the following additions:
  - a. Patients may be admitted for podiatric services by a podiatrist after obtaining the concurrence of the admitting physician.
  - b. Orthopaedic procedures performed by podiatrists shall be done under the overall supervision of the Chief of the Surgery Service or his designee.
  - c. At the time of admission, the name of the medical consultant must appear on the appropriate forms. This consultant shall be responsible for pre- and post-operative medical evaluation and care of the patient.
  - d. The podiatrist may discharge the patient after obtaining the concurrence of the attending physician.
  - e. Complete records, both podiatric and medical, shall be required on each patient and shall be part of the Hospital record.

## **VI. ALLIED HEALTH AFFILIATES.**

### **A. GENERAL PROVISIONS.**

1. Allied Health Affiliates shall consist of professionally competent allied health professionals who participate in Hospital care. Affiliates may practice relatively independently or under the direct supervision of a supervising physician, depending on their training and the authorities outlined in this Article. Allied Health Affiliates shall continuously meet the qualifications, standards and requirements as set forth in these Bylaws, associated policies of the Medical Staff and Hospital, and any principles of professional ethics applicable to Allied Health Affiliates. Allied Health Affiliates are not members of the Medical Staff and may not hold any Medical Staff office or vote at any Medical Staff meeting.
2. Allied Health Affiliates shall be divided into three (3) categories. Independent Allied Health Affiliates, Independent Allied Health Affiliates/Chiropractors, and Dependent Allied Health Affiliates. For purposes of credentialing processes, Independent Allied Health Affiliates and Dependent Allied Health Affiliates may be referred to as Advanced Practice Clinicians and Authorized Providers, respectively.

3. Each individual in these categories will present his qualifications for review by the Medical Staff in accord with the procedures as set forth herein for the appointment of Practitioners to the Medical Staff. The Director of Patient Care Services will review the credentials of all Registered Nurse Allied Health Affiliates, and will offer a recommendation to the Medical Executive Committee for their consideration. If approved by the Medical Executive Committee, the Governing Body may grant such individual privileges as described in Section VI.B and Section VI.C.
4. As a condition of appointment and the exercise of clinical privileges as an Allied Health Affiliate, each individual must meet the conditions set forth for Practitioners in Article VII of these Bylaws.
5. As a condition of being permitted to provide services in the Hospital, Allied Health Affiliates must follow all Hospital guidelines and rules established for their Medical Staff category and must meet and comply with all applicable statutory and regulatory requirements imposed by the State of Wisconsin.

B. INDEPENDENT ALLIED HEALTH AFFILIATES.

1. This category of Allied Health Affiliates shall consist only of the following professionals. These professionals must be credentialed regardless of their employment status with Flambeau Hospital, Inc.:
  - a. Individuals with a doctorate in psychology from an accredited college or university, and licensed in the State of Wisconsin;
  - b. Individuals with a masters degree in speech pathology from an accredited college or university, and licensed in the State of Wisconsin;
  - c. Nurse midwives, certified registered nurse anesthetists and other independent nurse practitioners, who are nurses registered under the laws of the State of Wisconsin and engaged in independent nursing practice in the community;
  - d. Individuals with a degree in orthotics and prosthetics from an accredited college or university, and certified by the appropriate accreditation agency;
  - e. Individuals with a degree in social work from an accredited college or university, and licensed in the State of Wisconsin;
  - f. Individuals with a degree in optometry from an accredited college or university, and licensed by the State of Wisconsin.
2. Independent Allied Health Affiliates may provide patient care services within the limits of their professional skills and abilities. The degree of participation by Independent Allied Health in patient care shall be determined according to protocols and/or policies recommended by the Medical Staff and approved by the Governing Body.

3. Applications for appointment and clinical privileges as an Independent Allied Health Affiliate shall be processed in accordance with the procedures set forth in Article VII of the Medical Staff Bylaws. An individual applying for appointment as an Independent Allied Health Affiliate must be continuously sponsored by an Active, Associate, or Courtesy member of the Medical Staff who will review the adequacy of their performance on a regular basis. The physician sponsor will attest to this in writing. There can be only one physician sponsor for an Allied Health Affiliate. A physician member of the Active, Associate, or Courtesy member of the Medical Staff shall have ultimate responsibility for patient care.
4. As a condition of continued privileges, such individuals may be required to attend meetings involving the clinical review of patient care in which they participated.

C. INDEPENDENT ALLIED HEALTH AFFILIATES/CHIROPRACTORS.

1. This category of Allied Health Affiliates shall consist of those individuals with a degree in chiropractic from an accredited college or university, and licensed in the State of Wisconsin.
2. Independent Allied Health Affiliates/Chiropractors may be granted privileges at Flambeau Hospital, Inc., per policies and the "Services Agreement" developed by the Medical Staff and approved by the Governing Body.
3. Applications for appointment and clinical privileges as an Independent Allied Health Affiliate/Chiropractor shall be processed in accordance with the procedures set forth in Article VII of the Medical Staff Bylaws. In addition to the application materials outlined in that Article, Chiropractors must sign and agree to abide by the terms of the "Service Agreement" for Chiropractors.

D. DEPENDENT ALLIED HEALTH AFFILIATES.

1. This category of Allied Health Affiliates shall consist of all other clinical technicians or professionals who are employees of an Active, Associate, or Courtesy member or members of the Medical Staff or who are engaged by the Hospital by contract and who perform a portion of their professional responsibilities within the Hospital while under the supervision of an Active, Associate, or Courtesy member or members of the Medical Staff as defined in Section VI.D.3, below.
2. The employer of the individual who is seeking approval as a Dependent Allied Health Affiliate shall present a written statement of the clinical duties and responsibilities of said individual to the Medical Executive Committee for its review and approval prior to allowing the individual to perform any professional responsibilities within the Hospital. The individual applicant shall supply information regarding his qualifications, including professional training, experience, and current competence, to the Medical Executive Committee for processing in accordance with the procedure set forth in Article VII of these Bylaws. Services provided by Dependent Allied Health Affiliates should not supplant services



provided by Hospital employees. Instead, dependent affiliates shall serve to augment the Hospital-related services normally provided by their physician employer(s).

3. The employer of the Dependent Allied Health Affiliate shall assume full responsibility, and be fully accountable for the conduct of said individual within the Hospital. The sponsoring physician shall provide continuous direct supervision of the Allied Health Affiliate and sign a statement attesting compliance with the Bylaws describing the requirements for Dependent Allied Health Affiliates. There can be only one physician sponsor responsible for the Allied Health Affiliate.

It is further the responsibility of the employer of the Dependent Allied Health Affiliate to acquaint said individual with the applicable Rules and Regulations of the Medical Staff and the Hospital, as well as appropriate members of the Medical Staff and Hospital personnel with whom said individual shall have contact at the Hospital. Said employer shall furnish evidence of professional liability insurance coverage for such individuals. Such coverage shall meet the requirements established by the State of Wisconsin and/or Flambeau Hospital, Inc.

4. In circumstances where the employer of the Dependent Allied Health Affiliate is a member of the Medical Staff, the clinical duties and responsibilities of said individual within the Hospital shall terminate if the Medical Staff membership of the employer is terminated for any reason or if the employer's clinical privileges are curtailed to the extent that the professional services of said individual within the Hospital are no longer necessary or permissible to assist the employer.

E. REMOVAL PROCEDURES AND STATUS.

1. Persons maintaining any of the foregoing positions are not members of the Medical Staff, and accordingly have none of the duties or prerogatives of staff members.
2. The Hospital retains the right, either through Administration or upon recommendation of the Medical Executive Committee, to suspend or terminate any or all of the privileges or functions of any category of Allied Health Affiliate, without recourse or on the part of such person or others to the review and appeal procedures of Article IX of these Bylaws.
3. Independent Allied Health Affiliates who are terminated or curtailed shall be told the reasons for such action, and if they so request, shall be entitled to have such action reviewed by the Medical Executive Committee or a committee duly appointed by the Medical Executive Committee. At any review meeting, the individual shall be present and allowed to fully participate.
4. Where a Dependent Allied Health Affiliate is terminated or curtailed, the employer shall be notified as to the reasons for such action and be afforded an opportunity of review by the Medical Executive Committee. The employer and the individual are entitled to be present and to present evidence to rebut the reasons for the action.

## **VII. CLINICAL PRIVILEGES.**

### **A. REGULAR PRIVILEGES.**

1. Medical and surgical privileges are granted to members of the Medical Staff by the Governing Body upon recommendation from the Medical Executive Committee. Every Practitioner practicing at Flambeau Hospital shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him by the Governing Body except as provided in Section VII.B and VII.C.
2. Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. Determination of initial privileges shall be based upon an applicant's training, experience, demonstrated ability, references and other relevant information. The applicant shall have the responsibility to establish his qualifications and competency for the clinical privileges he requests.

The periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the criteria set forth in Section VII.A.2 and on the direct observation of care provided, the member's health as it relates to the exercise of his clinical privileges, review of the records of patients treated in this or other Hospitals or clinics/offices, and review of the records of the Medical Staff which document quality assurance findings of the member's participation in the delivery of medical care including training, experience, current competence and satisfactory exercise of clinical privileges in the period last completed.

3. Privileges may be granted to dentists by the Governing Body, on the recommendation of the Medical Executive Committee, and the delineation of their clinical privileges shall be based on their training, experience, demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Admission of a dental patient shall be the dual responsibility of the dentist and a physician member of the Medical Staff. Surgical procedures performed by dentists shall be under the overall supervision of the Chief of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. The nature and degree of supervision is a matter of determination in each instance within the Medical Staff policy that governs the usual relationship and dual responsibility that should exist between the Medical Staff and the dentist. A physician appointee of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. The dentist is responsible for the dental history and physical examination, discharge summary and all appropriate elements of the patient's record.
4. Dentists may write orders within the scope of their license, as limited by the applicable statutes and as consistent with the Medical Staff regulations. Dentists shall agree to comply with all applicable Medical

Staff Bylaws, Rules and Regulations at the time of application for clinical privileges.

5. Oral surgeons who have been granted clinical privileges to do so may admit and discharge patients without medical problems without first obtaining the concurrence of a physician member of the Medical Staff, but such oral surgeons must designate a physician member of the Medical Staff with appropriate clinical privileges to be responsible for the care of any medical problem that may arise. If granted clinical privileges to do so, oral surgeons may, in lieu of a physician member of the Medical Staff, perform the admission history and physical examination and assess the medical risks of the proposed surgical procedures on those patients admitted without medical problems.
6. Privileges may be granted to podiatrists by the Governing Body, on the recommendation of the Medical Executive Committee, and the delineation of their clinical privileges shall be based on the applicant's training, experience, judgment and demonstrated competence. The scope and extent of surgical procedures that each podiatrist may perform must be specifically defined and recommended in the same manner as for all other surgical privileges. Admission of a podiatric patient shall be the dual responsibility of the podiatrist and a physician member of the Medical Staff. Podiatric surgical procedures undertaken must be under the overall supervision of the Chief of Surgery. All podiatry patients shall receive the same basic medical appraisal as patients admitted to other surgical services. The nature and degree of supervision is a matter of determination in each instance within the Medical Staff policy that governs the usual relationship and dual responsibility that should exist between the Medical Staff and the podiatrist. A physician member of the Medical Staff must be responsible for the general care of the patient during hospitalization. The podiatrist is responsible to the podiatric care of the patient, including the podiatric history and physical examination, discharge summary, and all appropriate elements of the patient's record.
7. Podiatrists may write orders within the scope of their license, as limited by the applicable statutes and as consistent with the Medical Staff regulations. Podiatrists shall agree to comply with all applicable Medical Staff Bylaws, Rules and Regulations at the time of application for clinical privileges.

B. TEMPORARY PRIVILEGES FOR MEDICAL STAFF APPLICANTS OR FOR LOCUM TENENS ONLY.

1. Practitioners applying for temporary privileges under this clause must be licensed in Wisconsin and meet at least one of the following criteria:
  - a. Be an active staff member in good standing at another health care facility; or
  - b. Have a sponsor on the Medical Staff who is willing to assume responsibility for the Practitioner.
2. Medical Staff applicants are required to submit a completed application at least thirty (30) days in advance to allow review prior to the

contemplated date of beginning practice. Temporary privileges will not be granted to applicants for Medical Staff membership during the processing of their applications, except in unusual circumstances.

3. Upon receipt of an application for Medical Staff membership from an appropriately licensed Practitioner, the Administrator may, after conference with the Chief of Staff and upon the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant, grant temporary admitting and clinical privileges to the applicant. Such privileges shall ordinarily not extend beyond 120 days.
4. A Practitioner who contemplates serving as locum tenens must complete an application as if he were applying for Medical Staff membership and must be reviewed, approved, and have privileges delineated according to these Bylaws. Temporary privileges may be granted for the locum tenens Practitioner for a period not to exceed sixty (60) days. Such privileges may be granted after review of the Practitioner's credentials by the Medical Executive Committee, subject to the approval of the Governing Body.
5. All Practitioners exercising temporary privileges shall do so under the supervision of the Chief of Staff or his designee.
6. No Practitioner is entitled to temporary privileges as a matter of right. A Practitioner shall not be entitled to the procedural rights afforded by Article IX because of his inability to obtain temporary privileges or because of any termination, modification or suspension of temporary privileges.
7. Temporary privileges may be terminated at any time at the direction of the Administrator on the recommendation of the Chief of Staff or the Chief of Service concerned when the conduct of the Practitioner exercising such privileges so indicates. Such termination shall not be subject to the procedural rights afforded by Article IX. In cases where it is deemed necessary to permit the Practitioner holding temporary privileges to continue treating a patient then under his care, the Practitioner shall be permitted to care for the patient until discharge of the patient. Where it is determined that the life or health of the patient would be endangered by the continued treatment by a Practitioner whose temporary privileges have been terminated, the Chief of the applicable Service or, in his absence, the Chief of Staff shall assign a member of the Medical Staff to assume responsibility for the care of the patient until the patient is discharged from the Hospital.
8. Before temporary privileges are granted, the Practitioner must acknowledge in writing that he has received and read the Medical Staff Bylaws, Rules and Regulations and that he agrees to be bound by the terms thereof in all matters relating to his temporary privileges.

C. TEMPORARY PRIVILEGES TO MEET AN IMPORTANT PATIENT CARE NEED.

1. The granting of temporary privileges is not encouraged and shall be limited to no more than 120 days pending review and approval of a

completed application and to circumstances where the individual is not seeking membership or locum tenens status but granting temporary privileges is deemed necessary or beneficial to Flambeau Hospital to meet an important patient care need. Practitioners applying for temporary privileges under this Section must be licensed in Wisconsin and have a sponsor on the Medical Staff who is willing to assume responsibility for the practitioner. Additionally, the practitioner must satisfy the requirements regarding professional liability insurance, health status, eligibility to participate in federally-funded health care programs, and the Wisconsin caregiver background check laws, as described in these Bylaws.

2. Upon the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant (including, at a minimum, the requirements identified in the preceding paragraph), temporary clinical privileges may be granted by the Chief of Staff or his designee, to a practitioner who is not an applicant for membership or for locum tenens status, when necessary to meet an important patient care need for a specified patient, provided that the practitioner first acknowledges in writing that he has received and read copies of the Medical Staff Bylaws, Rules and Regulations, and applicable policies and agrees to be bound by their terms in all matters relating to temporary clinical privileges. Temporary privileges granted under this subsection shall be limited to situations where the applicant is not a candidate for medical staff membership or locum tenens status but there is an important patient care need that mandates an immediate authorization to practice before all credentials information can be verified and approved. Temporary privileges granted under this subsection (other than disaster privileges granted pursuant to hospital Policy No. 770-H-166, entitled Emergency Credentialing) shall be restricted to the treatment of not more than two patients in any one year by any practitioner, after which the practitioner shall be required to apply for membership on the medical staff before being allowed to attend additional patients.

D. EMERGENCY PRIVILEGES.

1. In the case of emergency, any Practitioner, to the degree permitted by his license and regardless of Service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable.
2. When an emergency situation no longer exists, such Practitioner must request the privileges necessary to continue to treat the patient.
3. In the event such privileges are denied or he does not desire to request privileges, the appropriate Service Chief shall assign the patient to a member of the Medical Staff.
4. For the purpose of this Section, an "emergency" is defined as a condition in which serious harm could 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.

E. TELEMEDICINE PRIVILEGES.

1. "Telemedicine" for purposes of these Bylaws consists of interpretive and interactive telemedicine services.
2. "Interpretive telemedicine" for purposes of these Bylaws consists of providing official readings of images, tracings, or specimens through a telemedicine link, but not engaging in interactive telemedicine.
3. "Interactive telemedicine" for purposes of these Bylaws consists of 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.
4. Consideration for interpretive or interactive telemedicine privileges will only be given pursuant to a written services agreement with a telemedicine entity or a Medicare-participating hospital (distant sites).
  - a. The agreement shall comply with the applicable requirements set forth in the Medicare Conditions of Participation, 42 CFR 485.
5. Applicants based at distant sites may apply for telemedicine privileges through one of the following mechanisms, as selected by the credentials committee, either for the individual or for a designated class of applicants per policy decision of the credentials committee:
  - a. By submission of a telemedicine privileges application containing, at a minimum, the following information:
    - (1) Medical Staff, or employment status, and scope of current clinical privileges;
    - (2) Wisconsin licensure;
    - (3) Evidence of insurance meeting requirements for applicants for medical staff membership;
    - (4) Existence of any of the events or circumstances outlined in Bylaws Article III.C.6 ;
    - (5) Request for the specific telemedicine privileges desired;
    - (6) Acknowledgment that the applicant is subject to (1) Bylaws Article XIV in all respects in connection with the application for or exercise of clinical privileges, (2) Bylaws Article III.B. (with the exception of subpart (9)), (3) Bylaws Article III.C.6;
    - (7) A complete list of all hospital medical staff memberships held within the 5 years prior to application; and
    - (8) A release of the hospital from civil liability resulting from this use of all such information.
  - b. By submission of a copy of the most recently completed application for medical staff membership or clinical privileges at the distant site, provided the applicant supplies any supplemental information required by the Hospital that is not contained in the distant site's application.

- c. By submission of the same application required of all other applicants for Hospital medical staff membership or clinical privileges.
6. In processing requests for telemedicine privileges, the Hospital may utilize any of the following processes, as selected by the credentials committee, either for the individual or for a designated class of applicants per policy decision of the credentials committee:
- a. The Hospital's Governing Body may rely upon credentialing information obtained and verified by the distant site where the applicant currently holds medical staff membership or clinical privileges rather than directly obtaining primary source verification of the information supplied by the applicant. The distant site must attest to:
    - (1) Maintaining credentialing and privileging processes and standards that meet or exceed Hospital and legal standards; and
    - (2) Maintaining credentialing and privileging processes and to delivering services that will allow the Hospital to remain in compliance with the Medicare Conditions of Participation, designated accreditation agencies (if any), and other state and federal laws and regulations applicable to the Hospital.
  - b. The Hospital's Governing Body may rely upon the credentialing and privileging decisions made by the governing body of the distant site hospital regarding individual distant site physicians or practitioners. The Hospital's Governing Body must ensure, through its written agreement with the distant site hospital, that the following provisions are met:
    - (1) The distant site hospital providing telemedicine services is a Medicare-participating hospital;
    - (2) The individual distant site physician or practitioner is privileged at the distant site hospital providing the telemedicine services, which provides a current list of the distant site physician's or practitioner's privileges at the distant site hospital;
    - (3) The individual distant site physician or practitioner holds a license issued or recognized by the State of Wisconsin; and
    - (4) With respect to a distant site physician or practitioner, who holds current privileges at the Hospital, the Hospital has evidence of an internal review of the distant site physician's or practitioner's performance of these privileges and sends the distant site hospital such information for use in the periodic appraisal of the individual distant site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant site physician or practitioner to the Hospital's patients and all complaints the Hospital has received about the distant site physician or practitioner.
  - c. The Hospital's Governing Body may rely upon the credentialing and privileging decisions made by the governing body of the distant site telemedicine entity regarding individual distant site

physicians or practitioners. The Hospital's Governing Body must ensure, through its written agreement with the distant site telemedicine entity, that the following provisions are met:

(1) The distant site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at paragraphs 42 CFR 485.616 (c)(1)(i) through (c)(1)(vii);

(2) The individual distant site physician or practitioner is privileged at the distant site telemedicine entity providing the telemedicine services, which provides a current list to the Hospital of the distant site physician's or practitioner's privileges at the distant site telemedicine entity;

(3) The individual distant site physician or practitioner holds a license issued or recognized by the State of Wisconsin; and

(4) With respect to the distant site physician or practitioner, who holds current privileges at the Hospital, the Hospital has evidence of an internal review of the distant site physician's or practitioner's performance of these privileges and sends the distant site physician's or practitioner's performance of these privileges and sends the distant site telemedicine entity such information for use in the periodic appraisal of the distant site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant site physician or practitioner to the Hospital's patients and all complaints the Hospital has received about the distant site physician or practitioner.

F. LEAVE OF ABSENCE AND REAPPOINTMENT.

1. Any member of the Medical Staff may obtain a leave of absence from the Medical Staff for a period not to exceed his present term of appointment by submitting a written request to the Medical Executive Committee and the Administrator. The request shall state the start and anticipated end date of the requested leave and the reasons for the leave (such as military duty, additional training, family matters or personal health). Failure of a Practitioner to return or apply for extension of leave shall constitute a resignation from the Medical Staff, and shall not be subject to any hearings or appellate review. A request for Medical Staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for reappointments.
2. If the leave of absence was for medical reasons, then upon return the practitioner must submit a report from his attending physician indicating that the practitioner is physically and/or mentally capable of resuming a hospital practice and exercising the clinical privileges requested competently and safely. The practitioner shall also provide such other information as may be requested by the Medical Executive Committee or the Administrator at that time. After considering all relevant information, the Medical Executive Committee shall then make a recommendation regarding reinstatement to the governing body for final action.



3. If a leave of absence is requested to take remedial training as a result of corrective action or probation, the practitioner, after completion of the training, must present to the appropriate Service Chief and to the Medical Executive Committee satisfactory evidence that the special education/training corrected the deficiencies in clinical performance. The Medical Executive Committee shall evaluate the evidence presented and shall make a recommendation to the governing body for final approval. Any monitoring, review or similar processes affecting the practitioner prior to the leave of absence shall resume upon return of the practitioner from the leave.
4. A member in good standing who is granted a leave of absence for special training in his specialty to acquire new knowledge and/or skills shall present evidence of competence in the new or different procedure(s) to the Service Chief and the Medical Executive Committee. After review, the recommendations of the Medical Executive Committee shall be forwarded to the governing body for appropriate action.
5. Subject also to the conditions set forth above for specific types of leave, at the conclusion of the leave of absence, the individual may request reinstatement by filing a written statement with the Medical Executive Committee summarizing any relevant professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the Medical Executive Committee at that time. Notice of the individual's intent to return from leave must be received a minimum of 30 days before the termination of the leave of absence. The Medical Executive Committee will review the request and make a recommendation to the governing body regarding reinstatement. Reinstatement after a leave of absence is a matter of courtesy, not of right.
6. During the period of leave, the practitioner shall not exercise clinical privileges at the Hospital and membership rights and responsibilities shall be inactive but the obligation to pay dues, if any, shall continue unless waived by the Medical Executive Committee.
7. The practitioner shall be responsible for obtaining coverage for his patients during the leave.
8. A leave of absence may not extend beyond the term of the Practitioner's current term of appointment. If the Practitioner is not ready to return from leave before his current appointment term is set to expire, any application for reappointment will be held in abeyance for up to two years until the Practitioner identifies with reasonable certainty the date of anticipated return from leave. The Practitioner will then be required to supply interval data through the date of the notice of anticipated return from leave to begin the reappointment process. The Practitioner's Medical Staff membership shall be considered expired between the time of the expiration of the term in which the leave began and the date of reappointment.

G. ORDERS FROM INDIVIDUALS WITHOUT CLINICAL PRIVILEGES OR MEDICAL STAFF MEMBERSHIP.

1. The Hospital may accept and execute orders for patients from health care professionals who are not members of the Medical Staff and who have not been granted any clinical privileges at the Hospital only if all the following conditions are met:
  - a. The order is within the scope of practice, as established by state law, of the ordering professional.
  - b. The ordering professional is currently licensed in a field of practice recognized by Wisconsin law as a requirement for active Medical Staff membership and, upon the Hospital's request, provides evidence satisfactory to the Hospital of such current licensure.
  - c. 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.
  - d. The ordering professional does not hold himself to be associated or affiliated with the Hospital or its Medical Staff.
  - e. The ordering professional is not excluded from any federally-funded health program (such as Medicare or Medicaid).

**VIII. CORRECTIVE ACTION.**

A. PROCEDURE.

1. Whenever the activities or professional conduct of any Practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the Hospital, corrective action against such Practitioner may be requested by any officer of the Medical Staff, by the Chief of any Service, by the chairman of any standing committee of the Medical Staff, by the Administrator, or by the Governing Body. Activities not involving clinical issues that are considered disruptive to the operations of the Hospital can consist of, but are not limited to: sexual harassment or physical or verbal abuse of others, drug, alcohol or other addictions, or criminal, fraudulent or other improper business conduct. All requests for corrective action shall be in writing, shall be made to the Medical Executive Committee and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request, except that a summary suspension may be commenced without following this procedure.
2. Whenever the corrective actions could be a reduction or suspension of clinical privileges or when summary suspension was imposed prior to completion of an investigation into the conduct forming the basis for the suspension, the Medical Executive Committee shall forward such requests to the Chief of the Service wherein the Practitioner has such privileges. Upon receipt of such request or notice of a summary suspension, the Chief of Service shall immediately appoint an ad hoc committee to investigate the matter. If the Chief of Service is the

subject of the request, the Chief of Staff will designate an alternate member of the Service to perform the role of the Service Chief in investigating the request for corrective action.

3. Within thirty (30) calendar days after the Service's receipt of the request for corrective action or notice of a summary suspension, the Service shall make a report of its investigation to the Medical Executive Committee. Prior to the making of such report, the Practitioner against whom corrective action has been requested shall have an opportunity for an interview with the Service ad hoc investigating committee. At such interview, he shall be invited to discuss, explain or refute the general nature of the charges against him. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such interview shall be made by the Service and included with its report to the Medical Executive Committee.
4. Within sixty (60) calendar days following the receipt of a request for corrective action, or at its next regular meeting following receipt of a report from a Service following the Service's investigation of a request for corrective action involving reduction or suspension of clinical privileges, whichever occurs first, the Executive Committee shall take action upon the request. If the corrective action could involve a reduction of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected Practitioner shall be permitted to make an appearance before the Medical Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to a hearing shall apply hereto. A record of such appearances shall be made by the Medical Executive Committee.
5. The action of the Medical Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to require a physical or mental examination and report by a physician or psychologist chosen by or acceptable to the Medical Executive Committee and compliance with restrictions recommended as a result of such examination, to impose terms of probation or a requirement for consultation, to recommend a reduction, suspension or a revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that the Practitioner's staff membership be suspended or revoked or that other appropriate action be taken, including any combination of the above.
6. In formulating such action or recommendation, the acting body should have a reasonable believe that:
  - a. The action or recommendation is in furtherance of quality health care; and
  - b. Reasonable efforts were taken to obtain the pertinent facts; and
  - c. The action or recommendation is warranted by the facts.

7. Any recommendation by the Medical Executive Committee for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff shall entitle the affected Practitioner to the procedural rights provided in Article IX of these Bylaws. A requirement of consultation, monitoring or similar action shall not be a professional review action generating a right of hearing unless it also includes an actual limitation or reduction of the Practitioner's clinic privileges.
8. The chairman of the Medical Executive Committee shall promptly notify the Administrator in writing of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the Administrator fully informed of all action taken in connection therewith. After the Medical Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided as Section IV.C, and in Article IX, if applicable, of these Bylaws.

B. SUMMARY SUSPENSION.

1. Any one of the following – the chairman of the Medical Executive Committee, the Chief of Staff, a Chief of Service, the Administrator, and the Executive Committee of either the Medical Staff or the Governing Body – shall each have the authority, whenever action must be taken in the best interest of the patient care in the Hospital, to summarily suspend all or any portion of the clinical privileges of a Practitioner, and each summary suspension shall become effective immediately upon imposition. If a summary suspension is imposed prior to receipt of a request for corrective action or prior to completion of an investigation into the conduct forming the basis for the suspension, the appropriate Service Chief will be notified of the suspension and will appoint an ad hoc committee to investigate the matter further.
2. A Practitioner whose clinical privileges have been summarily suspended shall be entitled to request that a hearing be held on the matter within such reasonable time period thereafter as a hearing committee may be convened in accordance with Article IX of these Bylaws.
3. The Medical Executive Committee or Governing Body, as appropriate, may recommend modification, continuance, or termination of the terms of the summary suspension. If, as a result of such hearing, the Medical Executive Committee or Governing Body does not recommend immediate termination of the summary suspension, the affected Practitioner shall, also in accordance with Article IX, be entitled to request an appellate review by the Governing Body, but the terms of the summary suspension as sustained or as modified by the Medical Executive Committee or Governing Body shall remain in effect pending a final decision thereon by the Governing Body.
4. Immediately upon the imposition of a summary suspension, the chairman of the Medical Executive Committee or responsible Chief of Service shall have authority to provide for the alternative medical coverage for the patients of the suspended Practitioner still in the

Hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of such alternative Practitioner.

5. The Administrator may impose a summary suspension of all privileges for misconduct that does not directly involve clinical issues. Misconduct not involving clinical issues can consist of, but is not limited to: sexual harassment or physical or verbal abuse of others, drug, alcohol or other addiction, criminal, fraudulent or other improper business conduct. Upon notice of such action, the matter will be referred to the Chief of Staff, who will convene an ad hoc investigating committee within five (5) working days to investigate the matter.

C. TEMPORARY SUSPENSION.

1. A temporary suspension in the form of withdrawal of a Practitioner's admitting privileges, effective until delinquent medical records are completed, may be imposed after failure to complete delinquent medical records. Delinquent medical records shall be defined as indicated in Flambeau Hospital Health Information Management Policy No. 740-D-401, Delinquent Medical Records, and include any discharge summary not completed within 30 days from the date of discharge, history and physical not completed within 24 hours from date of admission, operations or procedures not completed within 24 hours of the operation or procedure being performed, and charts not authenticated within 30 days from date of discharge.
2. A decision to impose a temporary suspension shall be made jointly between the Chief of Staff and the Administrator, after the completion of the four-step reminder structure outlined in the Delinquent Medical Records policy has been completed and the records in question remain delinquent.

D. AUTOMATIC SUSPENSION.

1. Action by the applicable licensing board or by a court of competent jurisdiction revoking or suspending a Practitioner's license shall automatically suspend all of the Practitioner's clinical privileges. Suspension shall occur whether the action of the licensing board is unilateral or agreed to by the licensee. Any practice restrictions, limitations or other special conditions imposed by an applicable licensing board short of suspension shall automatically be considered conditions of the Practitioner's Medical Staff appointment and of the exercise of clinical privileges. A Practitioner who has special conditions imposed, is placed upon probation or whose practice is limited by a licensing authority shall, within 15 days of the action, have his privileges reviewed by the Medical Executive Committee, which shall immediately submit a report and recommendation to the Governing Body regarding the continued Medical Staff status and clinical privileges of the Practitioner.
2. An automatic suspension of all privileges shall be imposed upon a Practitioner's failure to renew his license to practice.

3. If a Practitioner's DEA number is revoked, restricted or voluntarily surrendered, this shall automatically suspend all of his Hospital privileges.
4. An automatic suspension of all privileges of a Practitioner shall be imposed upon notification received by the Administrator of the conviction of a Medical Staff member of a felony. The Medical Executive Committee may, upon request of the affected Practitioner, convene to review the matter and shall submit a recommendation to the Governing Body regarding the continuation of the membership and privileges of the Practitioner.
5. An automatic suspension of all privileges may be imposed upon a Practitioner's failure to notify the Administrator within five (5) days of receipt by the Practitioner of an initial sanction notice of a gross and flagrant violation, or of the commencement of a formal investigation or the filing of charges, by a Medicare quality improvement organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin. The Medical Executive Committee shall promptly review the matter and submit a recommendation to the Governing Body regarding the continued Medical Staff status and clinical privileges of the Practitioner. The Medical Executive Committee shall, if the Administrator concurs, be authorized to file or modify any such automatic suspension pending final determination by the Governing Body.
6. An automatic suspension may be imposed upon a Practitioner's failure without good cause to supply information or documentation requested by any of the following: the Administrator or his designee, the Medical Executive Committee or the Governing Body. Such suspension shall be imposed only if: (1) the request for information or documentation was in writing, (2) the request was related to evaluation of the Practitioner's current qualifications for membership or clinical privileges, (3) the Practitioner failed to either comply with such request or to satisfactorily explain his inability to comply, and (4) the Practitioner was notified in writing that failure to supply the requested information or documentation within fifteen (15) days from receipt of such 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 privileges and shall remain in effect until the Practitioner supplies the information or documentation sought or satisfactorily explains his failure to supply it.
7. Caregiver Background Check Suspension.
  - a. Subject to proof of rehabilitation review approval, an automatic suspension of all privileges of a Practitioner shall be imposed upon notification received by the Administrator that the Practitioner:
    - (1) Has been convicted of a serious crime, act or offense or has pending charges for a serious crime, act or offense as

defined in Chapter DHS 12 of the Wisconsin Administrative Code.

- (2) Has been found by a unit of government to have abused or neglected a client or misappropriated a client's property.
  - (3) Has been determined under the Children's Code to have abused or neglected a child.
- b. As soon as possible after an automatic suspension under Section VIII.D.6.a.(1) above, the Medical Executive Committee shall convene to review and consider the facts under which the individual was barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code. If the Practitioner demonstrates that rehabilitation review approval covering his Medical Staff appointment and clinical privileges has been received, the Medical Executive Committee may reinstate the Practitioner after determining whether it 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 Medical Executive Committee may then take such further corrective action as is appropriate under the circumstances.
8. A suspension of all privileges of a Practitioner may be imposed by the Administrator upon notification that a Practitioner:
- a. Is under investigation for a serious crime, act or offense as defined in Charter DHS 12 of the Wisconsin Administrative Code.
  - b. Is being investigated by a unit of government or an entity subject to DHS 12 for abuse or neglect of a client or misappropriation of a client's property.
  - c. Is being investigated under the Children's Code or an entity under DHS 12 for abuse or neglect of a child.
  - d. As soon as possible after suspension under Section VIII.D.7, the Medical Executive Committee shall convene to review and consider the facts under which the individual was suspended and to determine whether or not to continue the suspension pending the outcome of the investigation, terminate the suspension subject to monitoring or other safeguards pending the outcome of the investigation, or to take such further corrective action as is appropriate under the circumstances.
9. Suspension for Exclusion from Federally Funded Health Care Program.
- a. An automatic suspension of all privileges of a Practitioner shall be imposed if the Practitioner is excluded from a federally funded health care program. If the Practitioner immediately notifies the Administrator of any proposed or actual exclusion from any federally funded health care program as required by the Bylaws, a simultaneous request in writing by the Practitioner

for a meeting with the Administrator and the Chief of Staff, or their designees, to contest the fact of the exclusion and present relevant information will be granted. This meeting shall be held as soon as practicable but not later than five (5) business days from the date of the written request. The Administrator and the Chief of Staff or their designees shall determine within ten (10) business days following the meeting, and after such follow-up investigation as they deem appropriate, whether an exclusion has occurred, and whether the Practitioner's staff membership and privileges will be immediately terminated. The determination of the Administrator and the Chief of Staff or their designees regarding the matter shall be final, and the Practitioner will have no further procedural rights. The Practitioner will be given special notice of the termination decision.

- b. A member who does not immediately notify the Administrator of any proposed or actual exclusion from any federally funded health care program as required by the Medical Staff Bylaws will have his staff membership and privileges terminated, effective immediately, at such time as the Administrator or his designee receives reliable information of the member's exclusion. The member shall be given special notice of the termination as soon as practicable.

10. Failure to Meet Financial Responsibility

If at any time a Practitioner fails to maintain acceptable malpractice insurance coverage or provide other evidence of financial responsibility in the minimum amounts determined by Wisconsin Statutes covering all clinical privileges granted, the Practitioner's privileges that are no longer covered shall be automatically suspended until acceptable coverage or evidence of financial responsibility is secured. The Practitioner must provide proof of coverage or of financial responsibility before the suspension can be lifted.

- 11. Whenever a member's membership and privileges are terminated pursuant to an automatic suspension, the Chief of Staff and applicable Service Chief will assign any patients currently under the member's care in the hospital to the care of another appropriate Practitioner, taking the patient's wishes into account when possible.

- 12. Automatic suspension activated pursuant to this Section shall not be a professional review action and thus not give rise to any right of hearing or appellate review, including the maintaining of any suspension instituted as a result of licensing board action, except as otherwise expressly set forth above.

- 13. It shall be the duty of the Chief of Staff to cooperate with the Administrator in enforcing all automatic suspensions.

**IX. HEARING AND APPELLATE REVIEW PROCEDURE.**

A. RIGHT TO HEARING AND TO APPELLATE REVIEW.



1. When any Practitioner receives notice of a recommendation of the Medical Executive Committee that, if ratified by decision of the Governing Body, will be adverse in any of the following ways to his appointment to or status as a member of the Medical Staff or his exercise of clinical privileges, he shall be entitled to a hearing before an ad hoc committee of the Medical Staff:
  - a. Denial of initial staff appointment (not including an administrative denial pursuant to Section IV.B).
  - b. Denial of staff reappointment.
  - c. Suspension of staff membership for more than five (5) days (not including any automatic suspension imposed pursuant to Section VIII.D).
  - d. Revocation of staff membership (except revocation pursuant to Section VIII.D.8).
  - e. Limitation of admitting prerogatives except for medical record delinquency.
  - f. Denial of requested Service affiliation.
  - g. Denial of requested clinical privileges.
  - h. Reduction or suspension of clinical privileges for more than five (5) days (except as a result of any automatic suspension imposed pursuant to Section VIII.D).
  - i. Revocation of clinical privileges except as a result of an exclusive contract to another provider to provide certain services as provided in Section IV.B of the Medical Staff Bylaws or as provided in Section VIII.D.8.
  - j. Terms of probation that will limit clinical privileges.
  - k. Requirement of consultation that limits clinical privileges.
2. If the recommendation of the Medical Executive Committee following such hearing is still adverse to the affected Practitioner in any of the ways set forth above, he shall then be entitled to an appellate review by the Governing Body before the Governing Body makes a final decision on the matter.
3. When any Practitioner receives notice of a decision by the Governing Body that is adverse to his appointment to, or status as an appointee of the Medical Staff or his exercise of clinical privileges in any of the ways specified above, and such decision is not based on a prior adverse recommendation by the Medical Executive Committee with respect to which he was entitled to a hearing and appellate review, he shall be entitled to 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.

4. A warning or a letter of admonition or a letter of reprimand or any other action than those identified above, or imposition of terms of probation or requirement for consultation that does not limit clinical privileges, are not recommendations that will adversely affect the Practitioner's appointment to or status as an appointee of the Medical Staff or the Practitioner's exercise of clinical privileges and do not give rise to any hearing rights.
5. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article IX to assure that the affected Practitioner is accorded all rights to which he is entitled.

B. REQUEST FOR HEARING.

1. The Administrator shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected Practitioner who is entitled to a hearing or to an appellate review, by special notice. This notice shall include the following:
  - a. Advise the applicant of the nature of the adverse recommendation or decision, the reason for it, and his right to a hearing or an appellate review pursuant to Article IX of these Bylaws.
  - b. Specify that he shall have thirty (30) calendar days following the date of receipt of such notice within which to request a hearing or an appellate review and that such request must be in writing and received by the Administrator within that 30-day period.
  - c. State that failure to request a hearing or an appellate review in writing delivered to the Administrator within thirty (30) calendar days following the date of receipt of the notice shall constitute a waiver of his right to same.
  - d. State that following receipt of his request, he will be notified of the date, time and place for the hearing or appellate review, and the grounds upon which the adverse action is based.
  - e. A summary of the hearing procedures and the rights of the Practitioner.
  - f. If the Practitioner is under suspension that will continue in effect at least through the date of any hearing, state that the Practitioner may request that the hearing be held as soon as arrangements for it may reasonably be made, if his request for hearing expressly waives his right to thirty (30) days advance notice of the date of the hearing.
2. The failure of a Practitioner to request a hearing to which he is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his right to such hearing and to any appellate review to which he might otherwise have been entitled on the matter.

3. When the waived hearing or appellate review relates to an adverse recommendation of the Medical Executive Committee or of a hearing committee appointed by the Governing Body, the same shall thereupon become and remain effective against the Practitioner pending the Governing Body's decision of 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 IX.H. In either of such events, the Administrator shall promptly notify the affected Practitioner of his status by special notice.

C. NOTICE OF HEARING.

1. Following receipt of a request for hearing from a Practitioner entitled to the same, the Medical Executive Committee or the governing Body, whichever is appropriate, shall promptly schedule and arrange for such a hearing and shall, through the Administrator, notify the Practitioner at least thirty (30) days in advance of the time, place and date so scheduled, by special notice, except that a hearing for a Practitioner who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, if the Practitioner waives his right to thirty (30) days advance notice in his request for hearing.
2. The notice of hearing shall state in concise language the acts or omissions with which the Practitioner is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision. It shall also include a preliminary list of witnesses, if any, expected to testify on behalf of the body whose action or recommendation prompted the hearing.

D. PRE-HEARING PROCEDURE

1. At least ten (10) days prior to the hearing (or as far in advance as is possible in the case of an expedited hearing for a suspended Practitioner), each party shall furnish to the other a written list of the names and addresses of the individuals that party intends to call as witnesses at the hearing and a list of the exhibits the party intends to introduce at the hearing. Each party shall update its witness and exhibit lists when additional witnesses or exhibits are identified prior to the hearing. Neither party shall call witnesses not named nor introduce exhibits not identified at least two (2) business days in advance of the hearing except in rebuttal.
2. These hearings are not trials but hearings among peers. The right to discovery is limited as outlined in this Section and no other discovery rights exist outside of these Bylaws. The individual requesting the hearing shall be entitled, upon specific written request, to the following (provided that the written request indicates that all documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

- a. Copies of, and/or reasonable access to, all patient medical records referred to in the notice of hearing, at the individual's expense;
  - b. Reports of experts relied upon by the Medical Executive Committee or the governing body;
  - c. Written copies of reviews relative to the affected Practitioner's performance;
  - d. Written copies of relevant committee or service meeting minutes; and
  - e. Copies of any other documents relied upon by the Medical Executive Committee or the governing body.
3. Prior to the hearing, the Practitioner requesting the hearing shall, upon specific request, provide the Medical Executive Committee and/or the governing body copies of any expert reports or other documents relied upon by the Practitioner in presenting his case.
  4. If the hearing committee determines to require the parties to submit written statements of the case as provided in Section F.10 below, notice to that effect shall be provided to both parties at least fifteen (15) days prior to the hearing date. The written statements of the case shall be supplied both to the committee and to the other parties at least five (5) business days (excluding weekends and holidays) prior to the commencement of the hearing.
  5. There shall be no discovery regarding other individual Practitioners.
  6. Neither the affected Practitioner, nor his attorney, nor any other person on his behalf shall contact Hospital employees appearing on the Hospital's witness list concerning the subject matter of the hearing unless specifically agreed upon by counsel.
  7. Neither the Hospital nor its attorney, nor any other person on behalf of the Hospital shall contact those persons appearing on the Practitioner's witness list concerning the subject matter of the hearing unless the witness is also listed as a witness for the Hospital or unless specifically agreed upon by counsel.

E. COMPOSITION OF HEARING COMMITTEE.

1. When a hearing relates to an adverse recommendation of the Medical Executive Committee, such hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the Medical Staff appointed by the Chief of Staff in consultation with the Medical Executive Committee, and one of the members so appointed shall be designated as chairman. No staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee unless it is otherwise impossible to select a representative group due to the size of the Medical Staff.

2. When a hearing relates to an adverse decision of the Governing Body that is contrary to the recommendation of the Medical Executive Committee, the Governing Body shall appoint a hearing committee to conduct such hearing and shall designate one of the members of this committee as chairman. At least one representative from the Medical Staff not in direct economic competition with the Practitioner shall be included on this committee when feasible. Practitioners appointed to this committee who are not members of the Medical Staff are required to be licensed to practice medicine in the state of Wisconsin and be an Active Staff member of another Wisconsin hospital.
3. As an alternative to a hearing committee, a sole hearing officer may be selected to preside over the hearing.
4. A member of the Active or Associate Medical Staff or of the Governing Body shall not be disqualified from serving on a hearing committee because he has heard of the case or has knowledge of the facts involved, or what he supposes the facts to be, or has participated in the review or investigation of the matter at issue. For hearings occasioned by the action or recommendation of the Medical Executive Committee or the Governing Body, no member of the Medical Staff or Governing Body who requests corrective action shall serve as a voting member of the hearing committee. However, such individuals may appear before the committee if requested by either of the parties concerned. In any event, all members of a hearing committee shall be required to consider and decide the case with good faith objectivity.

F. CONDUCT OF HEARING.

1. There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy.
2. An accurate record of the hearing must be kept. The mechanism shall be established by the ad hoc hearing committee, and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by taking of adequate minutes.
3. 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 rights in the same manner as provided in Section IX.B and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Section IX.B.
4. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the ad hoc hearing committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the hearing committee.

5. The affected Practitioner shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing or by a member of his local professional society.
6. Either a hearing officer, if one is appointed, or the chairman of the hearing committee or his 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.
7. 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 shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.
8. The hearing committee shall be entitled to conduct independent review, research and interviews, but may use this information in its decision only if the parties are aware of and have the opportunity to rebut any information so gathered.
9. The hearing committee may meet without the parties to deliberate and/or establish procedures.
10. The hearing committee may require that the parties submit written, detailed statements of the case to the committee and to each other. Such statements of the case may set forth all the facts of the case. 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 can conclude that such failure constitutes a waiver of the party's case.
11. Statements from the Practitioners, Medical Staff members, nursing or other Hospital staff, other allied medical personnel, patients or others may be distributed to the hearing committee and the parties in advance of or at the hearing. They shall be made a part of the record of the hearing and given such credence 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, in person or by telephone, for questioning by either party if so requested.
12. The Medical Executive Committee, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff member to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Governing Body, when its action has prompted the hearing, shall

appoint one of its members to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected Practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or decision by showing through clear and convincing evidence that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious. The burden of proof at all times remains with the Practitioner.

13. The affected Practitioner and the Medical Staff 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 in his own behalf, he may be called and examined as if under cross-examination.
14. The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competence and conduct. However, the affected Practitioner, the Medical Executive Committee and the Governing Body each shall have the privilege of advice of legal counsel at any phase of the hearing and appellate procedure and, if prior written notice of the name, address and phone number of the attorney is provided to other party at least seven (7) days in advance of the hearing, representation by legal counsel at the hearing or the appellate review. If one of the parties gives notice of intent to be represented by an attorney, the other parties need not give such notice and shall be entitled to attorney representation at the hearing or the appellate review procedure automatically. If a party (the parties being the Practitioner, the Medical Executive Committee and the Governing Body) has not used an attorney at the hearing level and desires to have attorney representation at the appellate review level, the party must give the required notice under this paragraph to the other parties at least seven (7) days in advance of the appellate review. If a hearing officer is utilized, he may be an attorney at law.
15. The hearing committee may, without 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. 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.
16. The hearing committee shall make a written report of its findings and recommendations. The report should make a rational connection between the issues to be decided, the evidence presented, and the conclusions reached.

G. HEARING COMMITTEE REPORT AND FURTHER ACTION.

1. At no later than its next regular meeting after receipt of the report of the hearing committee, the Medical Executive Committee or Governing Body, as the case may be, shall consider the same and affirm, modify or reverse its recommendation or action in the matter. The results of that consideration shall be transmitted to the Administrator together with the hearing record, the report of the hearing committee and all other documentation considered.
2. If the Governing Body's result pursuant to Section IX.F.1 is favorable to the Practitioner, such result shall become the final decision of the Governing Body and the matter shall be considered finally closed.
3. If the Medical Executive Committee result is favorable to the Practitioner, the Administrator shall, within seven (7) days of his receipt of it, forward it, together with all supporting documentation, to the Governing Body for action.
4. The Governing Body shall, at its next meeting following its Chairman's receipt of a favorable result of the committee, take action thereon by adopting or rejecting the Medical Executive Committee's result in whole or in part, or by referring the matter back to the Medical Executive Committee for further reconsideration. Any referral back shall state the reasons for it, set a time limit within which a subsequent recommendation to the Governing Body must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Governing Body shall take final action.
5. Any favorable action by the Governing Body shall become its final action and the matter will be finally closed. Any unfavorable action by the Governing Body shall be controlled by Section IX.F.6.
6. If the result of the Medical Executive Committee or the Governing Body remains adverse to the Practitioner, the affected Practitioner shall have the right to request an appellate review by the Governing Body, and the Practitioner shall be advised of that right by special notice.

H. APPEAL TO THE GOVERNING BODY.

1. 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 Administrator by special notice, request an appellate review by the governing Body. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the Practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.
2. If such appellate review is not requested within fourteen (14) days from the date the Practitioner received notice of the right to appellate review, the affected Practitioner shall be deemed to have waived his right to the same, and to have accepted such adverse recommendation or



decision, and the same shall become effective immediately as provided in Section IX.B.

3. Within ten (10) days after receipt of such notice of request for 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 shall through the Administrator, by written notice sent by special note, notify the affected Practitioner of the same. The date of the appellate review shall not be less than seven (7) days, nor more than fourteen (14) days, from the date of receipt of the notice of request for appellate review, except that when the Practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than fourteen (14) days from the date of receipt of such notice.
4. The appellate review shall be conducted by the Governing Body or by a duly appointed appellate review committee of the Governing Body of not less than three (3) members.
5. The affected Practitioner shall have access to the report and record of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him. He shall have three (3) days to submit a written statement in his own behalf, in which those factual and procedural matters with which he disagrees, and his reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing Body through the Administrator by special notice at least three (3) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Medical Executive Committee or by the chairman of the hearing committee appointed by the Governing Body, and if submitted, the Administrator shall provide a copy thereof to the Practitioner at least three (3) days prior to the date of such appellate review by special notice. Failure by the Practitioner to submit this written statement constitutes withdrawal of his request for appellate review and the appellate review session will be cancelled.
6. 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 Section IX.G.5, 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 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 Medical Executive Committee or the 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.

7. New or additional matters not raised during the original hearing or in the hearing committee report, nor 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.
8. If the appellate review is conducted by the Governing Body, it may affirm, modify or reverse its prior decision, or, in its discretion, refer the matter back to the Medical Executive Committee for further review and recommendation within five (5) days. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve specified disputed issues.
9. If the appellate review is conducted by a committee of the Governing Body, such committee shall, within five (5) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Governing Body affirm, modify or reverse its prior decision, or refer the matter back to the Medical Executive Committee for further review and recommendation within five (5) days. Such referral may include a request that a Medical Executive Committee arrange for a further hearing to resolve disputed issues. Within five (5) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Body as above provided.
10. A majority of the appellate review committee must be present throughout the review and deliberations. If a member of the review committee is absent from any significant part of the proceedings, he shall not be permitted to participate in the deliberations or the decision.
11. The appellate review shall not be deemed to be concluded until all the procedural steps provided in this Section IX.G have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Governing Body may be taken by a committee of the Governing Body duly authorized to act.

I. FINAL DECISION BY GOVERNING BODY.

1. Within ten (10) days after the conclusion of the appellate review, the Governing Body shall make its final decision in the matter and shall send notice thereof to the Medical Executive Committee and, through the Administrator, to the affected Practitioner, by special notice. If this decision is in accordance with the Medical Executive Committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If this decision is contrary to the Medical Executive Committee's last such recommendation, the Governing Body shall refer the matter to the Joint Conference Committee for further review and recommendation within ten (10) days, and shall include in such notice of its decision a statement that a final decision will not be made until the Joint

Conference Committee's recommendation has been received. At its next meeting, after receipt of a Joint Conference Committee's recommendation, the Governing Body shall make its final decision with like effect and notice as first above provided in this Section IX.H.

2. Notwithstanding any other provision of these Bylaws, 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 Medical Executive Committee or by the Governing Body, or by a duly authorized committee of the Governing Body, or by both.

J. SUBSTANTIAL COMPLIANCE.

Technical or insignificant deviations from the procedures set forth in this Article IX shall not be grounds for invalidating action taken.

K. WAIVER OF TIME LIMITS.

Any time limits set forth in this Article IX may be extended or accelerated by mutual agreement of the Practitioner and the Administrator or the Medical Executive Committee. The time periods specified in this Article IX for action by the Medical Executive Committee, the Governing Body, the Administrator and the committees are to guide those bodies in accomplishing their tasks and shall not be deemed to create any right for the reversal of the professional review action if the fair hearing process is not completed within the time periods specified.

**X. OFFICERS.**

A. OFFICERS OF THE MEDICAL STAFF.

The officers of the Medical Staff shall be:

1. Chief of Staff.
2. Secretary.

B. QUALIFICATIONS OF OFFICERS.

Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

C. ELECTION OF OFFICERS.

1. Officers shall be elected at the annual meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote. Officers shall be elected by a majority vote of attending Active Staff members. If no nominee receives a majority on the first ballot, the candidate receiving the fewest votes shall be omitted from each successive ballot until one candidate obtains a majority.
2. The Medical Executive Committee shall be the nominating committee. It shall offer one or more nominees for each office. Nominations may also be made from the floor at the time of the annual meeting.

D. TERM OF OFFICE.

All officers shall serve a one (1) year term from their election date or until a successor is elected.

E. VACANCIES IN OFFICE.

The Medical Executive Committee shall fill vacancies in office during the Medical Staff year, except for the Chief of Staff. If there is a vacancy in the office of the Chief of Staff, the Secretary shall serve out the remaining term except that if the office of the Secretary is also vacant, both vacancies shall be filled by a special election called for that purpose.

F. DUTIES OF OFFICERS.

1. Chief of Staff: The Chief of Staff shall serve as the chief administrative officer of the Medical Staff to:

- a. Act in coordination and cooperation with the Administrator in all matters of mutual concern with the Hospital;
- b. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
- c. Serve on the Medical Executive Committee;
- d. Serve as ex-officio member of all other Medical Staff committees;
- e. Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, 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;
- f. Appoint committee members to all standing, special, and multidisciplinary Medical Staff committees except the Medical Executive Committee;
- g. Represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the Administrator;
- h. 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;
- i. Be responsible for the educational activities of the Medical Staff;
- j. Be the spokesperson for the Medical Staff in its external professional and public relations;
- k. Resolve disputes and address concerns between Medical Staff members, Allied Health Affiliates and Hospital staff in consultation with the Administrator; and

- i. To perform such other functions as may from time to time be delegated by the Medical Staff or the Governing Body.
  2. Secretary: The Secretary shall be a member of the Medical Executive Committee.
    - a. The Secretary shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the Chief of Staff, attend to all correspondence, and perform such other duties as ordinarily pertain to this office.
    - b. The Secretary, in the absence of the Chief of Staff, will assume all duties and have all the authority of the Chief of Staff.
    - c. The Secretary shall also be expected to perform such duties of supervision as may be assigned by the Chief of Staff.

G. REMOVAL OF OFFICERS.

In the event that the officers of the Medical Staff do not comply with the duties of officers as stated above, a majority vote of the physician members of the Active Medical Staff may be taken to remove an officer from his position.

**XI. SERVICES.**

A. ORGANIZATION OF SERVICES.

There shall be Services of Medicine, Surgery, Family Practice, and Emergency Medicine. Each Service shall be headed by a Chief of Service and shall be organized as a division of the staff as a whole.

B. QUALIFICATIONS, SELECTION AND TENURE OF SERVICE CHIEFS.

1. Each chief shall be a member of the Active Medical Staff qualified by training and experience and demonstrated ability for the position.
  - a. When circumstances do not allow for filling a Service Chief position by an Active Staff member, the Medical Executive Committee and Governing Body may approve appointment of a member of the Courtesy or Consulting Medical Staff as an interim Service Chief. All other qualifications shall apply.
2. Each chief shall be appointed by the Medical Executive Committee for a one-year term, subject to approval of the Governing Body.
3. Removal of a chief during his term of office may be initiated by a two-thirds vote of all Active Staff members. No removal shall be effective unless and until it has been approved by the Medical Executive Committee and by the Governing Body.

C. FUNCTIONS OF SERVICE CHIEFS.

Each Service Chief shall:

1. Be accountable for all clinically related activities of the Service to the Medical Executive Committee, and all administrative activities of the Service to the Administrator.

2. Be a member of the Medical Executive Committee, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding his own service in order to assure quality patient care.
3. Maintain continuing review of the professional performance of all individuals with clinical privileges in the Service and report regularly thereon to the Medical Executive Committee as appropriate.
4. Determine when consultation is being improperly withheld, inform the attending Practitioner of this fact, and inform the Medical Executive Committee of any ongoing problems that exist with members of the Service.
5. Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations within the Service.
6. Be responsible for implementation within the Service of actions taken by the Medical Executive Committee.
7. Transmit to the Medical Executive Committee the Service's recommendations concerning the staff classification, the reappointment, and the delineation of clinical privileges for all Practitioners and allied health professionals in his Service.
8. Establish, together with the Medical Staff and administration, the type and scope of services required to meet the needs of the patients in the Service and the Hospital.
9. Develop and implement policies and procedures that guide and support the provision of services in the service area.
10. Recommend to the Medical Executive Committee the criteria for clinical privileges in the service area.
11. Coordinate and integrate intradepartmental and interdepartmental services.
12. Recommend a sufficient number of qualified and competent persons to provide care and services.
13. Determine the qualifications and competence of allied health professionals in the service area.
14. Be responsible for maintaining quality control programs, as appropriate.
15. Be responsible for the orientation and education of all Medical Staff members in the service area.
16. Recommend space and other resources needed by the Service.
17. Be responsible for recommending the number of cases for monitoring new clinical privileges granted to Practitioners in the Service.

D. FUNCTIONS OF SERVICES.

The Services shall:

1. Maintain continuing surveillance of the professional performance of all members of the Medical Staff with privileges in their Service, and must report regularly thereon to the Medical Executive Committee.
2. Assure adherence to the Hospital Bylaws, and the Bylaws, Rules and Regulations of the Medical Staff by all Medical Staff members practicing in the Service.
3. Transmit to the Medical Executive Committee the Service's recommendations concerning the classification, the reappointment, and the delineation of clinical privileges for all members of the Service.
4. Recommend to the Medical Executive Committee the department's criteria for the granting of clinical privileges.
5. Conduct a primary retrospective review of selected completed records of discharged patients and other pertinent sources of medical data relating to patient care. Each Service shall also develop objective criteria that reflect current knowledge and clinical experience to be used in monitoring and evaluating patient care. Pursuant to these criteria, each Service shall review and consider selected deaths, unimproved patients, patients with infections, complications, problems in diagnosis and treatment, and such other instances as are believed to be important, such as patients currently in the Hospital with unsolved clinical problems.
6. Formulate policies relating to the functions of the department. Such policies shall be effective after approval by the Service, the Medical Executive Committee, and the Governing Body.

**XII. COMMITTEES.**

A. STANDING COMMITTEE.

1. The Medical Staff will meet as a committee of the whole and shall complete all Medical Executive Committee functions.
2. A quorum for any committee meeting shall constitute fifty percent of the voting members of that committee.
3. The Medical Executive Committee is a major component in the Hospital's program organized and operated to help improve the quality of health care in the Hospital and its activities 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 these statutes, including the protection of the confidentiality of committee records and proceedings, are intended to apply to all activities of the committee and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out

the duties and responsibilities of the committee, including but not limited to participating in monitoring plans.

4. In addition to the committees detailed in this Article, the Chief of Staff may appoint ad hoc committees of the Medical Staff to formulate recommendations on specific subjects. These committees shall be governed by the procedures set forth in Section XII.A. Upon completion of their assigned tasks, such committees shall be dissolved by the Chief of Staff.

5. MEDICAL EXECUTIVE COMMITTEE.

The Medical Executive Committee shall consist of the members of the Active Medical Staff. The Medical Executive Committee generally meets bi-monthly but shall meet as necessary and maintain a permanent record of its proceedings and actions. The Medical Executive Committee performs the functions ordinarily performed at hospitals by either a medical executive committee or a credentials committee.

- a. Medical Executive Committee functions shall include:

- (1) To be regularly involved in Medical Staff management including the enforcement of Medical Staff Bylaws, Rules and Regulations and committee and service areas as required;
- (2) To coordinate the activities and general policies of the various service areas as required;
- (3) To receive and act upon committee reports;
- (4) To represent the Medical Staff and to act on its behalf as needed under such limitations as may be imposed by these Bylaws;
- (5) To implement policies of the Medical Staff not otherwise the responsibility of clinical service personnel;
- (6) To take all reasonable steps to ensure professionally ethical conduct on the part of all members of the Medical Staff, and to initiate and/or participate in Medical Staff disciplinary or appeals measures as indicated;
- (7) To provide liaison between Medical Staff and the Administrator and the Governing Body;
- (8) To recommend action to the Administrator on matters of a medico-administrative nature;
- (9) To make recommendations to the Governing Body, including long range planning;



- (10) To fulfill the Medical Staff's accountability to the governing Body for the medical care rendered to the patients in the Hospital including monitoring of all medical care quality assurance activities and taking any necessary and appropriate action, or delegating the responsibility for such action to the appropriate Medical Staff committee;
- (11) To ensure that the Medical Staff is kept informed of the accreditation status of the Hospital;
- (12) To review the credentials of all applicants and to make recommendations for Medical Staff membership and delineation of clinical privileges;
- (13) To review periodically all information available regarding the performance and clinical competence of the Medical Staff members and others with clinical privileges;
- (14) To consider amendments to the Rules and Regulations of the Medical Staff as necessary for the proper conduct of its work;
- (15) To review and approve rules and regulations, subject to the approval of the Governing Body;
- (16) To be responsible for making recommendations to the Governing Body relating to the structure of the Medical Staff; the mechanism used to conduct, work at and revise the quality improvement activities of the Medical Staff; the mechanisms used to review credentials and delineate individual clinical privileges; the mechanisms by which memberships on the Medical Staff may be terminated; and the mechanism for fair hearing procedures;
- (17) To perform such other functions as may from time to time be delegated by the Medical staff or the Governing Body.

b. Credentials Committee functions of the Medical Executive Committee shall include:

- (1) To investigate the credentials of all applicants for membership, as well as applicants to the Allied Health Affiliates, and to make recommendations in conforming with Articles IV and VII of these Bylaws;
- (2) To investigate any breach of ethics that may be reported;
- (3) To make recommendations to the Governing Body on each applicant for Medical Staff appointment and practice privileges, as well as on each applicant to the Allied Health Affiliates and practice privileges;

- (4) To review reports that are referred by any of the Medical Staff committees;
- (5) To arrive at a decision regarding the performance of the staff members and formulate a recommendation to the Governing Body, or to refer the case to the full active staff if this is considered desirable;
- (6) To review all information available regarding the competence of staff members and, as a result of such reviews, to make recommendations for the granting of privileges, appointments and reappointments, and the assignment of members of the various divisions as provided in Articles IV, VII, and XI.

B. MULTIDISCIPLINARY COMMITTEES INVOLVING MEDICAL STAFF.

1. The Medical Staff shall appropriately participate in the maintenance and improvement of high professional standards throughout the Hospital by maintaining physician representation on all multidisciplinary committees that relate to the safety of and the quality of care rendered to patients.
2. These committees are major components in the Hospital's program organized and operated to help improve the quality of health care in the Hospital and their activities 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 these statutes, including the protection of the confidentiality of committee records and proceedings, are intended to apply to all activities of these committees and include activities of the individual members of the committee as well as other individuals designated by these committees to assist in carrying out the duties and responsibilities of these committees, including but not limited to participating in monitoring plans.
3. Members of the Medical Staff shall be assigned to these committees on an annual basis by the Chief of Staff, who shall also appoint a chair of each committee.
4. Multidisciplinary committees shall meet as necessary to fulfill their purpose and to meet accreditation standards unless otherwise provided herein, and shall maintain a permanent record of their proceedings and actions. Voting privileges are limited to members of the Medical Staff, except as otherwise stated in these Bylaws. These committees include but are not limited to:

a. UTILIZATION MANAGEMENT COMMITTEE.

- (1) The purpose of the Utilization Management Committee shall be:
  - (a) To describe the integration and coordination of hospital-wide utilization management activities.

- (b) To provide for an ongoing program to objectively and systematically monitor and evaluate utilization, allocation and cost efficiency of health care resources and medical care services.
- (2) The Utilization Management Committee shall be responsible for the following:
- (a) Review of records for appropriateness and medical necessity of admissions.
  - (b) Determine the level of care or service needed by the patient can be provided by the organization.
  - (c) Determine the clinical necessity of continued stay.
  - (d) Determine appropriateness, clinical necessity and timeliness of support services provided directly by the hospital or through referral contracts.
- (3) The Utilization Management Committee shall consist of Physician representation; Director of Patient Care Services; Chief Financial Officer; Director of Organizational Integrity; Medical Records representative; and Discharge Planners. The Administrator shall attend on an as-needed basis.
- (4) The committee shall meet at least bi-monthly.
- (5) The committee shall maintain a record of all activities relating to the Utilization Management Committee, and submit periodic reports and recommendations to the Medical Staff, and subsequently to the Department Managers, Staff, and Governing Body as appropriate.

b. PATIENT SAFETY AND MEDICAL ERROR REDUCTION COMMITTEE.

- (1) The Patient Safety and Medical Error Reduction Committee shall include Infection Prevention, Pharmacy & Therapeutics, and Environment of Care/Safety.
- (2) The purpose of the Patient Safety and Medical Error Reduction Committee shall be:
- (a) To establish a system to recognize risks, reduce risks, provide for internal reporting and an analysis of systems.
  - (b) To promote a safe, functional and effective environment in which to carry out our mission.
  - (c) To reduce the risks of endemic and epidemic nosocomial infections in patients and health care workers.

- (d) To measure, assess and improve the medication use processes of prescribing, preparing and dispensing, administering, and monitoring effects, in collaboration with the Ministry Pharmacy and Therapeutics Committee.
- (3) The Patient Safety and Medical Error Reduction Committee shall be responsible for the following:
- (a) Define the scope of occurrences from no harm, slips, and restraint injuries to sentinel events, with the emphasis on prevention, not reaction.
  - (b) Create a culture of cooperation and communication.
  - (c) Monitor the use of restraint and seclusion to promote risk reduction.
  - (d) Identify and log common and special cause nosocomial infections and promote a functioning, coordinated process, including staff training and infection control policies and procedures to prevent and control infections throughout the organization.
  - (e) Working in collaboration with the Ministry Pharmacy and Therapeutics Committee to maintain a drug formulary, develop medication use policies and procedures, and participate in ongoing monitoring and evaluating of: medication use, adverse drug reactions, and medication variances.
  - (f) Conduct ongoing monitoring and evaluating of: safety management, security management, hazardous materials and waste, emergency preparedness, fire prevention, life safety management, medical equipment management, and utility system management.
- (4) The initial pharmacy and therapeutics evaluation function is delegated to the Ministry Pharmacy and Therapeutics Committee. Membership on this committee shall include one or more representatives from Flambeau Hospital. The chair of the committee will be approved by the participating Hospitals' Medical Executive Committees. A Ministry pharmacist shall act as secretary for the committee.
- (a) The Ministry Pharmacy and Therapeutics Committee shall :
    - (i) Be responsible for the development and recommendation and, following approval by the Hospital, the maintenance of a formulary and policies and procedures regarding the continued evaluation, appraisal, selection, procurement,

storage, distribution, use, safety and all other matters relating to drugs in the Hospital in order to assure optimum clinical results and a minimum potential for hazard;

(ii) Perform regular review of adverse drug reactions reported to have occurred to hospitalized patients, which includes ongoing monitoring and process improvement activities, to reduce medication errors and adverse medication events;

(iii) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

(iv) Perform such other duties as assigned by the Chief of Staff or the Medical Executive Committee.

(v) Meet at least bi-monthly and maintain a record of all activities relating to the pharmacy and therapeutics function and submit periodic reports and recommendations to the Hospital Medical Executive Committee concerning the formulary, medications not on the formulary, and other drug utilization policies and practices in the Hospital.

(b) The Hospital Pharmacy and Therapeutics Committee shall meet bi-monthly to address items reported from the Ministry Pharmacy and Therapeutics Committee and Hospital-specific issues.

(5) The Patient Safety and Medical Error Reduction Committee shall consist of Safety/Risk Management Officer, Infection Prevention Nurse, Director of Patient Care Services, Director of Organizational Integrity, Pharmacist, Lab representation, and Physician staff representatives as appropriate. The Administrator shall attend on an as-needed basis.

(6) The Infection Prevention committee shall meet monthly. Environment of Care/Safety shall meet bi-monthly.

(7) The committee shall maintain a record of all activities relating to the Patient Safety and Medical Error Reduction Committee, and submit periodic reports and recommendations to the Medical Staff, and subsequently to the Department Managers, Staff, and Governing Body, as well as reports and recommendations on the Infection Control Plan, Exposure Control Plan, and Environment of Care Plan as appropriate.

c. SURGICAL SERVICES COMMITTEE.

(1) The Surgical Services Committee shall include Tissue & Transfusion, Lab reporting, and OR Committee.

- (2) The purpose of the Surgical Services Committee shall be to direct process design, measurement, assessment and improvement within the surgical services area.
- (3) The Surgical Services Committee shall be responsible for the following:
  - (a) Develop and/or monitor quality indicators for key clinical care processes.
  - (b) Analyze data to identify variances, trends, and patterns.
  - (c) Develop standards, policies, and procedures to direct and support services.
- (4) The Surgical Services Committee shall consist of Physician representation, Director of Patient Care Services, Director of Organizational Integrity, department coordinators, clinic risk manager, and staff representative(s) as appropriate. The Administrator shall attend on an as-needed basis.
- (5) The committee shall meet at least quarterly.
- (6) The committee shall maintain a record of all activities relating to the Surgical Services Committee, and submit periodic reports and recommendations to the Medical Staff, and subsequently to the department managers, staff, and Governing Body as appropriate.

d. PROCESS IMPROVEMENT COMMITTEE.

- (1) The purpose of the Process Improvement Committee shall be to direct a planned, systematic, organization-wide approach to process design and performance measurement, assessment and improvement.
- (2) The Process Improvement Committee shall be responsible for the following:
  - (a) Establish and prioritize quality goals.
  - (b) Assure consistence with mission and values.
  - (c) Assure effective mechanisms in measuring, assessing, and improving care.
  - (d) Communicate process improvement information to the appropriate individuals/groups.
- (3) The Process Improvement Committee shall consist of Physician representation, Administrator, Chief Financial Officer, Director of Patient Care Services, Director of Organizational Integrity, Risk Management, clinic risk

manager, and Home Health Process Improvement coordinator.

- (4) The committee shall meet at least bi-monthly.
- (5) The committee shall maintain a record of all activities relating to the Process Improvement Committee, and submit periodic reports and recommendations to the Medical Staff, and subsequently to the department managers, staff, and Governing Body as appropriate.

e. MEDICAL STAFF CLINICAL CARE TEAMS – INPATIENT COMMITTEE.

- (1) The Medical Staff Clinical Care Teams – Inpatient Committee shall include the disciplines of Med/Surg, and ICU.
- (2) The purpose of the Medical Staff Clinical Care Teams – Inpatient Committee shall be to direct process design, measurement, assessment, and improvement within the clinical service.
- (3) The Medical Staff Clinical Care Teams – Inpatient Committee shall be responsible for the following:
  - (a) Develop quality indicators for key clinical care processes.
  - (b) Analyze data to identify variances, trends, and patterns.
  - (c) Identify and implement opportunities to improve patient outcomes.
  - (d) Develop standards, policies, and procedures to direct and support services.
- (4) The Medical Staff Clinical Care Teams – Inpatient Committee shall consist of Physician representation, Director of Patient Care Services, Director of Organizational Integrity, department coordinators, staff representative(s) as appropriate. The Administrator shall attend on an as-needed basis.
- (5) The committee shall meet at least bi-monthly.
- (6) The committee shall maintain a record of all activities relating to the Medical Staff Clinical Care Teams – Inpatient Committee, and submit periodic reports and recommendations to the Medical Staff, and subsequently to the department managers, staff, and Governing Body as appropriate.

f. MEDICAL SERVICES – OUTPATIENTS COMMITTEE.

- (1) The Medical Services – Outpatients Committee shall include Emergency Medical Services, Trauma, Family Practice, Radiology, Ambulance, Cardiac Rehabilitation, and CPT.
- (2) The purpose of the Medical Services – Outpatients Committee shall be to direct process design, measurement, assessment, and improvement within the outpatient services area.
- (3) The Medical Services – Outpatients Committee shall be responsible for the following:
  - (a) Develop quality indicators for key clinical care processes.
  - (b) Analyze data to identify variances, trends, and patterns.
  - (c) Identify and implement opportunities to improve patient outcomes.
  - (d) Develop standards, policies, and procedures to direct and support services.
- (4) The Medical Services – Outpatients Committee shall consist of Physician representation, Director of Patient Care Services, Director of Organizational Integrity, and department coordinators. The Administrator shall attend on an as-needed basis.
- (5) The committee shall meet at least monthly.
- (6) The committee shall maintain a record of all activities relating to the Medical Services – Outpatients Committee, and submit periodic reports and recommendations to the Medical Staff, and subsequently to the department managers, staff, and Governing Body as appropriate.

C. JOINT CONFERENCE COMMITTEE.

1. The Joint Conference Committee shall be composed of three (3) members of the Medical Executive Committee and three (3) members of the Governing Body. The Administrator shall be an ex-officio member. The representatives from the Medical Staff shall include the Chief of Staff, the R.O.C. (Regional Operating Committee) representative, and one member-at-large. Two (2) alternates will be appointed in order that a full committee will meet for each meeting. The chairmanship will be alternated between the Governing Body and the Medical Staff each meeting. Physician members of the Governing Body are excluded from membership on this committee.



2. The Joint Conference Committee shall conduct itself as a forum for the discussion of matters of Hospital policy and practice, especially those pertaining to efficient and effective patient care, and shall provide medico-administrative liaison with the Governing Body, the Administrator, and the Governing Body.
3. The Joint Conference Committee shall meet only if there is disagreement by the Governing Body as to an action taken by the Medical Executive Committee and shall transmit written reports of its activities to the Governing Body and the Medical Executive Committee.

D. ADDITIONAL COMMITTEES.

The Medical Executive Committee may establish such other committees as may be required for the effective and efficient operation of the Hospital and for the proper discharge of the Medical Staff's responsibility for assuring quality patient care in the Hospital may provide for Medical Staff representation thereon. The Medical Executive Committee may also assign new functions to existing committees or make certain committee functions the responsibility of the Medical Staff as a whole. The Chief of Staff shall appoint members of the Medical Staff to special committees established by the Medical Executive Committee.

**XIII. MEETINGS.**

Meetings of Medical Staff Committees may be called in any venue or format believed to be efficient by the Chief of Staff or Committee Chair.

A. ANNUAL MEETING.

The annual meeting of the staff shall be in the month of April. At this meeting, the retiring officers and committees shall make such reports as shall be required and the officers for the ensuing year shall be elected. Recommendations for the various Medical Staff and committee appointments shall be made not later than the next regular meeting following the annual meeting.

B. REGULAR MEETINGS.

1. The primary objective of staff meetings is improvement in the care and treatment of patients in the Hospital.
2. The regular meetings of the Medical Staff shall be held on alternating months on a date, time and place set by standing resolution of the Medical Executive Committee, without further notice once the standing resolution is distributed in the same manner as for notice of special meetings.

If the Medical Staff is not scheduled to meet but has a critical agenda item requiring discussion, they can arrange to meet briefly with their business. Notice of this occurrence will be accomplished 48 hours prior to this special meeting.

3. The Medical Staff discussions at meetings held pursuant to this Article shall constitute a thorough review and analysis of the clinical work done in the Hospital, including consideration of deaths, unimproved cases,

infections, complications, errors in diagnosis, and results of treatment from significant cases in the Hospital at the time of the meeting, and analysis of clinical reports from each Service and reports of committees of the active Medical Staff.

C. SPECIAL MEETINGS.

1. Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Administrator and shall be called at the request of the Governing Body, the Medical Executive Committee or any three members of the Active Medical Staff.
2. At any special meeting no business shall be transacted except that stated on the notice calling the meeting.
3. Sufficient notice of any meeting shall be a notice placed in the physician's physical mailbox or delivered by e-mail at least forty-eight (48) hours before the time set for the meeting. The attendance of a member at a meeting or e-mail delivery receipt notification shall constitute a waiver of notice of such meeting. The agenda for said meeting shall accompany the notice of such meeting.

D. ATTENDANCE AT MEETINGS.

1. Active Medical Staff members are required to attend and participate in meetings unless unavoidably prevented from doing so. An Active Medical Staff member's failure to regularly attend meetings will be considered in considering whether to reappoint the member to Active Medical Staff membership.
2. Members of the Honorary, Associate, Consulting and Courtesy categories of the Medical Staff shall not be required to attend meetings, but it is expected that they will attend and participate in the meetings unless unavoidably prevented from doing so.
3. A member of any category of the staff who has attended a case that is to be presented for discussion at any meeting and has been notified of presentation shall be required to be present. Failure to attend two such consecutive meetings shall involve the following penalty: in case of a member of the Consulting or Active Staff, reverting to the Courtesy Staff, or in the case of a member of the Courtesy Staff, forfeiting his staff membership. Should any member of the staff be absent from any meeting at which a case that he has attended is to be discussed, it shall be presented, nevertheless, unless the member is unavoidably absent and has requested that discussion be postponed. In no case shall a postponement be granted for a period longer than that until the next regular meeting.

E. QUORUM.

Fifty percent (50%) of the total membership of the Active Medical Staff, excluding those active staff members whose primary duty is to staff the emergency department, shall constitute a quorum.

F. BOARD OF DIRECTOR REPRESENTATION.

The Administrator shall attend all meetings. In the absence of the Administrator, the Governing Body may appoint someone to represent the Administrator.

G. MINUTES.

1. Minutes of each regular and special meeting of a committee or Service shall be prepared and shall include a record of the attendance of members and the vote taken on each matter.
2. The minutes shall be signed by the presiding officer and copies thereof shall be promptly submitted to the attendees for approval; and after such approval is obtained, forwarded to the Medical Executive Committee. Each committee and Service shall maintain a permanent file of the minutes of each meeting.

H. 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 except they shall not be counted in determining the existence of a quorum, nor shall they have a vote unless otherwise specified. The Administrator and the Chief of Staff shall be ex-officio members of all committees, except that the Chief of Staff shall be a voting member of the Medical Executive Committee.

I. INSURANCE PROTECTION.

In order to fully protect staff appointees while serving on any and all Hospital committees, it shall be the responsibility of the Hospital to assure the staff appointees of continuing insurance protection consistent with insurance covering members of the Governing Body. It shall also be the responsibility of the Hospital to notify the staff if there be any change in insurance coverage.

**XIV. IMMUNITY FROM LIABILITY.**

The following shall be express conditions to any application for, or exercise of, clinical privileges or Medical Staff or Allied Health Staff membership at this Hospital:

- A. That any act, communication, report, recommendation, or disclosure, with respect to any such applicant or privilege-holder, performed or made in good faith and without malice, and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.
- B. That such privilege shall extend to members of the Hospital's Medical Staff and of its Governing Body, its other Practitioners, its Administrator and his representatives, 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 XIV, the term "third parties" means both individuals and organizations from which an authorized representative of the Governing Body or the Medical Staff has requested information.

- C. That there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.
- D. That such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:
  - 1. Applications for appointment or clinical privileges
  - 2. Periodic reappraisals for appointment or clinical privileges
  - 3. Corrective action, including summary suspension
  - 4. Hearings and appellate reviews
  - 5. Medical care evaluations
  - 6. Utilization reviews
  - 7. Profile and profile analyses
  - 8. Malpractice loss prevention
  - 9. Quality assessment functions
  - 10. Other hospital, Service, or committee activities related to quality patient care and inter-professional conduct.
- E. That the acts, communications, reports, recommendations and disclosures referred to in this Article XIV may relate to an applicant's or privilege-holder's professional qualifications, clinical competence, character, health status, ethics, or any other matter that might directly or indirectly have an effect on patient care.
- F. That in furtherance of the foregoing, each applicant or privilege-holder shall upon request of the Hospital execute releases in accordance with the tenor and import of this Article XIV in favor of the individuals and organizations specified in the second paragraph, 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. Execution of a release is not a prerequisite of this Article.
- G. That the consents, authorizations, releases, rights, privileges, and immunities provided by Section III.B of these Bylaws for the protection of this Hospital's Practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XIV. 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 other immunities provided by law and not in limitation thereof.

**XV. RULES AND REGULATIONS.**

- A. The Medical Staff shall adopt such Rules and Regulations as may be necessary for the proper conduct of its work.

- B. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended at any regular time without previous notice by a two-thirds vote of a quorum.
- C. In an emergency meeting with formal notification, a majority vote is sufficient when approved by the Governing Body.
- D. The Rules and Regulations shall delineate the required content and timeframe for completion of history and physical examinations. The attending physician or other qualified individual, in accordance with state law and hospital policy, shall document the history and physical examination pursuant to Medicare Conditions of Participation as follows:
  - 1. The medical history and physical examination must be completed no more than 30 days before or 24 hours after an admission. When the medical history and physical examination are completed within 30 days before admission, an updated medical record entry documenting an examination for any changes in the patient's condition must be completed within 24 hours after admission. (R&R IV.B)
  - 2. The history and physical examination must be completed within thirty (30) days before the date of surgery, provided any changes that may have occurred are assessed and recorded in the medical record within 24 hours following admission or registration for, but prior to, the surgery. (R&R V.P.8)

**XVI. PARLIAMENTARY AUTHORITY.**

The Flambeau Hospital Medical Staff will use as its parliamentary authority, Robert's Rules of Order, newly revised. It will adopt only such special rules contained in that manual.

**XVII. GENERAL PROVISIONS.**

- A. Technical or insignificant deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.
- B. Any time limits set forth in these Bylaws may be extended or accelerated by mutual agreement of the Practitioner and the Medical Executive Committee, Governing Body or Administrator. The time periods specified in these Bylaws for action by the Medical Executive Committee, Governing Body or Administrator and any other committees are to guide those bodies in accomplishing their tasks and shall not be deemed to create any right for reversal of any action taken by those bodies if such action is not completed in the time periods specified.

**XVIII. AMENDMENTS.**

- A. These Bylaws may be amended after notice given at any regular or special meeting of the Medical Staff. Such notice shall be referred to the special committee which shall report at the next regular or special meeting and shall require a two-thirds vote of those present for adoption.

- B. Amendments so made shall be effective when approved by the Governing Body. A unilateral action by neither the Governing Body nor the Medical Staff may be used to amend the Bylaws.
- C. In the event the Bylaws, Rules or Regulations must be amended and the Medical Staff either will not or cannot effectuate amendments, the Governing Body could do so after consultation with the Medical Executive Committee, and such amendments affected in this manner shall not constitute unilateral action.

**XIX. ADOPTION.**

These Bylaws, together with the appended Rules and Regulations, shall be adopted at any regular meeting of the Active Medical Staff, shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Governing Body of the Hospital. They shall, when adopted and approved, be equally binding on the Governing Body and the Medical Staff. Neither body may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.