

SAINT MARY'S HOSPITAL OF RHINELANDER, WISCONSIN

BYLAWS OF THE MEDICAL STAFF

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PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of medical, dental, and podiatric care provided at the Saint Mary's Hospital of Rhinelander, Wisconsin (the "Hospital") and that it must accept and assume this responsibility, subject to the ultimate authority of the Governing Body, the physicians, dentists, and podiatrists organize themselves into a Medical Staff in conformity with the Bylaws hereinafter stated. These Bylaws, with Medical Staff policies and Rules and Regulations, create a framework within which the Medical Staff members can act with a reasonable degree of freedom and confidence.

DEFINITIONS

- a) The term "Allied Health Professional" means an individual, other than a licensed physician, dentist or podiatrist, who is: admitted to practice in the Hospital either through the Medical Staff Bylaws process or an alternate approval process per Medical Staff policy; who is either licensed, certified or registered in the state or who is trained and qualified in a recognized health care discipline to exercise various degrees of judgment within the areas of his/her professional competence; and who is qualified to render direct or indirect medical care under the supervision of a Practitioner who has been accorded privileges to provide such care in the Hospital. Allied Health Professionals are not members of the Medical Staff, but are affiliated with the Medical Staff as a body known as the Allied Staff.
- b) The term "days," unless designated otherwise, shall mean calendar days. The term "business days" shall mean those days on which the administrative offices of the Hospital are open (and therefore excludes weekends and holidays).
- c) The term "Fair Hearing Plan" means those policies and procedures related to corrective action for Practitioners set forth in an appendix, and considered a part of these Bylaws.
- d) The term "Medical Staff" means the Hospital's organized component of physicians, dentists, and podiatrists appointed by the Governing Body and granted specific clinical privileges for the purpose of providing quality medical, dental, and podiatric care for patients of the Hospital.
- e) "Medical Staff Year" means the 12-month period commencing the 1st day of January and ending on the 31st day of December of each year.
- f) The term "President" means the individual appointed by the Governing Body to act in its behalf in the overall management of the Hospital.
- g) The term "Practitioner" means, unless otherwise expressly limited, any physician, dentist, or podiatrist applying for or exercising clinical privileges granted by the Hospital.
- h) The term "Provider" means, unless otherwise expressly limited, any Practitioner or Allied Health Professional applying for or exercising clinical privileges granted by the Hospital.

- i) The term “Governing Body” shall mean the Board of Directors of the Hospital.
- j) The term “Member” means any physician (M.D. or D.O.), dentist, or podiatrist holding a current license to practice within the scope of his or her license who is a member of the Medical Staff.
- k) The term “in good standing” for the purposes of these Bylaws will mean an individual who, at the time the issue of standing is raised, has not been suspended during the current term of appointment for any purpose as set forth in these Bylaws and the Rules and Regulations. Only members in good standing shall be eligible to vote for the election of officers, or for any other matters which are presented for vote at a Medical or Surgical Service meeting or at a General Medical Staff meeting.
- l) The term “Medical Executive Committee” means the Executive Committee of the Hospital’s Medical Staff.

SECTION 1 PURPOSES AND RESPONSIBILITIES

1.1 Purposes and Responsibilities

The purposes and responsibilities of the Medical Staff include, but are not limited to:

- (a) participate as a member of an organized health care arrangement (“OHCA”) in coordinating and supporting patient health information privacy and security practices as stated in the “Notice of Privacy Practices” and as required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”);
- (b) provide leadership in the development and implementation of the organization’s patient safety program and activities;
- (c) provide oversight in the process of analyzing and improving patient satisfaction;
- (d) provide that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital receive quality medical care;
- (e) be the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by individual Practitioners and the obligations of Medical Staff membership are fulfilled;
- (f) serve as the primary means for providing assurance as to the appropriateness of the professional performance and ethical conduct of its members and to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of healing arts and the resources locally available;
- (g) provide a means through which the Medical Staff may participate in the Hospital’s policy-making and planning process;

- (h) provide an acceptable level of professional performance of all Practitioners and Allied Staff authorized to practice in the Hospital through appropriate delineation of the clinical privileges that each Provider may exercise in the Hospital and through an ongoing and focused review and evaluation of each Provider's performance in the Hospital;
- (i) provide a continuing education program fashioned, at least in part, on the type and nature of care offered by the Hospital, on needs demonstrated through the patient care evaluation, and other quality improvement activities;
- (j) provide a utilization review and management program to allocate inpatient medical and health services based upon determinations of individual medical needs;
- (k) provide an organizational structure that allows continuous monitoring of patient care practices;
- (l) conduct reviews and evaluation of the quality of patient care through quality improvement activities;
- (m) prepare and complete, in compliance with these Bylaws, medical records for all the patients to whom care is provided in the Hospital;
- (n) recommend to the Governing Body action with respect to appointments, reappointments, staff category and corrective action;
- (o) assure the Governing Body that appropriate clinical privileges have been delineated;
- (p) account to the Governing Body for the quality and efficiency of patient care rendered to patients at the Hospital through regular reports and recommendations;
- (q) initiate and pursue corrective action with respect to Members when warranted;
- (r) develop, administer, and seek compliance with these Bylaws and the Rules and Regulations of the Medical Staff, other patient care related Hospital and Medical Staff policies and departmental/Service Rules and Regulations;
- (s) assure that members work cooperatively with Members, Allied Health Professionals, nurses, Hospital administration and others so as not to adversely affect patient care;
- (t) assure that Members make appropriate arrangements for coverage for their patients as determined by the Medical Staff;
- (u) assure that Members participate in such emergency service coverage or consultation panels as may be determined by the Medical Staff;

- (v) provide leadership in strategic planning, identifying community health needs, and in setting appropriate institutional goals and implementing programs to meet those needs;
- (w) conduct all its affairs involving the Medical Staff, patients, and employees in a manner and an atmosphere free of unlawful discrimination based on age, sex, sexual orientation, creed, disability, national origin, race, handicap or financial status or any other characteristic protected by law;
- (x) comply with OSHA Standards; and
- (y) discharge such other staff obligations as may be lawfully established from time to time by the Governing Body, Medical Staff or Medical Executive Committee.

1.2 On-Call Physicians

- (a) It is the policy of the Hospital, that if they routinely offer a service to the public, the service will be made reasonably available through on-call Emergency Department coverage. This includes the provision of physician services through members of the Active Medical Staff.
- (b) The Hospital will maintain a list of Active Medical Staff physicians, by individual name, who are designated as on-call for identified specialties, to provide requested evaluation and/or indicated stabilizing treatment to patients with an emergency medical condition, consistent with the Hospital's EMTALA policy.
- (c) Each major medical specialty on the Active Medical Staff, when so designated by the Governing Body following a recommendation of the Medical Executive Committee, must have an on-call schedule, listing physicians by individual name. Coverage shall be maintained within reason, depending on the number of physicians in a specialty, Medical Staff resource limitations, and other parameters established by law and the Hospital. A physician may not refuse to be included on the call schedule if required by their specialty. Likewise, a physician may not selectively take call for only his or her own patients or those of a partner, unless such arrangement has been agreed to and approved by the Hospital. Members of the Medical Staff taking call shall, within the scope of their privileges, provide emergency care to patients without regard to source of payment or ability to pay.
- (d) When a major medical specialty is comprised of Active Medical Staff physicians from a single professional group the call schedule shall be comprised of physicians from that group.
- (e) If a major medical specialty is comprised of Active Medical Staff physicians from two or more professional groups, coverage for a patient requiring the services of that specialty shall be provided in the following manner in descending priority depending upon the availability of the physician:

- (1) The physician with whom the patient has an existing professional relationship (i.e., his/her patients).
 - (2) A physician from a professional group practice with which the patient has a medical relationship (i.e., attached patients).
 - (3) A physician designated as on call for “unattached patients.” “Unattached patients” are defined as patients who have no medical relationship with a Staff Member of the Hospital.
 - (4) Each professional group will be responsible for creating and maintaining a call schedule for provision of coverage for both attached and unattached patients. Emergency Department unattached patient call coverage shall be provided equitably by all members of the Medical Staff within a given specialty. Each specialty shall be responsible for creating this call schedule; cases of dispute shall be resolved by the appropriate Service Chairperson. Cases of continuing dispute shall be resolved by the Medical Executive Committee which will serve as the final arbiter.
- (f) Active Medical Staff Members must comply with the call coverage requirements so established.
 - (g) In the event an on-call Active Medical Staff physician and Emergency Department (“ED” or “emergency”) physician disagree about whether the services for the on-call physician are required, the ED physician will make a determination of whether the on-call physician will report to the Hospital. Failure to respond to a request from the attending or emergency physician is grounds for corrective action.
 - (h) The Active Medical Staff physician on-call for each specialty is responsible for arranging coverage in his/her absence by another physician in the same specialty with appropriate privileges, and for notifying the Hospital switchboard of the coverage arrangement.
 - (i) In the event that a particular specialty is unavailable due to unforeseen conditions beyond the physician’s control, patient disposition will be determined by the attending Emergency Department physician, consistent with the Hospital’s EMTALA policy.

SECTION 2 MEMBERSHIP

2.1 Membership a Privilege

Membership on the Medical Staff is a privilege which shall be extended only to those Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Appointment to and membership on the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted by the Governing Body in accordance with these Bylaws.

2.2 Qualifications

- (a) Only Practitioners licensed in the State of Wisconsin, without restriction, who can document their background, experience, judgment, training and demonstrated current competence in the specialties for all privileges requested as demonstrated by peer data references and otherwise; their adherence to the ethics of their profession; their good reputation and character; their ability to work with others; and a capacity to practice effectively and efficiently within the institution, with sufficient adequacy to assure the Medical Staff and the Governing Body that any patient treated by them in the Hospital will be given the generally recognized quality of care, shall be qualified for membership on the Medical Staff. No Practitioner is entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of being licensed to practice medicine, dentistry or podiatry in this or any other state, or because of membership in any professional organization, or having had such privileges in the past or present at another hospital.
- (b) Physicians must provide evidence of graduation from a medical or osteopathic school meeting standards of the Accreditation Council of Graduate Medical Education or otherwise possess equivalent qualifications.

Dentists must provide evidence of graduation from a dental school meeting the standards of the Council on Dental Education of the American Dental Association or otherwise possess equivalent qualifications.

Podiatrists must provide evidence of graduation from a podiatric school meeting standards of the Council of Education of the American Podiatric Association or otherwise possess equivalent qualifications. Podiatrists seeking Medical Staff membership with surgical privileges at the Hospital will be required to have completed a podiatric surgical residency with training in the specific procedures for which surgical privileges are requested and meet the same performance standards for the requested privileges as physicians performing those procedures.

- (c) Medical Staff Members must submit, annually, evidence of financial responsibility in at least the minimum amount required by Chapter 655 of the Wisconsin Statutes, and participation in the Wisconsin Injured Patients and Families Compensation Fund, which may be satisfied by a certificate from an acceptable insurance company evidencing professional liability coverage. Failure to maintain such required financial responsibility shall be grounds for automatic suspension of a Member's clinical privileges, and, if within 90 days after written warning of the delinquency the Member does not provide evidence of required financial responsibility, the Member's membership and privileges shall be automatically terminated.
- (d) Acceptance of membership on the Medical Staff shall constitute the Member's agreement that he/she will strictly adhere to the ethics of his/her respective profession and the Ethical and Religious Directives for Catholic Health Care

Services as promulgated by the National Conference of Catholic Bishops, and that he/she will work cooperatively with others and be willing to participate in the discharge of Medical Staff responsibilities. All Members of the Medical Staff shall pledge that they will not receive from or pay to another Practitioner, either directly or indirectly, any part of a fee received for professional services.

- (e) At initial appointment, reappointment, and as a condition of new privileges, Medical Staff Members must submit a statement which certifies that their current health status does not in any way impair their ability to safely exercise the clinical privileges requested or to provide high quality care for patients. A disability which can be reasonably accommodated shall not bar the granting of membership or clinical privileges. As a part of this certification, Medical Staff Members must provide evidence of a current TB skin test and be assessed, by titer, for immunity to select vaccine-preventable diseases as delineated in Hospital policy. A recent chest x-ray and a completed Employee Health TB Questionnaire are required for positive TB skin test results. The requirement for a TB skin test and titers for vaccine-preventable diseases may be waived for telemedicine providers whose services are provided offsite and, therefore, do not have direct patient contact. As a part of the initial appointment process, Applicants must provide evidence of a health assessment including a physical exam. Thereafter, the Governing Body may precondition the granting of new privileges, reappointment, or continuing exercise of clinical privileges upon the Practitioner's undergoing a health examination, as requested by the Medical Executive Committee and subject to applicable law.
- (f) Medical Staff Members must submit, and at all times maintain on file in the Medical Staff Office, current evidence of continued, unrestricted licensure and DEA registration, if applicable.
- (g) No person, who is otherwise qualified, shall be denied membership/privileges by reason of race, color, creed, handicap, disability, sex, sexual orientation, national origin or other legally protected characteristic.
- (h) As part of their appointment and reappointment to the Medical Staff, Practitioners have a continuing obligation to comply with all Hospital and Medical Staff Bylaws, Rules and Regulations, policies and procedures, and federal and state laws and regulations, as well as The Joint Commission and other accreditation agency standards as designated by the Hospital, applicable to the practice of their profession in a hospital setting.
- (i) No applicant who is currently barred from providing services in the Hospital under Chapter DHS 12 of the Wisconsin Administrative Code is eligible or qualified for Medical Staff membership or for any clinical privileges.
- (j) No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified for Medical Staff membership or for any clinical privileges.

- (k) The foregoing qualifications will not be deemed exclusive and other qualifications and conditions deemed by the Hospital and the Medical Staff to be relevant may be considered in evaluating applications for membership or clinical privileges.
- (l) Practitioners employed by or subject to a contract with the Hospital, whether full or part time, whose duties are medico-administrative in nature and include clinical responsibilities or functions with the Medical Staff involving their professional capacity, must be Members of the Medical Staff, achieving this status by the same procedure provided for other Medical Staff members. Their privileges should be delineated in accord with their education, training, competency and judgment.

2.3 Conditions of Appointment and Reappointment

- (a) All initial appointments to the Medical Staff are provisional and shall be made by the Governing Body of the Hospital upon the recommendation of the Medical Executive Committee and shall be for a period of not less than one (1) nor more than two (2) years. Reappointments to the Medical Staff shall be for a period not to exceed two years.
- (b) The Governing Body shall not take action on an application for appointment or reappointment, or cancel an appointment previously made, without prior conference and consultation with the Medical Executive Committee.
- (c) Appointments to the Medical Staff shall confer on appointees only such privileges as are specified in the notice of appointment and in conformity with these Bylaws, Rules and Regulations and any other applicable Hospital or Medical Staff policies. Applicants for Active Staff membership must be able to render continuous care and supervision of their patients, or arrange for it in their absence, and agree to accept staff committee assignments and to provide emergency care and consultation within the scope of their privileges and practice for patients admitted to the Hospital.
- (d) As part of appointment and reappointment to the Medical Staff and the exercise of clinical privileges, Practitioners have a duty to notify the Hospital of each of the following. Practitioners also have a continuing obligation to promptly notify the President of, and to provide such additional information as may be requested regarding, each of the following:
 - (1) denial, reduction, voluntary or involuntary revocation, limitation, or suspension of his or her professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal governmental agency relating to his or her professional license, or the imposition of terms of probation or limitation by any state;
 - (2) denial, application withdrawal, voluntary or involuntary loss, reduction, change of membership category, relinquishment or suspension of staff membership or voluntary or involuntary loss, limitation, reduction, or

suspension of clinical privileges at any hospital or other health care institution, whether temporary or permanent, including all suspensions;

- (3) voluntary or involuntary cancellation, loss or change of professional liability insurance coverage;
- (4) receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or 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 of any state;
- (5) any proposed or actual exclusion from any federally-funded health care program, any notice to the individual or representative of proposed or actual exclusion, or any pending investigation of the individual from any health care program funded in whole or in part by the federal government, including Medicare and Medicaid;
- (6) receipt of notice of the filing of any suit against the member or submission of adversity to the Wisconsin Injured Patients and Families Compensation Fund alleging professional liability in connection with the treatment of any patient;
- (7) settlement of a claim by a payment from an insurance company (or by the Practitioner or any other party) or any agreement that results in a release from liability being given by a patient to the Practitioner;
- (8) any criminal conviction or pending criminal charges, including but not limited to any findings by a governmental agency that the Practitioner has been found to have abused or neglected a child or patient or has misappropriated the property of any patient;¹
- (9) removal from a managed care organization's provider panel for quality of care reasons or unprofessional conduct;
- (10) any notification by any quality improvement organization or a third party payor reimbursement program concerning any utilization or quality of care review or sanction imposed; and
- (11) any circumstance(s) or change in circumstance(s), including, but not limited to health status, that would materially affect his ability to perform essential functions of the Medical Staff or to exercise the clinical privileges granted, or that may put patients or Hospital staff at risk.

¹ A criminal conviction or pending criminal charge is not necessarily a bar to appointment, reappointment or the granting of privileges.

- (e) As a condition of appointment and reappointment, members shall act consistently with the Hospital's mission statement and written corporate compliance plan.

SECTION 3 MEDICAL RECORDS

3.1 History and Physical

- (a) A complete admission history and physical examination shall be completed and documented in the patient's medical record within 24 hours of admission by someone who has been authorized/privileged by the organization. When a patient is readmitted within 30 days for the same or a related condition, an interval note may reference the previous history, and the patient's medical record will be updated to document an examination for any changes in physical findings. The updated examination must be completed and recorded in the patient's medical record by a member of the Medical Staff (within no more than 24 hours of admission).
- (b) In order to use a History and Physical document from another organization, a Licensed Independent Practitioner (LIP) or other individual who has been authorized and privileged by our organization will need to:
 - (1) Review the history and physical examination document;
 - (2) Conduct a second assessment to confirm the information and findings;
 - (3) Update any information and findings as necessary (including a summary of the patient's condition and course of care during the interim period) and the current physical/psychosocial status; and
 - (4) Sign and date the information as an attestation to it being current within 24 hours after admission.

3.2 Pre-operative Evaluation

- (a) A pre-operative evaluation will be done and documented in the patient's record within 30 days of surgery or a procedure requiring anesthesia services. If the evaluation is done more than 24 hours before surgery or a procedure requiring anesthesia services, an interim note will be entered in the record that includes documentation of an updated history and physical. When the history and physical examination are not recorded before the time stated for an operation, the procedure shall be canceled unless the attending Practitioner states in writing that such delay would constitute a substantial hazard to the patient.

- (b) The attending physician shall countersign the history, physical examination and preoperative note when they have been recorded by an Allied Health Professional.

3.3 Progress Notes

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Patients shall be seen and progress notes shall be written by the responsible Practitioner at least daily and more frequently when warranted, such as for critically ill patients or where there is difficulty in diagnosis or management of clinical problems.

3.4 Operative Notes

Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be written or dictated immediately following surgery for all surgical patients and the report promptly signed by the surgeon and made a part of the patient's current medical record. Failure to do so could result in suspension of O.R. privileges if the report is not received within 24 hours.

3.5 Consultations

Consultations shall include a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and the recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" is not acceptable. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations and the fact of emergency should be documented.

3.6 Requirements

- (a) The attending Practitioner is responsible for the preparation of a timely, accurate, complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include

- (1) identification data;

- (2) a typewritten history and physical examination including, at a minimum, a) the reason for admission, b) history including present illness, past history, allergies, medications, and pertinent psychosocial history, with family history and review of systems, including positive and negative results, c) physical examination including vitals, general, HEENT, heart, lungs, and abdomen, with pelvic/rectal,

musculoskeletal, and neurologic exams, as indicated by diagnosis, d) plan of care, e) provisional diagnosis, and f) treatment;

(3) consultations,

(4) progress notes,

(5) operative report, if appropriate;

(6) final diagnosis; and

(7) discharge summary, if required.

- (b) Documentation must support services rendered, substantiate severity of illness and justify admission of the patient to the Hospital. The other components of a complete medical record, including laboratory, radiology and other diagnostic orders and reports, anatomical gift information, and autopsy reports, are the responsibility of the appropriate department, service, or Practitioner
- (c) The current obstetrical record shall include a complete prenatal record (unless an emergency delivery), including Rh factor, complications and other pertinent information. The prenatal record may be a legible copy of the attending Practitioner's office record transferred to the Hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
- (d) Appropriate laboratory work and x-ray studies shall be ordered by the Practitioner, depending upon the circumstances of each case.
- (e) All clinical entries in the patient's medical record shall be time-dated and authenticated with the name and the title of the person making the entry. The responsible Practitioner shall countersign clinical entries when they have been made by Medical Staff affiliates or medical preceptees. Practitioners may authenticate each other's orders, provided they accept full responsibility for the order, including the diagnosis, appropriateness of dosage and choice of medication.
- (f) Errors must be corrected in the acceptable format, i.e., a single line drawn through the text accompanied by the word error. The writer must sign, date, and time all corrections.
- (g) A Practitioner's orders must be permanently recorded (not written in pencil) and written clearly, legibly and completely. Orders that are illegible or improperly written will not be carried out until rewritten or understood by the person authorized to execute the order.
- (h) Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of accepted abbreviations, and "do not use"

abbreviations, as delineated in house-wide policy 1.110, is accessible on the Hospital Intranet.

- (i) A Practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed, and signed by the Practitioner.

3.7 Discharge and Record Completion

- (a) A discharge summary shall be written or dictated within 7 days of discharge or death on all medical records of inpatients except for normal deliveries and normal newborn infants and should answer briefly the following five questions. In all instances, the content of the medical record shall be sufficient to justify the diagnoses and warrant the treatment and end result. All summaries shall be authenticated by the responsible Practitioner.
 - (1) The reason for admission. (A brief clinical statement of the chief complaint and history of the present illness;
 - (2) The pertinent laboratory, x-ray and physical findings. (Negative findings may be as pertinent as positive ones;)
 - (3) Medical and/or surgical treatment, (including the patient's response, complications, consultations and the like;)
 - (4) The patient's condition on discharge. (Ambulation, self-care, able to work;)
 - (5) Instructions for continuing care. (Medication by name and dosage, physical activity and diet, other therapeutic measures, referrals and follow-up appointments)
- (b) Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and time-dated and signed by the responsible Practitioner upon discharge of patient. This will be deemed equally as important as the actual discharge order.
- (c) Medical records must be completed within 30 days after death or discharge of the patient except in special circumstances. Failure to complete records within the allotted time may result in suspension of admitting privileges until such records are completed. Habitual record delinquency shall be sufficient grounds for

permanent suspension of privileges. See Hospital-Wide Policy #1.713, Incomplete/Delinquent Medical Records.

- (d) When a record is incomplete because of a Practitioner's death or change of location, the record shall be completed to the extent possible based upon the information available at the time and declared complete for administrative purposes and a note attached to the record explaining the reason for filing the record incomplete.

3.8 Release of Records

- (a) Written informed consent of the patient as defined by Wisconsin law and the Health Information Portability and Accountability Act ("HIPAA") is required for release of medical information to persons not otherwise authorized to receive that information.
- (b) Original medical records may be removed from the Hospital jurisdiction and safe keeping only in accordance with a court order, statute or with the permission of the Chief Executive Officer or his/her designee. All records are the property and responsibility of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer (or his designee). In case of readmission of the patient, all previous records shall be available for the use of the Practitioner providing care.
- (c) If waiver of individual patient authorization has been approved by the applicable institutional review board or a privacy board in accord with federal privacy regulations, and the researcher has made the representations required under the privacy regulations, access to medical records free of charge of all patients shall be afforded members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients, provided the release is authorized under state and federal law and the patient has not filed a written objection with the Hospital. The medical record director shall have the authority to evaluate whether the release is authorized by law and to then provide such records. If there are questions as to the volume of work or appropriateness of the study, the request may be submitted to the Medical Executive Committee for consideration. For purposes other than research, subject to the discretion of the Chief Executive Officer or his/her designee, former members of the Medical Staff shall be permitted free access to information from medical records of their patients covering all periods during which they attended such patients in the Hospital so long as the Practitioner is caring for the patient at the time of the request or has written consent of the patient.

SECTION 4 CATEGORIES OF THE MEDICAL STAFF

4.1 The Medical Staff

The Medical Staff shall be divided into Provisional, Active, Affiliated, Courtesy and Consulting staff categories. The Hospital may designate Practitioners who have retired from active hospital practice as honorary Medical Staff members, but such designation shall convey no Medical Staff rights, prerogatives or obligations.

4.2 The Provisional Medical Staff

The Provisional Medical Staff shall consist of Practitioners who are being considered for advancement to membership on the Active Staff. They are allowed to admit patients to the Hospital. They shall be appointed to a specific Service and may attend and vote at Service meetings. They shall be eligible to vote and serve on all Medical Staff committees, except the Medical Executive Committee, and the Quality Improvement Committee. Exceptions may be made in special circumstances at the discretion of the Medical Executive Committee. They shall be ineligible to hold any office. They may attend and vote at General Medical Staff meetings. Membership on the Provisional Medical Staff may not exceed two (2) full Medical Staff years, at which time the failure to advance an appointee from Provisional to another staff status shall be deemed a termination of staff appointment.

4.3 The Active Medical Staff

The Active Medical Staff shall consist of Practitioners who have been advanced from Provisional Staff. Active Medical Staff members who admit patients to the Hospital must be located close enough to the Hospital to provide proper care to their patients, and assume all the functions and responsibilities of membership on the Active Medical Staff, including emergency care and consultation assignments if appropriate to their specialty as required by the Hospital. Practitioners who provide emergency on-call coverage may not take call selectively for their own patients or those of a partner. Members of the Active Medical Staff shall be eligible to vote, hold office and serve on Medical Staff committees.

4.4 The Affiliated Medical Staff

- (a) The Affiliated Medical Staff shall consist of physicians who wish to fully participate in the functions of the Active Medical Staff but do not meet the criteria for Active Staff membership because they do not attend patients at the Hospital. Affiliated Medical Staff members shall complete a provisional period, as described in Section 4.8. Active medical staff membership at another hospital is not required.
- (b) They may order outpatient diagnostic procedures and provide history and physical examinations.

- (c) A review of office practice may be performed to provide a basis for evaluation of the member's professional competence and judgment. Members of the Affiliated Medical Staff must reasonably comply with all requests for such practice information, data, and/or reports.
- (d) Affiliated Medical Staff members may serve and vote on all Medical Staff committees except the Medical Executive Committee, and the Quality Improvement Committee, but may not hold office. They may attend and vote at General Medical Staff meetings. They will be assigned to a Service and may attend meetings and vote, but may not hold office.
- (e) Members of the Affiliated Medical Staff who wish to attend patients in the Hospital will be required to either request a change in status to Provisional Staff (before being advanced to Active Staff, if appropriate), or request a change to Courtesy Medical Staff, as appropriate.

4.5 The Courtesy Medical Staff

- (a) The Courtesy Medical Staff shall consist of Practitioners who attend patients in the Hospital but who are unable to actively participate in the functions of the Medical Staff. Courtesy Members shall complete a provisional period, as described in Section 4.8.
- (b) Members of the Courtesy Medical Staff may serve and vote on all Medical Staff committees, with the exception of the Medical Executive Committee, and the Quality Improvement Committee, but may not hold office. They may attend General Medical Staff meetings but may not vote.
- (c) Members of the Courtesy Medical Staff must be members of the Active or Provisional staff of another hospital where they actively participate in a patient care evaluation program and other quality improvement activities similar to those required of the Active Staff of the Hospital. Members of the Courtesy Staff must reasonably comply with all requests for practice information, data and/or reports. The requirement for Active Staff membership on another hospital's staff shall be waived if his/her practice is limited to the Emergency/Urgent Care Department.
- (d) Members of the Courtesy Medical Staff shall be allowed to occasionally admit patients to the Hospital. "Occasional" is considered not more than twelve (12) inpatient admissions during any Medical Staff Year. If a member of the Courtesy Medical Staff admits more than twelve (12) patients in any Medical Staff Year, the member will be required to request a change in status to the Provisional Medical Staff and will be subject to Section 4.2 of these Bylaws.
- (e) Physicians other than Active or Provisional Staff who contract to staff the Hospital's Emergency Department will be appointed to the Courtesy Staff upon satisfactory completion of the credentialing process. The scope of privileges granted to Courtesy Staff Emergency Department physicians, unless otherwise

specified by the Medical Executive Committee, is outlined in the Rules and Regulations.

- (f) If a member of the Courtesy Staff has not attended a patient at the Hospital for a period of two (2) years, an application for reappointment will not be sent. The member will be considered to have voluntarily resigned unless the member requests an application for reappointment in writing prior to the end of his/her current appointment.
- (g) Locum tenens/temporary physicians whose services are needed for more than one hundred twenty (120) consecutive days may be appointed to the Courtesy Staff for one 2-year period. The requirement for Active Staff membership on another hospital's Medical Staff may be waived. These physicians may have an unlimited number of admissions. In unusual circumstances, the Medical Director of the appropriate Service will be consulted to determine if a locum tenens/temporary physician may be reappointed to the Courtesy staff for an additional 2-year period. If he/she concurs, an application for reappointment will be sent.

4.6 The Consulting Medical Staff

- (a) The Consulting Medical Staff shall consist of recognized specialists who are active in their specialties and have signified a willingness to accept such appointment to the Medical Staff. Members of the Consulting 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.
- (b) Members of the Consulting Staff shall have such non-surgical clinical privileges as may be granted by the Governing Body in accordance with these Bylaws. All surgical privileges require Active, Provisional, or Courtesy Staff membership. Consulting Members shall complete a provisional period, as described in Section 4.8.
- (c) Members of the Consulting Staff may serve on all Medical Staff committees, with the exception of the Medical Executive Committee. Members of the Consulting Staff may not hold office. They may attend general Medical Staff meetings but may not vote.
- (d) A member of the Consulting Staff must be a member of the Active or Provisional Staff of another hospital where he/she actively participates in a patient care evaluation program and other quality maintenance activities similar to those required of the members of the Active Staff of this Hospital. Members of the Consulting Staff must reasonably comply with all requests for practice information, data and/or reports.
- (e) The requirement for Active Medical Staff membership at another hospital shall be waived for telemedicine providers whose practice at the Hospital is limited to providing preliminary reads/diagnoses.

- (f) If a member has not consulted for a patient at the Hospital for a period of two years, an application for reappointment will not be sent. The member will be considered to have voluntarily resigned unless the member requests an application for reappointment in writing prior to the end of his/her current appointment.

4.7 Residents

Resident Staff includes the full-time Post Graduate (PG) staff in training having assigned responsibility for patient care under an Active Medical Staff member as part of an accredited training program. Resident Staff physicians do not have sole responsibility for patient care and have no direct admitting privileges, except through an Active Medical Staff member. Residents are not credentialed through the Medical Staff process, but instead, are deemed qualified to practice in the hospital under the auspices of an accredited training program and its related educational affiliation agreements.

4.8 Allied Health Professionals

PART ONE: AUTHORIZATION AND CONTROL PROVISIONS

I. QUALIFICATIONS OF THE ALLIED HEALTH PROFESSIONAL STAFF

An allied health professional (AHP) is an individual other than a physician who is qualified by academic and clinical training and by prior and continuing experience and current competence in a discipline that the Board of Directors has approved to practice in the Hospital and who either:

- a.) is licensed by the State of Wisconsin to provide services independently without the direction or immediate supervision of a physician (Advanced Practice Professional - APP);

or
- b.) functions in a medical support role and under the direction and supervision of a physician or functions by contract for a specific scope of practice with or without direct physician supervision. (Authorized Provider).

Allied Health Professionals are not members of the Medical Staff.

Allied Health Professionals must certify biennially 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. A disability which can be reasonably accommodated shall not bar the granting of membership or clinical privileges. Allied Health Professionals must provide evidence of a current tuberculin skin test (TST) or Quantiferon Gold (QFG) lab test and be assessed, by titer, for immunity to select vaccine-preventable diseases as delineated in the Health Assessment Questionnaire.

The Board of Directors may precondition the exercising of clinical privileges based on the practitioner undergoing a health examination. A health examination may also be requested by the Medical Executive Committee at any time. Following appointment, Allied Health Professionals must complete a TB screening form annually.

Evidence of the member's current Wisconsin licensure, and, if applicable, current DEA registration and current certification must be maintained electronically in the Credentialing software.

Allied Health Professionals must submit, annually*, evidence of financial responsibility in at least the minimum amount required by Chapter 655 of the Wisconsin Statutes. This requirement may be satisfied by a certificate from an insurance company evidencing professional liability coverage. (*If a member is a locum tenens provider and insured by a locum tenens agency, evidence of current liability coverage will be required prior to providing services.)

Failure to maintain such required financial responsibility shall be grounds for suspension of a practitioner's clinical privileges.

If within ninety (90) days after written warning of the delinquency, the practitioner does not provide evidence of required financial responsibility, they shall voluntarily be terminated from the staff and their privileges relinquished.

As part of their appointment and reappointment to the Allied Health Staff, practitioners have a continuing obligation to comply with Federal and State laws and regulations applicable to the practice of their profession in a hospital setting.

No applicant who is currently barred from providing services in the Hospital under Chapter HFS 12 of the Wisconsin Administrative Code is eligible or qualified for Allied Health Professional status.

No applicant who is currently excluded from any health care program funded in whole or in part of the federal government, including Medicare or Medicaid, is eligible or qualified for Allied Health Professional status.

The foregoing qualifications will not be deemed exclusive and other qualifications and conditions deemed by the Hospital and the Medical Staff to be relevant may be considered in evaluating applications for membership or clinical privileges.

II. CURRENT DISCIPLINES OF ALLIED HEALTH PROFESSIONALS

Pursuant to this policy adopted by the Board of Directors, the following are the only disciplines of Advanced Practice Clinicians and Authorized Providers authorized to provide services in the Hospital:

- a.) Advanced Practice Clinicians
 - Advanced Practice Nurse Prescribers
(Nurse Practitioners and Clinical Nurse Specialists)
 - Certified Registered Nurse Anesthetists
 - Physician Assistants
 - Dentists

- Licensed Clinical Social Workers
- Optometrists
- Podiatrists
- Psychologists

b.) Authorized Providers

- Surgical Resource Personnel (not employed by the hospital)
 - Surgical Procedure Assistants
 - Surgical Technologists
 - Surgical First Assistants
 - Surgical Sub-Specialty Assistants
- Registered or license practical nurses and clinical technicians who are employees of an active or courtesy staff member or members of the Medical Staff.
- Certified Orthotists & Prosthetists (must have a contract in place for inpatient/outpatient hospital services)

Advanced Practice Clinicians will be organized into two categories:

- Active Advanced Practice Clinicians – these clinicians shall consist of practitioners who have an active patient practice in the hospital. The active clinicians will have voting rights (with the exception of election of officers.

Active Advanced Practice Clinicians on the Allied Health Professional staff who have had no hospital activity for two years shall have been deemed to have requested voluntary termination of their membership and relinquishment of clinical privileges. Future activity would require a full reapplication to the Allied Health Professional Staff.

- Affiliated Advanced Practice Clinicians – these clinicians shall consist of practitioners whose professional practice is clinic based. The affiliated clinicians may provide in hospital consultative services. The affiliated clinicians will not have voting rights and will not be subject to meeting attendance requirements.

III. PROCEDURE FOR APPROVAL OF A NEW DISCIPLINE OF ALLIED HEALTH PROFESSIONAL

- a.) Request: A request to establish a new AHP discipline should:
1. include a statement outlining the need for the discipline;
 2. include the statement of qualifications required under Part IV below;
 3. and the description of the scope of services.

Requests must be submitted in writing to the Medical Executive Committee.

- b.) Review and Recommendations: The Medical Executive Committee (MEC) shall review the request, and shall transmit its recommendation on the discipline, the statement of qualifications, and the scope of services to the Board of Directors.

If the recommendation of MEC is not unanimous, the nature of and reason for the dissenting view must be documented and transmitted with the majority's recommendation. The Board of Directors shall review the recommendations and any dissenting views. It shall refer the matter back for input as appropriate to the applicable Department Chairperson for additional input and subsequent recommendation or shall take action to recommend or deny the request.

IV. QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS

Every AHP who applies for appointment and reappointment, must demonstrate to the satisfaction of the appropriate authorities of the Medical Staff and of the Hospital the following qualifications and any additional qualifications as are set forth for his/her particular discipline of AHPs:

a.) LICENSURE

Current license, registration, certificate or such other credential, if any, as may be required by Wisconsin state law.

b.) PROFESSIONAL EDUCATION AND TRAINING

As defined by the minimum threshold criteria to request core privileges as defined for each specific discipline.

c.) EXPERIENCE AND PROFESSIONAL PERFORMANCE

Current experience and documented evidence of the ability to provide patient care services at an acceptable level of quality and efficiency in each Hospital setting where specified services are or will be provided.

d.) COOPERATIVENESS

Ability to work cooperatively with others in the Hospital environment, specifically to include refraining from conduct which over time constitutes a pattern of disruption such as to adversely affect the quality or efficiency of patient care services in the Hospital.

e.) SATISFACTION OF OBLIGATIONS

Satisfactory compliance with the obligations outlined in Section VII of these policies.

f.) PROFESSIONAL ETHICS AND CONDUCT

To be of high moral character and to adhere to generally recognized standards of professional ethics.

g.) HEALTH STATUS

Physical or Mental Impairment: AHPs should be free of any mental or physical impairment with or without accommodation that could interfere with the performance of all or any of the specified services requested or granted, unless reasonable accommodations can be made for such impairment consistent with the interests of sound patient care.

In the event of such a physical or mental impairment, the AHP shall promptly notify the appropriate Chairperson so that a determination can be made as to whether or not there is reasonable accommodation that can be made for the impairment that will permit the AHP to continue his/her duties.

Substance / Chemical Abuse: To be free from abuse of any type of substance or chemical that interferes with, or presents a reasonable probability of interfering with, the AHPs ability to satisfy any of the qualifications required by Section IV or his/her ability to perform all or any of the specified services requested or granted.

h.) COMMUNICATION SKILLS

Ability to read, write and understand the English language, to communicate in the English language in an intelligible manner, and to prepare any authorized medical record entries and other required documentation in a legible manner.

i.) FOR HOSPITAL EMPLOYMENT

Hospital employees must satisfy any additional requirements applicable to employment by the Hospital.

j.) PROFESSIONAL LIABILITY INSURANCE

Professional liability insurance coverage must be issued by a recognized company-and of a type and in an amount equal to or greater than the limits required by Wisconsin Statutes.

V. EFFECTS OF OTHER AFFILIATIONS

No AHP shall be automatically entitled to specified services merely because he/she:

- a.) is authorized to practice in this or in any other state; or
- b.) is a member of any professional organization; or
- c.) is certified by any board; or
- d.) had, or presently has, those specified services at another healthcare facility or in another practice setting; or
- e.) had, or presently has, those specified services or is employed at this Hospital; or
- f.) is or is about to become affiliated with a practitioner or another AHP who is, or with a group of practitioners or AHPs one or more of whose members are, affiliated with the Hospital through employment, contract, Medical Staff appointment or otherwise.

VI. PREROGATIVES OF ALLIED HEALTH PROFESSIONALS

The prerogatives of an AHP are to:

- a.) Perform such specified services in accordance with the granted clinical privileges or scope of practice under the degree of supervision or direction of a physician member of the Medical Staff and consistent with any limitations stated in the policies governing the AHP's practice in the Hospital and any other applicable Medical Staff or Hospital policies.
- b.) Serve on committees, if so appointed.
- c.) Attend, when invited, to clinical meetings of the Medical Staff, a Department or other clinical unit when appropriate to his/her disciplines.
- d.) Attend education meetings of the Medical Staff, a Department or other clinical unit, or the Hospital.
- e.) Exercise such other prerogatives as the MEC, with the approval of the Board of Directors, may afford AHPs in general or a specific discipline of AHPs.

VII. OBLIGATIONS OF ALLIED HEALTH PROFESSIONALS

Each AHP shall:

- a.) Provide patients with care or other services at the level of quality and efficiency professionally recognized as appropriate at facilities such as the Hospital.
- b.) Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing specified services and, when necessary and as appropriate to the circumstances of the case, either arrange or alert the principal attending practitioner of the need to arrange a suitable alternative for such care and supervision.
- c.) Participate in quality performance/improvement activities appropriate to his/her discipline and in discharging such other functions as may be required from time to time.
- d.) When requested, attend clinical and educational meetings of the Medical Staff and of the Department and any other clinical units with which he/she is affiliated and any individual conference requested by any applicable Department Chairperson, medical director of a special unit, or Hospital Department Director.
- e.) Abide by the Medical Staff Bylaws, policies/procedures, this policy and those attached hereto specific to his/her particular discipline, and all other lawful standards, and hospital policies.

- f.) Prepare and complete in a timely fashion, as appropriate and authorized, those portions of patients' medical records documenting services provided and any other required records.
- g.) Immediately notify the Chairperson of:
 - 1.) any criminal charges brought against the AHP (other than minor traffic violations not involving a DUI charge);
 - 2.) any change made or formal action voluntarily or involuntarily initiated that could result in a change in the status of his/her license/certificate to practice, professional liability insurance coverage, employment by or other affiliation with a physician identified as one who supervises the AHP, and affiliation with or specified services at other institutional affiliations where he/she provides specified services.
- h.) Refrain from any conduct or acts that are or could reasonably be interpreted as being beyond, or an attempt to exceed, the scope of specified services authorized within the Hospital.
- i.) Abide by the ethical principle of his or her profession.
- j.) Participate as a member of an organized health care arrangement in coordinating and supporting patient health information privacy and security practices as stated in the "Notice of Privacy Practices" and as required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

As warranted by the circumstances, failure to satisfy any of these obligations is grounds for termination or non-renewal of staff appointment and clinical privileges, or for such other disciplinary action as deemed appropriate under Part Four of these Policies.

VIII. TERMS AND CONDITIONS OF AFFILIATION

An AHP shall be individually assigned, as appropriate, to the clinical Department and/or Hospital Department appropriate to his/her professional training and authorized scope of services and is subject to an initial probationary period, formal periodic reviews and disciplinary procedures as set forth in Parts Three and Four of these Policies.

An AHP's provision of specified services within any Department is subject to the rules and regulations of that Department, and to the authority of the Chairperson thereof. The quality and efficiency of the care provided by AHPs within any such Department shall be monitored, and reviewed as part of the regular Medical Staff and/or Hospital mechanisms.

The specified services authorized for an AHP shall automatically terminate if the clinical privileges of his/her supervising physician are terminated or not renewed.

Similarly, an AHP's specified services shall be automatically suspended effective upon and for the same term as suspension of the clinical privileges of his/her supervising physician.

IX. SCOPE OF SPECIFIED SERVICES

Notwithstanding the apparent scope of specified services permitted to any particular discipline of AHPs or any individual AHP under state or federal regulations or licensure, limitations may be placed on the AHPs authorized scope of services in the Hospital as deemed necessary either for the efficient and effective operation of the Hospital or any of its departments or services, or for management of personnel, services and equipment, or for quality or efficient patient care, or as otherwise deemed by the Board of Directors to be in the best interests of patient care in the Hospital.

X. SPECIAL PROVISIONS FOR ADVANCED PRACTICE NURSE PRESCRIBERS

1. Advanced Practice Nurse Prescribers (NP, CNS, CRNA) must meet the criteria set forth in Wisconsin State Statutes relative to "Prescriptive Authority".
2. APNP's must have a physician agree to work in collaboration with them and must have a copy of the signed collaborative agreement on file as part of the appointment and reappointment processes. The collaborating physician must be credentialed as an Active, Courtesy or Affiliated Staff member and privileged to practice at Saint Mary's Hospital. Collaboration is defined as described under Medicare Part B (latest update December 15, 2001), Federal definition.

Collaboration – Collaboration is a process in which an APNP works with one or more physicians (MD or DO) to deliver health care services, with medical direction and appropriate supervision as required by the law of the State in which the services are furnished.

In the absence of State law governing collaboration, collaboration is to be evidenced by APNPs documenting their scope of practice and indicating relationships that they have with physicians to deal with issues outside their scope of practice.

3. CRNAs will work-in a collaborative relationship with a physician. The collaborative relationship is a process in which a CRNA is working with a physician, in each other's presence when necessary, to deliver health care services within the scope of the practitioner's professional expertise.

Preoperative anesthetic evaluation shall be performed by the CRNA with assessment of the patient's health status as it relates to the relative risks involved with anesthetic management of the patient during the performance of an operative procedure.

The CRNA shall develop a plan of anesthesia and shall implement the appropriate anesthetic plan. The CRNA shall take corrective action to counteract problems that may develop during implementation of the anesthesia plan.

The surgeon and/or the physician in charge of the patient's medical care shall be responsible for diagnosing new medical problems associated with the patient's care. The anesthetist shall inform and consult with the surgeon and/or the physician in charge of the patient's medical care regarding medical complications during implementation of the patient's surgery or anesthesia plan. The CRNA shall provide necessary post-anesthesia care and shall discuss potential complications or conditions requiring further treatment with the surgeon and/or the physician in charge of the patient's medical care.

4. NPs and CNSs may request privileges for inpatient practice consistent with their collaborating physician's department affiliation; however, they will not be privileged to admit patients.

They may treat inpatients but only under the supervision of a physician credentialed as an Active, or Courtesy Staff member at Saint Mary's Hospital.

XI. SUPERVISING PHYSICIAN'S OBLIGATIONS

(Applicable to Physician Assistants)

A physician supervising an AHP in the care of the patient is obligated to comply with the following:

- a.) Accept full legal and ethical responsibility for the AHP's performance if the AHP is not a Hospital employee;
- b.) the correction and resolution of any problems that may arise;
- c.) be physically present or immediately available by telephone to provide further guidance when the AHP performs any task or function, except in life-threatening emergencies;
- d.) maintain ultimate responsibility for directing the course of the patient's medical treatment;
- e.) assure that the AHP provides specified services in accordance with accepted medical standards;
- f.) provide active and continuous overview of the AHPs activities in the Hospital to ensure that directions and advice are being implemented;
- g.) abide by all policies and rules governing the use of AHPs in the Hospital, including refraining from requesting that the AHP provide specified services beyond, or that might reasonably be construed as being beyond, the AHP's authorized scope of practice in the Hospital;
- h.) immediately notify the Chairperson and the Medical Staff Office in the event any of the following occur:
 - 1.) The scope or nature of his/her professional arrangement with the AHP changes;

- 2.) His/her approval to supervise the AHP is revoked, limited, or otherwise altered by action of the applicable state licensing authority;
 - 3.) Notification is given of investigation of the AHP or of his/her supervision of the AHP by the applicable state licensing authority;
 - 4.) His/her professional liability insurance coverage is changed insofar as coverage of the acts of the AHP is concerned.
- i.) obtain consents from all patients to be treated by the AHP in accordance with such rules and regulations pertaining thereto as may be adopted by the Hospital from time to time and as are required under Wisconsin state law;
 - j.) comply with all laws and regulations and all policies specific to the particular discipline of AHPs as appended to these policies governing his/her supervision of the AHP.
 - k.) to ensure that the AHP has been properly oriented to hospital services and applicable policy and procedures.

XII. IDENTIFICATION

At all times while on Hospital premises, the AHP shall wear a picture identification.

PART TWO: APPLICATION PROCEDURE FOR ALLIED HEALTH PROFESSIONALS

I. APPLICATION AND CONSENT

Application for specified services must be submitted by the AHP in writing, signed, and on the Hospital approved form. The applicant must furnish complete information concerning at least the following:

- a.) **Personal Information:** Full name, social security number, addresses and telephone numbers for office and residence.
- b.) **Physician Supervision Information:** For supervised AHPs, the name of the physician/group who employs the AHP and designated to supervise the AHP. Each such physician or group leader must sign the supervising physician acknowledgment form accompanying the application and delineation of specified services form for the AHP.
- c.) **Education:** School name and location, major degrees awarded, and dates attended for all undergraduate and/or professional/other graduate schools relevant to the category of allied health professional for which applying.
- d.) **Postgraduate/Continuing Education:** Institution/school name, dates attended and completed, and if applicable, program director.

- e.) **Professional Licenses/Registration/Certifications:** Prior and current professional state licenses; if applicable, DEA registration, if applicable, date of certification by the professional college or specialty board, where applicable (e.g., National Commission on Certification of Physician Assistants), and other professional certifications, where applicable.
- f.) **Chronology of Professional Career** (all present and prior): Hospital affiliations, other institutional affiliations, employment with solo, group, partnership practice. Information must include affiliation name, nature and location of each, inclusive dates, and experience at each in the specified services being requested. The chronology must cover all periods from professional education and training to current.
- g.) **Professional Society Memberships:** Current and pending.
- h.) **Disciplinary Actions** (pending and completed): Denials, revocations, limitations, probation, non-renewals, voluntary relinquishments (A voluntary relinquishment or voluntary non-renewal is for disciplinary reasons when the relinquishment or non-renewal is done to avoid an adverse action, preclude an investigation, or is done while the licensee is under investigation related to professional conduct.) of or withdrawals of application for any of the following: professional registration/license/certificate, academic, appointment, hospital/other institutional affiliation, authority to provide services, professional society membership, board certification, professional liability insurance; full details of each to be provided.
- i.) **Professional Liability Insurance:** Names of present and past insurance carriers, appropriate coverage amounts; any claims, suits, settlements or arbitration proceedings pending or concluded with appropriate details; covering occurrences in practice over the past 5 years.
- j.) **Health Status:** Attestation of health status (which means mental, physical, emotional health and stability) to exercise the services requested in a safe and competent manner (with reasonable accommodation). Additional details as indicated on the health assessment questionnaire shall be assessed following a favorable recommendation for appointment by the Medical Executive Committee.
- k.) **Completed Background Information Disclosure Form** as required under the provisions of sections 48.685 and 50.065 of the Wisconsin State Statutes.
- l.) **Notification** of the authorization, release and immunity provisions of the Medical Staff Bylaws and their applicability to consideration of the AHPs application and his/her provision of specified services in the Hospital and evidence of the applicant's agreement with them.
- m.) **APN Collaborative Agreement** must be completed by the APN and the collaborating physician.
- n.) **Supervising physician acknowledgment** to assume and carry out the obligations required by the policies specific to the particular discipline involved.

o.) **References:**

Advanced Practice Clinicians: The names of at least two (2) professionals (at least one should be in the AHPs own discipline when available) who have personal knowledge of the applicant's current clinical ability, ethical character, health status and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from Hospital or Medical Staff authorities. The named individuals must have acquired the requisite knowledge through recent (within the past two years) observation of the applicant's professional performance over a reasonable period of time.

In addition, if the applicant completed a training program within the last three years, a reference will be requested from the program director where training was obtained. A reference will also be requested from the collaborating/supervising physician from the applicant's most recent employment.

Authorized Providers: The name of the applicant's current , or most recent, supervising physician or professional healthcare provider who can attest to the applicant's current clinical ability, ethical character, health status and ability to work cooperatively with others.

p.) **Such other information or references** as may be established in the specific policies governing the discipline of AHP for which application is being made.

II. EFFECT OF APPLICATION

The AHP must sign the application and in so doing:

- a.) Attest to the correctness and completeness of all information furnished and acknowledges that any misstatement or misrepresentation in or omission from the application, whether intentional or not, constitutes grounds for denial of specified services or for automatic revocation of previously authorized services in the event they were granted prior to the discovery of the misstatement, misrepresentation, or omission;
- b.) Signifies his/her willingness to appear for interviews in connection with the application.
- c.) Agrees to abide by the terms of these policies, the related manuals, rules, regulations, policies and procedure manuals of the Medical Staff and those of the Hospital.
- d.) Agrees to maintain ethical behavior and to refrain from misrepresenting his/her position, status or scope of authorized service to any patient, Hospital visitor, Hospital employee, Medical Staff members, or any other person affiliated with or coming in contact with the Hospital;
- e.) Agrees to notify, promptly and in writing, the Department Chairperson or his/her designees and the Medical Staff Office, of any change in any of the information provided on the application;

- f.) Authorizes and consents to Hospital representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to their inspecting all records and documents that may be material to evaluation of said qualifications and competence;
- g.) Releases from any liability all those who review, act on or provide information regarding the AHPs background, experience, clinical competence, professional ethics, character, health status, and other qualifications.

For the purpose of this section, the term “hospital representative” means: the Board of Directors of the Hospital and any member or committee thereof; the Hospital President or his/her respective designees; the Medical Staff and any member, officer, or committee thereof; employees of the Hospital; and any individual authorized by any appropriate authority of the Medical Staff or Hospital to perform specific information gathering, analysis, use or disseminating functions.

III. PROCESSING THE APPLICATION

A. ALLIED HEALTH PROFESSIONAL’S BURDEN AND PROOF OF IDENTITY

AHP’s Burden: The AHP and his/her supervising/collaborating physician, if applicable, have the burden of producing adequate information for a proper evaluation of the AHPs experience, training, current competence, ability to work cooperatively with others, and health status, and of resolving any doubts about these or any of the qualifications required for the requested specified services, and of satisfying any reasonable requests for information or clarification made by appropriate Medical Staff or Board authorities.

B. VERIFICATION OF INFORMATION

The completed application, accompanied by a list of the requested clinical privileges or scope of practice the AHP seeks to provide in the Hospital and, as applicable, the level of supervision required for each, must be submitted to the Medical Staff Office. The Medical Staff Office staff will organize and coordinate the collection and verification of the references, licensure, certification, education, training, affiliations and other qualifications, and promptly notify the AHP and, when applicable, the supervising/collaborating physician in writing of any gaps or additional information the AHP is to provide in the appropriate time frame. Failure to provide the information within the required time frame is deemed a withdrawal of the application, unless the Hospital Department Director or Department Chairperson determines that the failure to respond was caused by circumstances beyond the control of the AHP. When collection and verification is accomplished, the Medical Staff Office shall notify the applicable Hospital Department Director (when appropriate) and the applicable Department Chairperson that the application and all supporting material are available for review.

C. HOSPITAL DEPARTMENT EVALUATION AND MEDICAL STAFF DEPARTMENT EVALUATION

Each applicable Hospital Department Director and each applicable Medical Staff Department Chairperson, or their respective designees, shall review the application and its supporting documentation and forward their recommendation to the Medical Executive Committee.

The applicable Hospital Department Director and/or applicable Medical Staff Department Chairperson, or their respective designees, may also interview the AHP.

If the Hospital Department Director or Department Chairperson requires further information, he/she may defer transmitting their recommendation. In case of a deferral, the Department Chairperson and Director shall notify, through the Medical Staff Office the AHP of the deferral. If the AHP is to provide the additional information or a specific release/authorization to allow Hospital representatives to obtain information, the notice to him/her must so state, and must include a request for the specific data/explanation or release/authorization required and the deadlines for response.

Failure to respond in a satisfactory manner by that date is deemed a withdrawal of the application, unless the Hospital Department Director or Department Chairperson determines that the failure to respond was caused by circumstances beyond the AHPs control.

D. MEDICAL EXECUTIVE COMMITTEE EVALUATION

The Medical Executive Committee (MEC) reviews the supporting documentation, along with any applicable reports from the Hospital Department Directors, the Department Chairpersons, and any other relevant information available to it. The MEC shall take one of the following actions on the application with the effect as described:

1. Deferral: If the MEC requires further information, it may defer transmitting its report, and it must notify the AHP and, when applicable, the supervising/collaborating physician, through the Medical Staff Office of the deferral. If the AHP is to provide the additional information or a specific release/authorization to allow Hospital representatives to obtain information, the notice to him must so state and must include a request for the specific data/explanation or release/authorization required and the deadline for response.

Failure to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application, unless the MEC determines that the failure to respond was caused by circumstances beyond the AHP's control.

2. Favorable Recommendation: A favorable MEC recommendation shall be promptly transmitted to the Board of Directors with the AHPs application and information, and shall be acted on as set forth in Part Two III F below.

If an application meets the requirements for an expedited appointment, the Medical Executive Committee may recommend that the application and supporting documentation be reviewed by a subcommittee of the Board of Directors, to include three voting members, in lieu of the regularly scheduled Board of Directors meeting.

3. Adverse Recommendation: If the MEC recommendation is adverse to the AHP, the President of the Medical Staff shall promptly so inform the applicant by special notice, and he/she shall be entitled to the procedural rights as provided in Part Four of this policy.

E. EXPEDITED APPROVAL PROCESS

An expedited process allows for a subcommittee of the Board to grant approval of an appointment and/or clinical privileges/scope of practice. In the event any of the following has occurred, an applicant will be ineligible for the expedited process:

- The application is incomplete;
- The Medical Executive Committee makes a final recommendation that is adverse or with limitation.

The following situations are evaluated on a case-by-case basis and may result in ineligibility for the expedited process:

- There is a current challenge or a previously successful challenge to licensure or registration;
- The applicant has received an involuntary termination of allied health staff membership at another organization;
- The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; or
- There has been a payment by, or on behalf of an applicant, in settlement of or satisfaction in whole or in part, of a claim or judgment against such practitioner.

F. BOARD OF DIRECTOR'S ACTION

If, in its deliberations pursuant to Part F, the Board of Directors determines that it requires further information, it may defer action but generally for not more than 60 days except for a good cause, and it shall notify the AHP, the supervising/employing physician when applicable, and the President of the Medical Staff in writing of the deferral and the grounds.

If the AHP is to provide additional information or a specific release/authorization to allow Hospital representatives to obtain information, the notice to him/her must so state and must include a request for the specific data/explanation or release/authorization required and the deadline for response.

Failure to respond in a satisfactory manner by that date is deemed a withdrawal of the application, unless the Board of Directors determines that the delay was due to circumstances beyond the AHP's control.

1. On Favorable Recommendation: The Board of Directors or the Subcommittee of the Board of Directors may adopt or reject, in whole or in part, a favorable MEC recommendation or refer the recommendation back to the MEC for further consideration

stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made back to the Board of Directors.

If the Board of Directors action is favorable to the AHP, it is effective as the final decision and a letter is sent to the applicant informing him/her of this action.

2. Adverse Recommendation: If the Board of Directors action is adverse to the AHP, the President of the Medical Staff shall promptly so inform the applicant by special notice, and he/she shall be entitled to the procedural rights as provided in Part Four of this policy.

PART THREE: RE-EVALUATION PROCEDURES FOR ALLIED HEALTH PROFESSIONALS

I. MONITORING PERIOD FOR ALLIED HEALTH PROFESSIONALS

A. APPLICABILITY, DURATION AND CONDITIONS

For purposes of these policies, each AHP shall be subject to a monitoring period for a period of three to six months to determine clinical/technical competence and evaluate overall quality, timeliness and appropriateness of care and treatment.

Any grant of additional clinical privileges to an existing AHP shall also be subject to a review period as determined by the Department Chairman. A Hospital-employed AHP is also subject to such terms and conditions of probation as set forth in the Hospital's Human Resources policies.

B. REQUIREMENTS FOR SUCCESSFUL CONCLUSION OF PROVISIONAL PERIOD

Prior to the end of the monitoring period, a performance evaluation from the department director and/or supervising/collaborating physician, a summary of significant findings from quality assessment/improvement activities and other relevant information concerning the AHP's satisfaction of the obligations set forth in Part One VII (Obligations of AHP Professionals) of these policies shall be assessed for continued membership.

Prior to the end of the monitoring period, the appropriate Department Chairperson shall review the information on the AHPs practice and transmit a statement to the Medical Executive Committee as to whether or not, based on that information, the AHPs clinical performance is acceptable and whether or not he/she has observed or been informed of, or is otherwise aware of, any rule, procedure or protocol violations, failure to satisfy obligations, or any other incidents that have occurred in connection with the AHPs provision of specified services in the Hospital that indicate actual or potential problems.

The Medical Executive Committee shall make a determination as to whether the review period has or has not been successfully completed or whether an extension of defined duration is appropriate. The AHP will be informed in writing as to whether their review period has or has not been successfully completed.

II. BI-ENNIAL REAPPOINTMENT FOR ALLIED HEALTH PROFESSIONALS

At least ninety (90) days prior to the AHPs biennial reappointment date, the AHP must review and update the information on the reapplication form, , and submit a request for the specified privileges/scope of practice requested for the upcoming term, including any basis for changes from the specified privileges/scope of practice currently authorized.

Failure without good cause to return the reapplication form shall be deemed a voluntary relinquishment of staff membership and clinical privileges at the expiration of the member's current term of appointment.

The Medical Staff Office will compile for the AHPs file information regarding his/her satisfaction of the obligations attendant to his/her affiliation with the staff and the frequency, quality and efficiency of services he/she is providing. Processing is as described in Part Two III C. through III. F. of these policies.

If an AHP has been appointed to the staff to provide locum tenens services and has not provided services within the previous two years, the AHP will not be eligible for reappointment, unless specifically requested by the Hospital Department Director, and shall be deemed to have voluntarily relinquished their membership and clinical privileges at the expiration of their current term of appointment.

PART FOUR: DISCIPLINARY ACTION PROCEDURES FOR ALLIED HEALTH PROFESSIONALS

I. CRITERIA FOR INITIATING

Criteria for initiating routine, summary or automatic suspension of an AHPs delineated privileges are the same as provided in the Medical Staff Credentialing policy/procedures for instituting such action against a Medical Staff member or a practitioner with clinical privileges. Authorized initiating parties are also the same, plus the director of any applicable Hospital services. In addition, an AHPs violation of any provision of these policies or of any staff or hospital rule, policy or procedure relating to his/her particular discipline may be grounds for automatic and permanent revocation of the AHPs affiliation or delineated privileges.

If an AHP's employment by or affiliation with the supervising/collaborating member of the Medical Staff is terminated, said Medical Staff members shall notify the Medical Staff Office of the termination including the reason for the termination. During review of the circumstances surrounding the termination, the AHP's delineated privileges may not be exercised. If it is determined that the AHP is eligible for continued staff appointment, the AHP must provide evidence of new employment by, or affiliation with, a supervising/collaborating member of the medical staff.

Staff appointment and privileges will automatically terminate if the AHP does not meet staff requirements at the time of their next scheduled reappointment.

A hospital-employed AHP is also subject to such policies concerning discipline and termination of employment as set forth in the Hospital's Human Resources policies.

II. PROCESSING INDEPENDENT & NON-HOSPITAL EMPLOYED ALLIED HEALTH PROFESSIONALS

When disciplinary or an adverse action is proposed or has been taken against an AHP, the Medical Staff President promptly notifies him or her and his/her supervising/collaborating physician when applicable, by special notice.

If further processing is required, the matter shall be referred to the applicable Department Chairperson, or to the Credentials Committee and further processing shall follow the procedures set forth in Part Two III. C. through III F. of these policies as applicable.

Except as required by law, nothing contained in this Policy shall be interpreted to entitle an Allied Health Professional to the hearing and appeal rights in the Medical Staff Bylaws.

When applicable, an AHP who is the subject of an adverse action must first attempt resolution with his/her supervising physician.

Any problem which is not satisfactorily resolved in this manner should be put in writing and brought to the relevant Department Chairman within seven (7) days of the adverse action. The Department Chairman will review all aspects of the situation and provide a written decision to the AHP and supervising physician within seven (7) days.

If the problem is not resolved at this level, the AHP may request, in writing, a Medical Executive Committee review. The Medical Executive Committee has the option to appoint a fact-finding committee to investigate the problem and recommend appropriate action. The Medical Executive Committee will provide a written decision to the AHP and the supervising physician within seven (7) days.

Following action by the Medical Executive Committee, the AHP may request, in writing, a review by the Hospital President. The Hospital President will review all circumstances and provide a written decision to the AHP. This decision will be final.

III. PROCESSING HOSPITAL EMPLOYED ALLIED HEALTH PROFESSIONALS

When disciplinary action involving a hospital-employed AHP is proposed or required to be taken under the criteria set forth in Part Four I, the matter shall be referred to the Director of Human Resources for processing in accordance with Human Resources procedures.

PART FIVE: REAPPLICATIONS AND MODIFICATION OF PRIVILEGES

I. REAPPLICATION AFTER ADVERSE CREDENTIALS DECISIONS

Except as otherwise determined by the Medical Executive Committee in light of exceptional circumstances, an AHP who has received a final adverse decision, or who has voluntarily resigned or withdrawn an application for specified services, is not eligible to reapply for services for a period of one (1) year from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal.

Any such reapplication must include the information as required under Part Two 1. of these policies, must be processed as an initial application, and must include such additional information as the applicable authorities of the Medical Staff and the Board may reasonably require in demonstration that the basis for the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and will not be further processed. No AHP may submit or have in process at any given time more than one application for services.

II. REQUESTS FOR MODIFICATION OF DELINEATED PRIVILEGES

AHP's may, either in connection with reappointment or at any other time, request modification of delineated privileges by submitting a written request to the Medical Staff Office. A modification request must contain all pertinent information supportive of the request and is processed as set forth in Part Two III C. through III F. of these policies, including such verification with primary sources external to the hospital and compilation of such internal data as necessary to properly evaluate the request.

An AHP who determines to no longer exercise particular delineated privileges which he/she has been granted, shall send written notice of the same, through the Medical Staff Office, identifying the particular privileges involved and, as applicable, the restriction or limitation to the appropriate Department Director, Department Chairperson, Medical Executive Committee and Board of Directors.

4.9 All Initial Appointments Provisional

- (a) Each initial appointment to the Medical Staff shall be provisional for a period of one year. At the end of this one-year provisional appointment, the Medical Executive Committee, upon written recommendation of the Chairman of the Service to which the Practitioner was assigned, may recommend: to advance the Practitioner to the Active Staff, continue the provisional status for an additional period of up to one (1) year; change the Practitioner's staff category; or terminate membership and privileges. Reappointment upon advancement from provisional status may be for a period of up to two (2) years, with the length of appointment running from the date of advancement off of provisional status to the next date the Practitioner's specialty is scheduled for reappointment.
- (b) Initial appointees shall be assigned to a Service and shall have their performance observed by the Service Chairman, or his/her representative, during the provisional period. During the first six (6) months of the provisional appointment, it will be the responsibility of the Chairman of the appropriate Service to orient the Practitioner to the Service and it shall be the responsibility of the President of the Medical Staff to establish and oversee a monitoring protocol as set forth in Credentials Policy, Proctoring-QI Process.
- (c) The monitoring protocol shall afford the Hospital and the Practitioner the following:

- (1) the ability to establish pretreatment consultation requirements;
 - (2) a current review of the clinical abilities of the Practitioner;
 - (3) a resource person or committee to whom the Practitioner can or must seek voluntary or required consultations;
 - (4) a resource, in the form of the monitor or monitoring committee, with whom other staff members or Hospital personnel may confer concerning the Practitioner on interim status; and
 - (5) a basis for recommending privileges at the completion of the interim status.
- (d) At the conclusion of the initial six-month monitoring period as set forth above, or upon completion of the review and satisfactory evaluation of the appropriate type and number of cases as determined by the Service Chairman/designee Service Chairman shall recommend that the interim monitoring process be terminated, that an additional interim period of monitoring be established, that the Practitioner's Medical Staff membership be terminated and privileges withdrawn, or that other action be taken as deemed appropriate by the Medical Executive Committee. Should the Medical Executive Committee determine to extend the interim monitoring of a Practitioner for a second period, not to exceed six months, such may be done with no further action being required by the Medical Executive Committee or the Governing Body. Further, the Practitioner shall not be entitled to a hearing or review of such decision in accord with the Fair Hearing Plan. Any decisions to extend such monitoring protocol beyond two (2) initial six-month periods must be recommended by the Medical Executive Committee and ratified by the Governing Body. If the Practitioner has not attended a patient at the Hospital during his/her provisional year, the Practitioner may have his/her membership terminated and privileges withdrawn or may request to have his/her staff category changed.
- (e) During the provisional period, the provisional Member of the Medical Staff shall have the prerogatives and be subject to the restrictions as set forth in these Bylaws for the category of the Medical Staff in which regular appointment is being sought.
- (f) A Member of the Medical Staff whose appointment is provisional and who does not qualify for advancement to regular staff status within two (2) years should be scheduled for a personal interview with the president of the Medical Staff and the Chairman of the appropriate Service to discuss the status of the Practitioner's continued interest in membership on and privileges with the Medical Staff of the Hospital. The president of the Medical Staff shall report to the Medical Executive Committee, which may recommend to the Governing Body conditional appointment with continued monitoring, appointment to the regular staff, or termination of the staff appointment and privileges. A provisional appointee

whose membership is so terminated shall have the hearing and appeal rights afforded by these Bylaws to a Member of the Medical Staff who has failed to be reappointed.

SECTION 5 PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

5.1 Application for Appointment

- (a) Applicants desiring appointment to the Medical Staff or for designation as Allied Staff status (hereafter “Applicant”) shall obtain an application and privilege request form from the President who will, in addition to the forms, supply or make available to the Applicant a copy of the appointment process and a copy of the Bylaws, Rules and Regulations, pertinent policies of the Medical Staff, the Ethical and Religious Directives for Catholic Health Care Services and the Hospital’s mission statement. Physician applicants shall also receive the Medicare Notice to Physicians acknowledgement form.
- (b) All Applicants shall have the burden of producing adequate information or a proper evaluation of his/her current clinical competence, character, judgment, ethics, and other qualifications, and for resolving any doubts about such qualifications. Failure to adequately complete the application form, withholding requested information, omitting significant information, or providing false or misleading information (whether intentional or not) or omitting material necessary for a full picture of the Applicant’s professional history shall be a basis for denial of the application/privileges or removal from the Medical/Allied Staff and termination of privileges.
- (c) Contracted Providers who desire membership/clinical privileges are subject to the same procedures as all other Applicants.
- (d) All applications for the Medical/Allied Staff shall be in writing and shall be signed by the Applicant on a form prescribed by the Medical Executive Committee. The application shall require, at a minimum but as applicable, detailed information concerning the Applicant’s professional education, graduate professional training, licensure, registrations, board certifications and/or other certifications, financial responsibility, previous practice and institutional affiliations (including a list of all prior hospital Medical/Allied Staff associations), CME, current health status, and at least two (2) professional references (other than program directors) pertaining to the Applicant’s professional competence and ethical character. Professional references should have had direct contact with the Applicant within the preceding twenty four (24) months; have personal knowledge of the Applicant’s general competencies, including patient care, medical/clinical/technical knowledge and skills, practice-based learning and improvement, interpersonal and communication skills, clinical judgment, professionalism, and systems-based practice; and be willing to provide specific

written comments on these matters upon request from Hospital or Medical Staff authorities. Professional references from residents and fellows in training programs and relatives of the Applicant are not acceptable as references. Relevant practitioner-specific data,

- (e) as compared to aggregate data and morbidity and mortality data, when available, shall also be considered.
- (f) The application shall include information as to whether the Applicant's membership and/or clinical privileges have ever been or are in the process of being voluntarily or involuntarily revoked, suspended, reduced, denied or not renewed, or subject to probationary conditions, disciplinary action or sanctions at any other hospital or institution and whether the Applicant voluntarily or involuntarily resigned membership or privileges, withdrew an application for membership or privileges, or voluntarily or involuntarily reduced privileges as a result of peer evaluation or investigation. The application shall also include information as to whether his/her membership in local, state or national professional societies or his/her license/certification/registration to practice any profession in any jurisdiction or other professional registration (State, District or DEA) had ever been voluntarily or involuntarily revoked, suspended or reduced, or conditions of probation imposed, and as to any currently pending challenges or investigations relating to any licensure or registration, and whether he/she has ever been reprimanded or otherwise disciplined by any state or federal agency relating to the practice of his/her profession. Further, the application shall provide for the furnishing of information about professional liability claims pending or finalized and as to whether or not the Applicant has ever been refused professional insurance or had coverage canceled, had limitations placed on scope of coverage or had coverage rated up because of unusual conditions. The application shall also include information as to any past or pending involvement in any quality inquiry, sanction action or formal investigation by Medicaid, Medicare, a peer review or quality improvement organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or of any state.
- (g) The application must contain a request for the specific clinical privileges desired by the Applicant.
- (h) The application form shall include a signed statement that a Practitioner Applicant agrees to provide continuous care for his/her patients. All Applicants shall attest that he/she has read and understands the Bylaws and Rules, Regulations, the Ethical and Religious Directives and pertinent policies of the Medical Staff and agrees in writing to be bound by the terms thereof during the consideration of his/her application for membership on the staff and/or for clinical privileges, whether or not granted membership or clinical privileges.
- (i) The application shall include information as to whether the Applicant has any criminal conviction or pending criminal charge, any findings by a governmental

agency that the applicant has been found to have abused or neglected a child or patient or has misappropriated the property of any patient. The Applicant must provide a fully completed Background Information Disclosure form with the completed application and must cooperate with the Hospital in obtaining any additional information required for the Hospital to comply with the requirements of Chapter DHS 12 of the Wisconsin Administrative Code. Medical and Allied Staff will be required to complete a Background Information Disclosure form every four (4) years or as frequently as required for compliance with Wisconsin Administrative Code.

- (j) The Applicant shall sign and submit, along with the completed application, such other consents, authorizations, and releases as may be required under these Bylaws or as requested by the Hospital for the proper evaluation of the Applicant's qualifications for membership and/or privileges. The Applicant must present a current picture hospital ID card or a valid picture ID issued by a state or federal agency.
- (k) Each Applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application, authorizes the Hospital to consult with members of Medical Staffs and administration of other hospitals with which he/she has been associated, and with others who may have information bearing on his/her current competence, judgment, character, relevant training, physical and emotional stability, and ethical qualifications; consents to the Hospital's inspection of all records and documents that may be material to any evaluation of his/her professional qualifications and competence to carry out the clinical privileges requested, as well as of his/her moral and ethical qualifications and physical and emotional health for staff membership and/or privileges; releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in connection with evaluating the Applicant and his/her credentials; and releases from any liability all individuals and organizations who provide information to the Hospital concerning the Applicant's current competence, ethics, judgment, character, relevant training, and other qualifications for staff appointment and/or clinical privileges, including otherwise privileged or confidential information.

5.2 Initial Appointment Process

- (a) The completed application form is to be presented to the President or his/her designee. The President or his/her designee will obtain verifying information from, as applicable, the National Practitioner Data Bank, the appropriate state licensing boards, peer recommendations, data from professional practice review by an organization(s) that currently privileges the Applicant (if available) and other pertinent sources. The Hospital will obtain written primary source verification of the Applicant's information whenever feasible. If required, the Applicant will authorize any special releases these agencies may require. Action on an application for initial appointment/privileges will be withheld until the information is available and verified.

- (b) Reasonable effort (two (2) written requests) will be made to secure replies from individuals/institutions listed on the application. It is the Applicant's responsibility to secure the necessary references within sixty (60) days after notification of deficiencies in the application. If an Applicant fails to obtain necessary references within sixty (60) days after notification, the application will be considered withdrawn and will cease to be processed without recourse to the Fair Hearing Plan. Exceptions may be made when information is not obtainable for good cause.
- (c) After collecting references and other materials deemed pertinent, the President shall transmit the application and all supporting materials to the Chairman of the Clinical Service in which the Applicant seeks privileges for his/her documented opinion as to staff appointment, staff category assignment and/or clinical privileges and then to the Medical Executive Committee.
- (d) Within sixty (60) days after receipt of the completed application for membership and/or clinical privileges, including references, reports and other supporting data requested of the Applicant, the Chairman of the Clinical Service shall make a written report of its recommendations to the Medical Executive Committee, or, in the case of a non-surgical Allied Health II, as set forth in Section 4.7. In preparing this report, the Chairman of the Clinics Service shall examine the character, professional competence, judgment, qualifications, training and ethical standing of the Applicant and shall verify, through information contained in the references given by the applicant and from other sources available to the Chairman of the Clinical Service. The Medical Executive Committee may require the Applicant to arrange for a personal interview with such individuals as the Medical Executive Committee may designate, including the Chairman of the Service in which the applicant has requested clinical privileges. The Service Chairman shall provide the Medical Executive Committee specific written recommendations for delineating the Applicant's clinical privileges, Refusal to participate in the interview may be grounds for Administrative denial.
- (e) As part of this process, the Medical Executive Committee shall specifically assess competence in six core areas:
 - (1) Patient Care: Providers are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
 - (2) Medical/Clinical Knowledge: Providers are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
 - (3) Patient-Based Learning and Improvement: Providers are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

- (4) Interpersonal and Communication Skills: Providers are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
 - (5) Professionalism: Providers are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and responsible attitude toward their patients, their profession, and society.
 - (6) System-Based Practice: Providers are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.
- (f) The Medical Executive Committee shall make a recommendation to the Governing Body to approve, defer, or reject the application of those Providers whose applications are presented consistent with these Bylaws.
 - (g) The Governing Body or Medical Executive or Service may, at any time, request additional information in connection with a completed application, and the processing of the application shall be suspended for sixty (60) days or until the Applicant has provided the information requested or satisfactorily explains his or her failure to do so, whichever occurs first.
 - (h) If the Medical Executive Committee recommendations are favorable, a Practitioner or Allied Health I and designated Allied Health II applicants shall be requested to submit information regarding his/her health status, which shall be verified and appended to the reports of the Medical Executive Committee, for consideration by the Governing Body.
 - (i) When the recommendation of the Medical Executive Committee is to defer an application for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation for provisional appointment with specified clinical privileges or for rejection for Medical Staff membership and/or clinical privileges.
 - (j) When the recommendation of the Medical Executive Committee is favorable to the Applicant, the President shall promptly forward it, together with all supporting documentation, to the Governing Body.
 - (k) Upon receipt of the reports of the Medical Executive Committee and the Provider's health status information, the Governing Body, at its next regular meeting (generally within thirty (30) days), shall consider the reports and provisionally accept, defer, or reject the application. Any recommendations for initial appointment/privileges may include probationary conditions relating to clinical privileges and practice.

- (l) The Governing Body's determination on appointment, reappointment, and/or granting of clinical privileges is based on its review and evaluation of the services of the Applicant in connection with the Hospital's program to help improve the quality of health care and to avoid improper utilization of services or facilities.
- (m) When the recommendation of the Medical Executive Committee will constitute a professional review action for a Practitioner as defined in the Fair Hearing Plan, prior to any referral of the recommendation to the Governing Body for action, the Practitioner should be notified of the recommendation and given an opportunity either to waive, by accepting the recommendation, or to exercise any procedural rights to review as set forth in the Fair Hearing Plan.
- (n) The Governing Body's determination includes independent criticism and evaluation of the applicant's practice based on documentation submitted by the Medical Staff. The Governing Body's consideration is independent from the conclusions of the Medical Executive Committee and may involve further investigation, but such recommendations will be taken into account in the Governing Body's review of the applicant's practice.
- (o) The quality of patient care in the Hospital is considered by the Governing Body, the Medical Executive Committee, and all other committees as a primary goal in the staff appointments, reappointments, and the granting or limiting of clinical privileges.
- (p) While the recommendations regarding appointment to the Medical Staff and/or clinical privileges shall be based primarily on the professional competence of the applicant, the present and future composition of the Medical and Allied Staffs shall be a consideration and criterion, as well as the ability of the Hospital to provide adequate facilities and supportive services for the Applicant and his/her patients, and patient care needs for additional staff members with the Applicant's skill and training, and the geographic location of the Applicant and his/her practice to the extent it affects the Applicant's ability to provide effective continuity of care for Hospital patients.
- (q) Solely the Governing Body shall determine whether to select or reject any Applicant based on the limitations of facilities, services, staff, support capabilities, or any combination thereof. Decisions to deny membership or privileges to any otherwise qualified Provider 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.
- (r) The Governing Body shall, at its next regular meeting after receipt of the application and supporting material and the recommendation of the Medical Executive Committee, either:

- (1) refer the application back to the Medical Executive Committee, indicating reasons for non-acceptance and setting a time limit in which a subsequent recommendation is to be made; or
 - (2) take final action on the application, after which the President will submit the decision to the Applicant, except that if the Governing Body's proposed final action will be contrary to the Medical Executive Committee's recommendation, the Governing Body shall submit the matter to a Joint Conference Committee with equal representation of the Medical Staff and the Governing Body for review before the Governing Body makes its final decision.
- (s) When the regular Governing Board meeting schedule would delay the timely approval of a routine application that meets the criteria set forth in the Medical Staff policy on expedited credentialing, an expedited review/approval process, as set forth in the "Expedited Credentialing" policy, may be implemented following an in depth review and positive recommendation of the application by the appropriate Service Chairman, and the Medical Executive Committee.
 - (t) The President will notify the president of the Medical Staff, the Service Chairman concerned, and the Applicant of the Governing Body's final decision. If the Applicant is granted membership and/or clinical privileges, the notice will state the specific Medical Staff category/type and privileges granted.

5.3 Reappointment Process

- (a) The President will provide each Medical Staff Member or Allied Health Professional whose clinical privileges and/or membership are about to expire with an appropriate application for reappointment and/or renewal of clinical privileges which must be completed and submitted by a specified date. Failure without good cause to return the form and/or supporting documentation may be deemed a voluntary resignation from the Medical/Allied Staff and of all Hospital clinical privileges at the expiration of the Member's/Allied Health Professional's current appointment. A Practitioner whose membership and/or privileges are so terminated shall be entitled to the procedural rights provided in the Fair Hearing Plan for the sole purpose of determining the issue of good cause.
- (b) The reappointment year will occur biennially by birth month.
- (c) Contracted physicians, Medical Staff Officers, and Service Chairmen who desire membership and clinical privileges are subject to the same procedures as all other applicants.
- (d) The reappointment application form shall include all information necessary to update the information contained in the Member or Allied Health Professional's initial application for appointment and/or clinical privileges since the last time such information was updated, including, as applicable and without limitation:

- (1) voluntary or involuntary changes in Medical Staff membership and/or clinical privileges at any other hospital or institution, including, without limitation, any revocation, suspension, reduction, denial, relinquishment, or non-renewal thereof, and any withdrawal of any application for membership or privileges and the imposition of probationary conditions or disciplinary action;
- (2) voluntary or involuntary suspension or revocation of licensure or registration (State, District or DEA) or any reprimand or imposition of sanctions related thereto or suspension or revocation of membership or imposition of other sanctions by any local, state or national professional society;
- (3) any malpractice claims, suits, settlements or judgments, whether pending or finally determined, and any refusal or cancellation of professional liability insurance;
- (4) any additional training, education or experience relevant to the privileges sought on reappointment;
- (5) certification of current freedom from physical or mental disability that would affect the Provider's ability to safely exercise the privileges sought, and documentation of the health assessment required by law and Hospital policy for persons providing direct patient services in the Hospital;
- (6) any criminal conviction(s) or pending criminal charges;
- (7) such other information about the Provider's ethics, qualifications, and ability as may be relevant to his/her current ability to provide quality patient care at the Hospital;
- (8) current evidence of licensure and DEA registration and of professional liability insurance coverage;
- (9) any proposed or actual exclusion from any health care program funded in whole or in part by the federal government; or any notice to the individual or his representative of proposed or actual exclusion or any pending investigation of the individual from any health care program funded in whole or in part by the federal government, including Medicare and Medicaid;
- (10) receipt of any quality inquiry letter, an initial sanction notice or notice of proposed sanction or of the initiation of a formal investigation or the filing of charges related to 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 any state;

- (11) updated information regarding any findings by a governmental agency that the Provider has been found to have abused or neglected a child or patient or has misappropriated the property of any patient including a fully completed Background Information Disclosure form;
 - (12) minimum CME requirements to maintain the license to practice his/her profession; and
 - (13) such other information about the Provider's ethics, qualifications and ability as may be relevant to his/her ability to provide quality patient care at the Hospital including, without limitation, a current NPDB report.
- (e) In a timely manner before the monthly meeting of the Governing Body prior to the expiration of the individual's current appointment and/or clinical privileges, the Medical Executive Committee shall review all pertinent information available on each appointee scheduled for periodic appraisal for the purpose of determining its recommendations for reappointments to the Medical Staff and/or for the granting of clinical privileges
 - (f) In arriving at recommendations for the reappointment of each Medical Staff member and/or the assignment of privileges to a Provider, specific consideration will be given, as appropriate, to the individual's licensure, DEA registration, professional liability coverage, current professional competency and clinical judgment in the treatment of patients, ethics and conduct, physical and mental capabilities, as they relate to the individual's ability to perform the privileges requested, participation in continuing education, the individual's pattern of care and performance within the Hospital, based on such reliable information as may be available, attendance at Medical Staff and Service meetings and participation in staff affairs, compliance with the Hospital Bylaws and the Medical Staff Bylaws, Rules & Regulations, and pertinent policies (including the timeliness of medical record completion), cooperation with Hospital personnel, efficient and effective use of the Hospital's facilities for patients, relations with other staff members, and general attitude toward patients, the Hospital and the public and other information as deemed necessary and appropriate for a proper evaluation. The applicant for reappointment and/or renewal of clinical privileges is required to submit any reasonable evidence of current health status relevant to the performance of duties that may be requested by the Hospital.
 - (g) Reappointment consideration will include review of the periodic appraisal of the professional activities of each member of the Medical Staff and all other individuals granted clinical privileges through the Medical Staff credentialing process, as well as periodic appraisal of health status.
 - (h) The results of quality assessment and improvement activities, and any monitoring performed during the prior term of appointment, if any, shall be considered in the appraisal of the applicant's professional performance, judgment, and technical or clinical skills.

- (i) In a timely manner before the bimonthly meeting of the Governing Body prior to the expiration of the Practitioner, Allied Health I or designated Allied Health II's current appointment, the Medical Executive Committee shall make its recommendations concerning the reappointment or non-reappointment, as applicable, and the continuation or alteration of privileges for the next appointment period of each Provider scheduled for reappraisal. In all cases when non-reappointment or a change in staff status or clinical privileges is recommended, the reasons for the recommendation shall be stated and documented.
- (j) When the recommendation of the Medical Executive Committee is a professional review action against a Practitioner giving rise to hearing rights as specified in the Fair Hearing Plan, prior to any referral of the recommendation to the Governing Body for action, the appointee involved shall be notified of the negative recommendation, and given an opportunity either to use the procedural rights contained in the Fair Hearing Plan or to accept the recommendation.
- (k) Thereafter, the procedure provided herein relating to recommendation on applications for initial appointments shall be followed.
- (l) When the regular Governing Board meeting schedule would delay the timely approval of a routine application that meets the criteria set forth in the Medical Staff policy on expedited credentialing, an expedited review/approval process, as set forth in the expedited credentialing policy, may be implemented following an in depth review and positive recommendation of the application by the appropriate Service Chairman, and the Medical Executive Committee.

5.4 Modification of Membership Status or Privileges

- (a) A member of the Medical Staff or any Allied Health Professional may, either in connection with the reappointment or re-privileging process or at any other time, as applicable, request modification of his/her staff category, Service assignment, or clinical privileges by submitting a written application to the President on the prescribed form, subject to the limitations of Section 5.5. Such application shall be processed in the same manner as provided in Section 5.3 above for reappointment.
- (b) Requests for privileges that involve either technology or procedures new to the Hospital shall not be processed until the process for approving new technology and/or new procedures, as established by Medical Staff policy, has been completed.
- (c) Requests for additional clinical privileges shall include:
 - Documentation of training and experience for the privilege(s) being requested;
 - Outline of course curriculum, if applicable;
 - Applicable guidelines and standards from recognized specialty boards, societies, etc.;

- Patient outcome information if available; and
 - Letter from proctor/Chair/etc. attesting to competency to perform the procedure/privilege being requested.
- (1) Such requests shall be processed in a similar manner as provided for reappointment. Any grant of new, extended or increased clinical privileges shall also be subject to evaluation and to monitoring.
 - (2) Requests for privileges that involve either technology or procedures new to the Hospital shall not be processed until the process for approving new technology and/or new procedures, as established by Medical Staff policy, has been completed.
- (d) Because it is inevitable that from time to time, some Providers will develop physical or mental conditions that may limit their ability to safely exercise the clinical privileges granted them, it shall be the responsibility of all Providers to bring to the attention of the president of the Medical Staff, the appropriate Service Chairman, or the President, such conditions. Refer to Medical Staff policy entitled "Providers' Health."
 - (e) If, as a result of a Provider's self-reporting of a condition, the Medical Executive Committee recommends modification of membership status or privileges, the affected Provider shall be notified, in writing, of the recommendation. The recommendation shall not be considered a professional review action unless and until the Provider chooses to exercise the right to hearing available under the Fair Hearing Plan and the notice to the Provider shall so state. If the Medical Executive Committee recommends modification of membership status or privileges due to a Provider's condition initially discovered by means other than self-reporting, such recommendation shall constitute a professional review action without regard to whether or not the Provider exercises the hearing rights available under the Fair Hearing Plan.

5.5 Reapplication After Adverse Action

- (a) A Provider 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 the Fair Hearing Plan, shall not be eligible to reapply for the membership status or privileges that were the subject of the adverse action for a period of six (6) months from the date of final adverse action.
- (b) A Provider who has received a final adverse professional review action regarding appointment or clinical privileges or both, and who exercised some or all of the hearing rights provided in the Fair Hearing Plan, shall not be eligible to reapply for the membership status or privileges that were the subject of the adverse action for a period of two (2) years from the date of final adverse action.
- (c) Any reapplication under this Section 5.5 shall be processed as an initial application, but the Applicant shall submit such additional information as the

Medical Executive Committee, Service or Governing Body may require in demonstration that the basis for the earlier adverse action no longer exists.

- (d) If the recommendation of the Medical Executive Committee, or the action proposed by the Governing Body, upon a reapplication under subsection 5.5(b) continues to be adverse to a Provider, the scope of the hearing and review to which the Provider 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.

5.6 Leave of Absence and Reappointment

- (a) Any member of the Active, Consulting, Courtesy Staff and any Allied Health Professional who will be absent for a period of time exceeding eight (8) weeks must provide written notification to the Medical Staff president or the President. Written notification of a leave will also be accepted from Clinic Administration. Such notification shall state the start and, if known, anticipated end dates of the leave and the reasons for the leave (i.e., military duty, additional training, family matters or personal health). If the Provider fails to return before the last day of approved leave (including any extension granted up to the end of the current term of appointment), and does not reapply as describe below, the Provider shall be considered to have resigned his or her membership and/or clinical privileges, as applicable, and shall not be entitled to any hearing or appellate review. A request for Medical Staff membership and/or clinical privileges subsequently received from a Provider so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for reappointments.
- (b) Upon return from leave of absence prior to the expiration of the Provider's then current term of appointment, the Provider shall be required to submit a written request for reinstatement to the appropriate Service Chairman and the Medical Executive Committee. The Provider may be required to submit such additional information as may be relevant to his/her request for reinstatement, including interval status information. The Credentials Committee and the Service Chairman will review the request and submit their recommendations to the Medical Executive Committee or otherwise consistent with Section 4.7. Thereafter, the process for reappointment contained in Sections 5.3(e) through 5.3(i) shall be followed.
- (c) The Practitioner or Clinic Administration, or, in the case of an Allied Health I, the Allied Health Professional and/or his/her sponsoring Practitioner, when applicable, shall be responsible for obtaining coverage for his/her patients during the leave.
- (d) A leave of absence may not extend beyond the term of the Provider's current term of appointment. If the Provider is not able to return from leave before his/her current appointment term and/or clinical privileges are set to expire but has submitted an application for reappointment and/or renewal of clinical privileges,

action on the application will be deferred for up to two (2) years until the Provider identifies with reasonable certainty the date of anticipated return from leave. Deferring the application due to continued leave of absence shall not give Providers any rights to hearing or appeal. The Provider 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 Provider's Medical Staff membership and/or clinical privileges shall be considered expired between the time of the expiration of the term in which the leave began and the date of reappointment.

5.7 Time Periods for Processing

Applications for appointment or reappointment and clinical privileges 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 in this Section 5. 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 Provider to have his/her application processed within those periods nor to create a right for a Provider to be automatically appointed, reappointed for the coming term or granted requested privileges.

5.8 Administrative Denial

The Medical Staff Office may, with the approval of the President of the Medical Staff, deny any application for appointment or reappointment to the Medical Staff and/or for clinical privileges, without further review, if it is determined that the Applicant: does not hold a valid Wisconsin license/certification/registration and no application is pending; does not have adequate professional liability insurance; is not eligible to receive payment from the Medicare or Medicaid programs or is currently excluded from any health care program funded in whole or in part by the federal government; is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code; or is applying for privileges in a clinical area where the Hospital has granted exclusive privileges to other Providers. Applicants who are administratively denied under this Section do not have the right to a fair hearing under the Fair Hearing Plan, but may submit evidence to the Medical Staff Office to refute the basis for the administrative denial.

SECTION 6 PRIVILEGES

6.1 Delineation of Clinical Privileges

- (a) A Provider providing clinical services in the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Governing Body pursuant to the procedures set forth in these Bylaws, except as provided in Sections 6.2 and 6.3 of this Section, or as otherwise described in Section 4.7.
- (b) Every initial application for staff appointment and/or designation as an Allied Health Professional must contain a request for the specific clinical privileges desired by the Provider. The evaluation of such request shall be based upon the Provider's current licensure, education, training, specific and relevant experience,

judgment, demonstrated current competence, peer references, evidence of physical ability to perform the privileges requested, professional practice review data, and other relevant information. The Provider shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests. A separate file is provided for each individual.

- (c) Periodic redetermination of clinical privileges, and the increase or curtailment of same, shall be based upon the criteria set forth in subsection 6.1(b) above and factors such as: direct observation of care provided; the health of the Provider as it relates to the Provider's ability to safely perform the privileges requested; review of records of patients treated in the Hospital, other hospitals or the Provider's clinic/office, as applicable; and review of the records of the Medical Staff which document the evaluation of the Provider's participation in the delivery of patient care. Whether the individual has actually exercised all the requested privileges with sufficient frequency since the time of last appointment to indicate current proficiency shall also be a factor in the redetermination process.
- (d) Requests to modify clinical privileges or to obtain additional clinical privileges shall be made in writing to the President on a prescribed form on which the type of clinical privileges desired and the Provider's relevant recent training and/or experience must be stated. The President shall then forward such request to the Medical Executive Committee. The request shall then be reviewed and it shall be processed in the same manner and pursuant to the same criteria as an application for initial appointment and clinical privileges.
- (e) If the Provider voluntarily relinquishes staff appointment and/or clinical privileges, the Provider may not reapply for appointment and/or for the same clinical privileges for a period of one year. If privileges and/or appointment are restricted by the Governing Body, Section 5.5 shall determine when the Provider may reapply.
- (f) Privileges granted to dentists and podiatrists should be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist and podiatrist may perform must be specifically defined and recommended in the same manner as all other surgical privileges. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chairman of Surgical Services. All dental and podiatric patients must receive the same basic medical appraisal as patients admitted to other services. A physician Member of the Medical Staff must be responsible for the general care of the patient during hospitalization. The dentist or podiatrist is responsible for the dental or podiatric care of the patient including the dental or podiatric history and physical examination, discharge summary and all appropriate elements of the patient's record.
- (g) Practitioners and Allied Health Professionals may write orders within the scope of their license, as limited by law and as consistent with Medical Staff regulations.

- (h) Privileges granted to Allied Health Professionals shall be based upon the criteria set forth in Section 6.1(b) above, as well as direct observation by the Medical Staff.
- (i) Each individual with clinical privileges agrees to provide for continuous quality care for patients.
- (j) Providers granted privileges to perform history and physical examinations must complete and document the results of the history and physical examination no more than thirty (30) days before or twenty-four (24) hours after admission or registration of each patient, but prior to surgery or a procedure requiring anesthesia services. When the history and physical examination is completed within the thirty (30) days prior to admission or registration, an examination of the patient must be documented in the medical record within twenty four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. Additional rules and policies may be present for examinations for specific conditions, which, if present, also apply.
- (k) Clinical privileges shall be reviewed for renewal or revision biennially and shall coincide with the reappointment process or re-privileging process for Allied Health Professionals, as applicable.

6.2 Temporary Privileges

The granting of temporary privileges is not encouraged and shall be done only in circumstances where it is deemed necessary or beneficial to the Hospital to meet important patient care needs.

- (a) Upon receipt of a complete application for privileges, and when the Practitioner is otherwise qualified, the President and the president of the Medical Staff, or their designees, upon the recommendation of the Chairman of the Service concerned or his/her Service designee, shall have the authority to grant temporary clinical privileges for a period of one hundred twenty (120) days. Certain minimum information, as delineated in Medical Staff policy, including verification of current licensure and a comprehensive background check, will be required prior to the granting of temporary privileges. Temporary privileges will not be granted during pendency of application, except in unusual circumstances, and then only when information provided in the application materials reasonably supports favorable determination of qualifications and the Practitioner has provided evidence of financial responsibility in accordance with the requirements of these Bylaws. In exercising such privileges, the Practitioner shall act under the supervision of the Chairman of the Service to which he/she is assigned, or under the supervision of a member of that clinical Service selected by the Chairman.
- (b) The President and/or his/her designee, upon the recommendation of the Medical Staff president, may grant temporary privileges to a Practitioner who is neither a member of the Medical Staff nor an applicant for membership in the same manner

and upon the same conditions as in granting temporary privileges for an applicant for Medical Staff membership. Under these circumstances, however, temporary privileges are granted to attend not more than six (6) patients in any one year, after which the Practitioner to whom such temporary privileges have been granted shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients. Before being granted such privileges, the applicant must sign an acknowledgment that he/she has received a copy and read the Medical Staff Bylaws, Rules and Regulations and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges.

- (c) A Practitioner serving as a locum tenens for a member of the Medical Staff may be permitted to attend patients for a period not to exceed one hundred twenty (120) days without applying for membership on the Medical Staff, provided the Practitioner's credentials have been approved by the Chairman of the Service concerned and the President. Except in unusual circumstances, locum tenens Practitioners whose services are required for more than the one hundred twenty (120) days allowed for locum tenens privileges, may be appointed to the Courtesy Staff pursuant to these Bylaws.
- (d) In connection with the granting of temporary privileges, special requirements of supervision and reporting may be imposed on the individual to whom such privileges are granted. Failure to comply with such special conditions shall immediately terminate such Practitioner's temporary privileges. Temporary privileges may be suspended or revoked at any time by the President, the president of the Medical Staff, or the Service Chairman without right of hearing or appeal by the individual whose temporary privileges have been terminated. In the event of such termination, the Practitioner's patients then in the Hospital shall be assigned to a Medical Staff member by the president of the Staff, The wishes of the patient shall be considered, where feasible, in choosing a substitute.
- (e) No Practitioner is entitled to temporary privileges, as a matter of right nor to the procedural rights afforded by the Fair Hearing Plan because of his/her inability to obtain temporary privileges or the termination, modification or suspension of temporary privileges.

6.3 Emergency Privileges

In the case of an emergency, any Provider is permitted to provide any type of patient care necessary as a life-saving measure or to save the patient from serious harm, regardless of his/her Medical Staff status or clinical privileges as long as the care provided is within the scope of the individual's license. When the emergency situation resolves, the Provider must then request and obtain the privileges necessary to continue to treat the patient. An emergency is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

6.4 Disaster Privileges

- (a) A modified credentialing and privileging process for eligible volunteer physicians may be implemented when the disaster plan has been implemented, and the Hospital is unable to handle immediate patient care needs. The President (or designee) or the Medical Staff president (or designee) are authorized to grant disaster privileges. Decisions to grant privileges will be made on a case-by-case basis, in accordance with the needs of the organization and its patients and the qualifications of volunteer physicians, upon presentation of a valid government-issued photo ID and at least one of the following: (1) a current picture hospital ID card that clearly identifies professional designation; (2) a current license to practice or primary source verification of the license; (3) identification indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), MRC, ESAR-VHP or another recognized state or federal organization or group; (4) identification indicating the individual has been granted authority to render patient care treatment, and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity); or (5) identification by current Hospital or Medical Staff member(s) who possess knowledge regarding the individual's ability to act as a Practitioner during a disaster.
- (b) In the case of a disaster, any physician, to the degree permitted by his/her license, regardless of Medical Staff status or clinical privileges, shall be authorized to do everything reasonably necessary to preserve the life or health of a patient. Members of the Active Medical Staff will be expected to respond if called.
- (c) The Medical Staff will oversee the professional practice of volunteer physicians.
- (d) Primary source verification of licensure will begin as soon as the immediate disaster situation is under control and must be completed within seventy-two (72) hours from the time the volunteer physician presents to the organization, or as soon as possible in the extraordinary circumstance that primary source verification cannot be completed within seventy-two (72) hours. If extraordinary circumstances exist, there must be documentation of why primary source verification could not be performed in the required time frame, evidence of the physician's demonstrated ability to continue to provide adequate care, treatment, and services, and an attempt to rectify the situation as soon as possible. Based on information obtained regarding the professional practice of the volunteer, the Hospital will make a decision regarding the continuation of the initially granted disaster privileges within seventy-two (72) hours.
- (e) Medical Staff Services will issue a Hospital badge to volunteer physicians who have been granted disaster privileges identifying them as a credentialed disaster volunteer physician.
- (f) Disaster privileges will be granted for the period needed during the disaster, and will automatically terminate at the end of that time. Privileges will be terminated, immediately, upon receipt of adverse information or upon receipt of evidence that

the volunteer physician is not competent to render services. Termination of disaster privileges does not entitle the volunteer to a fair hearing or appeal under the Fair Hearing Plan. All documentation will be retained in the Medical Staff Office.

6.5 Limited Clinical Privileges

- (a) Limited clinical privileges may be granted to Practitioners in residency or fellowship training at another institution when additional coverage is needed to ensure quality care.
- (b) Limited clinical privileges may be granted for up to one 2-year period, will expire upon completion of residency or fellowship training, and may not be requested after submission of an application for Medical Staff membership.
- (c) Application for limited clinical privileges does not preclude subsequent formal application for Medical Staff membership upon completion of the Practitioner's formal training.
- (d) Practitioners in residency or fellowship training may apply for core privileges only. Special requirements of supervision and reporting may be imposed on Practitioners who have been granted such privileges. Failure to comply with such special conditions shall immediately terminate the Practitioner's privileges.
- (e) See Credentials Policy, Clinical Privileges for Residents and Fellows.

6.6 Telemedicine Privileges

Applicants based at distant sites requesting any form of Telemedicine Privileges may apply for privileges through one of the following mechanisms as selected by the Committee either for the individual applicant or for a designated class of applicants per policy decision of that committee:

- By submission of the same application required of all other Applicants to be processed pursuant to the application process described in these Bylaws;
- By submission of the same application required of all other Applicants to be processed in conjunction with a credentials verification organization as permitted by law, any applicable accreditation agency and Medical Staff policy; and
- In reliance upon the privileging decision of the distant site when and as permitted by law, any applicable accreditation agency and Medical Staff policy, and as approved by the Governing Body.

6.7 Focused Professional Practice Evaluation

- (a) A period of focused professional practice evaluation shall be implemented:

- (1) for all initially requested privileges; and
 - (2) in response to concerns regarding the provision of safe, high quality patient care. Triggering events for such evaluation may consist of single incidents or evidence of a clinical practice trend.
- (b) The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of the Provider's current clinical competence, practice behavior and ability to perform the requested privilege.
 - (c) Information for focused professional practice evaluation includes, as appropriate, chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient.

6.8 Ongoing Professional Practice Evaluation

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

information shall help determine whether existing privileges should be maintained, revised or revoked.

SECTION 7 IMMUNITY FROM LIABILITY

7.1 Conditions

The following shall be conditions to any individual's application for Medical Staff membership or exercise of clinical privileges at the Hospital:

- (a) any act, communication, report, recommendation or disclosure, with respect to any individual performed or made 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) such privileges shall extend to members of the Medical Staff and Governing Body, the President and designated representatives and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purposes of this Section, the term "third parties" means both individuals and organizations that have supplied information to or received information from an authorized representative of the Governing Body or of the Medical Staff.
- (c) there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged;
- (d) such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with 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 reappointment or clinical privileges;
 - (3) investigations and corrective action, including summary suspension;
 - (4) hearings and appellate reviews;
 - (5) medical care evaluations;
 - (6) monitoring of members of the provisional staff or of any other individual under the monitoring protocol established by the Medical Staff;
 - (7) utilization reviews;

- (8) profiles and profile analyses;
 - (9) malpractice loss prevention; and
 - (10) other Hospital, Service, or committee activities related to quality patient care and inter-professional conduct,
- (e) the acts, communications, reports, recommendations and disclosures referred to in this Section may relate to an individual's professional qualifications, clinical competency, character, ethics, conduct, judgment, or any other matter that might directly or indirectly have an effect on patient care;
 - (f) in furtherance of the foregoing, each individual shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Section in favor of the individuals and organizations specified in Section 7.1(b), subject to such requirement, including the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state. Execution of such releases is not a prerequisite to the effectiveness of this Section;
 - (g) the consents, authorizations, releases, rights, privileges and immunities provided by Section 5.1 of Section 5 of these Bylaws for the protection of this Hospital's Practitioners, Allied Health Professionals, appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointments, shall also be fully applicable to the activities and procedures covered by this Section. All provisions in these Bylaws and in other forms used in the credentials process relating to authorizations, confidentiality of information and immunity from liability are in addition to and not in limitation of other immunities provided by law; and
 - (h) each individual who exercises clinical privileges or performs any service that is monitored under the monitoring protocols established under these Bylaws, as a condition of exercising the clinical privileges or performing the service, shall indemnify and hold harmless all members of the Medical Staff and Governing Body, the President, and their designated representatives from any liability arising from or out of the services performed by the individual being monitored, including but not limited to claims of malpractice, negligent supervision, and any other basis. The exercise of clinical privileges or performance of any service that is monitored constitutes the individual's acceptance of the terms of this indemnification agreement.

SECTION 8 CORRECTIVE ACTION AND HEARING RIGHTS

8.1 Hearing Rights

Whenever privileges are denied, suspended, reduced, limited or terminated; staff membership denied, suspended, or revoked; admitting prerogatives limited; consultation required which limits clinical privileges; or terms of probation/preceptorship imposed

which limit clinical privileges, the Provider affected may have a right to have a hearing in the manner and according to the limits set forth in the Fair Hearing Plan.

8.2 Corrective Action

All Providers shall be subject to corrective action. The grounds for requesting corrective action, actions that may be taken in response to the request, when the action is deemed adverse and when the Provider is entitled to a fair hearing, are set forth in the Fair Hearing Plan. The Medical Executive Committee is the disciplinary body and all requests for corrective action shall be directed to that body in the manner and according to the limits set forth in the Fair Hearing Plan.

8.3 Exceptions

Neither the issuance of a warning, a letter of admonition, or a letter of reprimand, nor the denial, termination or reduction of temporary privileges, nor any other action except those specified in the Fair Hearing Plan shall give rise to any right to a hearing or appellate review.

8.4 Agreements with Providers

Notwithstanding any other provision of the Bylaws, the Hospital may provide by agreement that a Provider's membership on the Medical Staff and/or clinical privileges, as applicable, are contingent on terms therein and/or shall expire or terminate simultaneously with such agreement or understanding. In the event that an agreement has such a provision or there is such an understanding, the provisions of these Bylaws with respect to review, hearings, appeals, appellate review, etc., shall not apply.

SECTION 9 OFFICERS

9.1 Officers of the Medical Staff

(a) The officers of the Medical Staff shall be:

- (1) President
- (2) Vice President

9.2 Qualifications of Officers

Officers shall be Active Medical Staff members in good standing who are certified by an appropriate specialty board or have demonstrated competence in their fields of practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of Hospital and Medical Staff activities. Failure to maintain Active Staff membership in good standing shall immediately create a vacancy in the office involved.

9.3 **Election of Officers**

- (a) Nominations for officer positions may be identified by the Hospital's Nominating Committee, or may occur from the floor if the nominee is present and consents to the nomination.
- (b) The Nominating Committee shall consist of a minimum of three Provisional/Active/Affiliated Staff Members, including the immediate Past President, appointed by the president of the Medical Staff.
- (c) The Nominating Committee will nominate one or more candidates for the positions of:
 - (1) President
 - (2) Vice President
- (d) Officers shall be elected by a majority vote of the Active Medical Staff Members present, every other year, as further described herein.
- (e) Election years for Medical Staff officers will be staggered with the election years of Service Chairman and Service Representatives to the Medical Executive Committee.

9.4 **Term of Office**

All officers shall serve a two-year term unless they are removed pursuant to Section 9.7. No officer may serve more than three (3) consecutive terms. Officers shall take office on the first day of the Medical Staff Year.

9.5 **Vacancies in Office**

When there is a vacancy in the office of the president, the vice president shall serve out the remaining term. When there is a vacancy in the office of the vice president, the Medical Executive Committee will appoint a replacement to complete the remainder of the current term.

9.6 **Duties**

- (a) **President**: The president shall serve as the chief administrative officer of the Medical Staff and report to the Medical Executive Committee and the Governing Body. The Medical Staff president's duties are to:
 - (1) act in coordination and cooperation with the President of the Hospital in all matters of mutual concern within the Hospital;
 - (2) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

- (3) be responsible for accurate and complete minutes of all meetings, attend to all correspondence, and, if there are funds, act as treasurer;
- (4) be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations and policies; for implementation of sanctions where these are stipulated for noncompliance; and for presentation to the Medical Executive Committee in those instances where corrective action may be recommended to the Governing Body;
- (5) appoint committee members to all standing and special Medical Staff committees, including multidisciplinary committees, except the Medical Executive Committee and appoint all committee Chairmen who may serve an unlimited number of two-year terms;
- (6) serve as ex officio member of all Medical Staff committees and Chairman of the Medical Executive Committee;
- (7) represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and President of the Hospital;
- (8) serve as the responsible representative of the Medical Staff to receive, understand and interpret the policies of the Governing Body to the Medical Staff and to report and interpret to the Governing Body, in return, on the performance and maintenance of quality of its delegated responsibility to provide medical care;
- (9) ensure, with the President, that the Hospital's quality assurance program is implemented and effective for all patient care related services; that the findings of the program are incorporated into a well-defined method of accessing staff performance; and that the findings, actions and results of the program are reported to the Governing Body as necessary;
- (10) be responsible for the orientation and educational activities of the Medical Staff, subject to the policies of the Governing Body;
- (11) be spokesman for the Medical Staff in its external professional and public relations;
- (12) in conjunction with the Chairmen of Medical and Surgical Services:
 - oversee the clinical and administrative activities of the Medical Staff;
 - oversee the professional performance of all Medical Staff members and recommend clinical privileges for each member;
 - recommend criteria for clinical privileges relevant to care provided in each Service;

- recommend off-site sources needed for patient care;
 - ensure the Medical Staff is involved in the integration of the primary functions of the organization;
 - oversee the integration of interdepartmental and intradepartmental services;
 - recommend a sufficient number of qualified competent persons to provide care/services;
 - determine the qualifications and competence of staff who are Practitioners or Allied Health Professionals;
 - ensure that the Medical Staff continually assesses and improves its performance through participation in quality improvement activities;
 - recommend space and other resources needed by the Medical Staff; and
- (13) perform such other functions as may from time to time be delegated by the Medical Staff or the Governing Body.
- (b) **Vice President:** In the absence of the president, he/she shall assume all the duties and have the authority of the president. He/she shall be a member of all committees as assigned.

9.7 **Removal from Office**

- (a) Bases for removal from office may include, without limitation:
- (1) failure to continuously meet the qualifications for office
 - (2) failure to satisfactorily perform the duties of office
- (b) An officer of the Medical Staff may be permanently removed from office by a 2/3 majority vote of the Governing Body following its receipt of a recommendation of a 2/3 majority vote of the Provisional/Active/Affiliated Medical Staff and a recommendation from the Medical Executive Committee.
- (c) An officer may be temporarily removed from office by a majority vote of the Medical Executive Committee. The temporary removal will be effective until the next meeting of the Provisional/Active/Affiliated Medical Staff at which time removal may become permanent if approved by the Governing Body as provided in Section 9.7(b).

SECTION 10 CLINICAL SERVICES

10.1 Organization of Services

- (a) Each Service in the Hospital shall be organized as a separate division of the Medical Staff, and shall elect a Chairman who shall be a member of the Medical Executive Committee and responsible to the Medical Executive Committee and the president of the Medical Staff.
- (b) The Hospital's clinical Services are comprised as follows: Medical Services (Internal Medicine, Family Practice, Hospitalist, Emergency Medicine, Psychiatry, Oncology, Pediatrics, Radiation Oncology, Rheumatology, Neurology, Dermatology, Occupational Medicine, Physiatry, Cardiology) and Surgical Services (General Surgery, Orthopedic Surgery, Anesthesiology, Obstetrics/Gynecology, Radiology, Pathology, Ophthalmology, Otolaryngology, Urology, Podiatry, Dentistry, Pain Management) and others as designated by recommendation of the Medical Executive Committee and approved by the Governing Body, from time to time.
- (c) The creation of additional Services or sections, or the termination of Services or sections shall be accomplished as the need arises by the Hospital Medical Executive Committee with the approval of the Governing Body.
- (d) Medical and Surgical Service meetings will be scheduled quarterly in January, April, July, and October.

10.2 Qualifications, Selection and Tenure of Service Chairmen

- (a) The Service Chairman shall be a member of the Hospital's Active Medical Staff, qualified by training and experience and demonstrated ability for the position and in the Service's clinical area, and who is willing and able to discharge the functions of a Service Chairman.
- (b) The Chairman shall be certified by an appropriate specialty board or shall have affirmatively established comparable competence through the credentialing process.
- (c) The Chairman shall be elected by a simple majority vote at a fall Service meeting on the odd-numbered years, by those Provisional, Active and Affiliated Medical Staff Members assigned to the Service. In the event of a tie vote among the top vote-getters, the names of the tied Practitioners will be sent on a second ballot.
- (d) The Chairman shall serve a two-year term beginning the first day of the Medical Staff year but no more than three consecutive terms.
- (e) Election years for Service Chairmen will be staggered with the election years of Medical Staff Officers.

10.3 Functions of Service Chairmen

- (a) The Chairman shall be responsible for the clinically-related and administratively-related activities of the Service, including the functioning of the Service. He/she shall have general supervision over the clinical work within the Service, and shall report to the Medical Staff president and the Medical Executive Committee.
- (b) The Chairman shall be responsible for continually assessing and improving the quality of care, treatment, and services and performance through participation in quality improvement activities, for coordinating the integration of interdepartmental and intradepartmental services, for integrating the Service into the overall functioning of the organization, and for the maintenance of quality control programs.
- (c) The Chairman will be responsible for the orientation and continuing medical education of all Service members.
- (d) The Chairman is an essential element in the line of authority within the Medical Staff organization and shall be accountable to the Medical Executive Committee and president of the Medical Staff for all professional and Medical Staff administrative activities in the department.
- (e) The Chairman is responsible for the implementation of actions taken by the Medical Executive Committee.
- (f) The Chairman must maintain continuing surveillance of the professional performance of all Members of the Medical Staff and other Providers with privileges in the Service and must report regularly thereon to the Medical Executive Committee.
- (g) The Chairman shall assure adherence to the Hospital Bylaws and the Medical Staff Bylaws and Rules and Regulations by all Medical Staff members practicing in his/her Service.
- (h) The Chairman is responsible for recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Service and shall transmit to the Medical Executive Committee the Service's recommendations concerning the classification, reappointment, and delineation of clinical privileges for all members of the Service.
- (i) The Chairman, together with the Medical Staff and administration, shall establish the type and scope of services required to meet the needs of the patients and the Hospital, including recommendations for space and other resources needed within the Service and off-site sources for needed patient care, treatment, and services not provided by the Service or the organization.
- (j) The Chairman shall develop and implement policies and procedures that guide and support the provision of care, treatment, and services in the Service.

- (k) The Chairman shall be responsible for recommending a sufficient number of qualified and competent persons to provide care, treatment, and services within the Service,
- (l) The Chairman is responsible for determining the qualifications and competence of Hospital Staff, including those who are not Practitioners or Allied Health Professionals, in the Service who provide patient care, treatment, and services.

10.4 Removal from Service Chairmanship

- (a) Bases for removal from Service Chairmanship include, without limitation:
 - (1) failure to continuously meet the qualifications for the position
 - (2) failure to satisfactorily perform the duties of the position
- (b) A Service Chairman may be permanently removed from the position by a 2/3 majority vote of the Governing Body following its receipt of a recommendation of a 2/3 majority vote of the Provisional, Active, and Affiliated Medical Staff and a recommendation from the Medical Executive Committee.
- (c) A Service Chairman may be temporarily removed from the position by a majority vote of the Medical Executive Committee. The temporary removal will be effective until the next meeting of the Provisional, Active, and Affiliated Medical Staff at which time removal may become permanent if approved by the Governing Body as provided in Section 10.4(b).

10.5 Vacancies in Service Chairmanship

When there is a vacancy in the position of Chairman prior to the end of the elected term, the Medical Staff president will appoint a replacement to complete the remainder of the current term.

10.6 Function of the Service

- (a) Each clinical Service must recommend to the Medical Executive Committee its own criteria for the granting of clinical privileges in that Service based on the medical specialties involved.
- (b) The Medical Staff Services, whether acting through their Service Chairpersons, subcommittees, or as a whole, are 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 Service records and proceedings, are intended to apply to all activities of the Service and include activities of the individual members of the Service as well as other individuals designated by the Service to assist in carrying out the duties and

responsibilities of the Service (including but not limited to participating in monitoring plans) including Hospital administration and the Governing Body. Service and/or Service committees may also be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act and a “review body” as referenced in the Wisconsin Statutes.

- (c) Each medical specialty, through its designated Service, shall develop objective criteria that reflect current knowledge and clinical experience to be used in assessing and improving patient care. Pursuant to these criteria, each Service will have representatives serve on the Quality Improvement Committee to review and consider selected deaths, unimproved patients, patients with infections, complications, problems in diagnosis and treatment, and such other instances believed to be important. In addition, high risk, high volume, or problem prone populations will be selected for in depth evaluation.
- (d) Each Service is responsible for acting on reports from Medical Staff committees.
- (e) The medical specialties within each Service shall be encouraged, but not required, to meet separately monthly to review and analyze, on a peer-group basis, the clinical work of the specialty.

10.7 Assignment to Services

- (a) Assignments of members of all categories of the Medical Staff and all other Providers with clinical privileges to clinical Services shall be made by the Governing Body on the recommendation of the Medical Executive Committee pursuant to Section 5 of these Bylaws or provided in Section 4.7. Members of the Services shall be well qualified, meeting the criteria established by the individual Service.
- (b) Providers may have clinical privileges in one or more Service in accord with their experience and training, and shall be subject to all the rules of each Service and to the jurisdiction of the Chairman of the clinical Service involved. A Provider should identify himself/herself with one clinical Service for the purposes of participating in required functions of the Medical Staff, holding office, or fulfilling any of the other obligations which go with Medical Staff membership.

SECTION 11 COMMITTEES

The Medical Staff shall maintain a Medical Executive Committee, as described below, and those special or ad hoc committees as are necessary to properly conduct its business and provide quality care. In an effort to achieve the highest quality of care possible, the resources of the Hospital may be combined for purposes of other standing and special committees.

11.1 Standing Committees

The members of all Standing committees of the Medical Staff, except the Medical Executive Committee, shall be appointed biennially by the president of the Medical Staff

and approved by the Medical Executive Committee. A committee member shall serve in the same capacity until such time as he or she is replaced by a new appointee, unless otherwise specified in these Bylaws. Committee Chairmen will be appointed, biennially, by the president of the Medical Staff and may serve an unlimited number of consecutive 2-year terms.

(a) **The Medical Executive Committee:**

- (1) The Medical Executive Committee will be composed of the president, the vice president, the Medical and Surgical Service Chairmen, two internal medicine representatives, two individuals representing specialties with fewer than three physicians, and one individual from each specialty with three or more physicians. The Service Chairmen and Medical Staff Officers shall be the representatives of their respective specialties. When the Service Chairman or Medical Staff Officer is from a specialty having two representatives, only one additional representative from that specialty will be elected. Medical Executive Committee membership may include Providers other than physicians so long as the majority of the voting members are fully licensed physician members of the Medical Staff actively practicing in the Hospital. No Medical Staff member actively practicing in the Hospital is ineligible for membership on the Executive Committee solely because of his/her professional discipline or specialty. The President and/or his designees, and the Nurse Executive of the Hospital, should attend all meetings of this committee ex officio and without vote.
- (2) The Medical Executive Committee is empowered to act on behalf of the organized Medical Staff, between meetings of the Medical Staff, and to coordinate the activities and general policies of the various administrative departments and the Services, as indicated by the Medical Staff Bylaws and Rules and Regulations. The Medical Executive Committee shall meet monthly and maintain a permanent record of its proceedings and actions.
- (3) Election to the Medical Executive Committee. The Medical Staff president and vice president are elected as set forth in Section 9.3. Service Chairmen are elected as set forth in Section 10.2. Individuals on the Medical Executive Committee representing particular specialties or groups of specialties are elected biennially by the members of the specialty groups they represent at the last specialty meeting of the Medical Staff Year.
- (4) Removal from the Medical Executive Committee.
 - (i) Upon written request of 20% of the Active Medical Staff directed to the chair of the Medical Executive Committee, or the Medical Staff president or the President, or by certification by two physicians with special qualification in the appropriate medical field(s) that the member cannot be expected to perform his duties

because of illness for minimum of three months, a member will be considered for removal. Such request shall include a list of the allegations or concerns precipitating the request for removal.

- (ii) Reasons for Removal may include: removal from current office or Service Chair position; or loss or suspension of medical staff appointment.
 - (iii) A member removed from service pursuant to this Section shall be so notified in writing by the Medical Staff president and advised of his rights to a review by the remaining Medical Executive Committee, if any. If the Medical Staff president is the member in question, the immediate past-president of the Medical Staff shall carry out the duties of the president during the removal process until the issue is resolved, at which time the president (if not removed) will resume his duties or the vice president will take over the remaining term of the removed president. The member in question will be relieved of his Medical Executive Committee duties until the question is resolved.
 - (iv) A meeting of the Medical Executive Committee shall be called within seven (7) business days to consider the matter. A quorum of the Medical Executive Committee must be present to act on the matter. The member in question shall have no vote in the matter and may be excluded from the meeting. The member in question shall be permitted to make an appearance before the Medical Executive Committee prior to its taking final action on the request. A member may be removed by an affirmative vote of two-thirds of the Medical Executive Committee members present at a meeting at which there is a quorum. The final decision of the Medical Executive Committee shall be given promptly to the member in question in writing by the Medical Staff president.
- (5) The duties of the Medical Executive Committee shall be:
- (i) to represent the Medical Staff and to act on its behalf as needed under such limitations as may be imposed by these Bylaws;
 - (ii) to be regularly involved in Medical Staff management including the enforcement of Medical Staff Rules and Regulations and committee and Service affairs;
 - (iii) to coordinate the activities and general policies of the Medical Staff as required;
 - (iv) to receive and act upon reports from the Medical Staff Services, functions, committees, and other assigned activity groups;

- (v) to formulate and implement policies of the Medical Staff not otherwise the responsibility of clinical Service personnel;
- (vi) 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;
- (vii) to provide liaison between Medical Staff and the President and the Governing Body;
- (viii) to recommend action to the President on matters of a medico-administrative nature;
- (ix) to make recommendations to the Governing Body, including long range planning;
- (x) to fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to the patients in the Hospital. The Medical Executive Committee shall monitor all medical care quality assessment and improvement activities and be responsible for taking any necessary and appropriate action or delegating the responsibility for such action to the appropriate Medical Staff or multi-disciplinary committee or group;
- (xi) to ensure that the Medical Staff is kept abreast of the accreditation status of the Hospital;
- (xii) to report to each of the Services through the Service Chairmen who are Medical Executive Committee members;
- (xiii) to review the credentials of all Applicants and to make recommendations for Medical Staff membership, assignment to Services, and delineation of clinical privileges;
- (xiv) to consider periodically all information available regarding performance and clinical competence of Medical Staff members and others with clinical privileges;
- (xv) to request evaluations of Providers privileges through the Medical Staff process in instances where there is doubt about an applicant's ability to perform the privileges requested;
- (xvi) to consider amendments to the Bylaws, Rules and Regulations, Organization and Function Manual, and policies of the Medical Staff as necessary for the proper conduct of its work;

- (xvii) to have the option to review and approve Service rules and regulations subject to the approval of the Governing Body;
- (xviii) to be responsible for making recommendations to the Governing Body relating to the structure of the Medical Staff; the mechanisms used to review credentials and delineate individual clinical staff may be terminated; the mechanism for fair hearing procedures; and the participation of the Medical Staff in Hospital performance improvement activities;
- (xix) to be responsible for annual review of the adequacy and appropriateness of all services; and
- (xx) to perform such other functions as may from time to time be delegated by the Medical Staff or Governing Body.

The Committee will investigate the credentials of all Applicants and make a recommendation in compliance with Section 4 of these Bylaws. The established procedure must assure a fair evaluation of the qualifications and the competence of each applicant for appointment and/or clinical privileges, and for periodic reappointment or reappraisal. Whatever the procedure, it should be objective, impartial and fair; broad enough to recognize professional excellence; and strict enough to safeguard patients. The selection of persons to be recommended for appointment and/or clinical privileges shall depend upon a thorough study of the qualifications of each Applicant. The granting or denial of membership and/or privileges shall be based on an objective evaluation of the Applicant's professional competence, adherence to ethics, experience, training, health, good reputation, ability to work with others, and capacity to practice effectively and efficiently within the institution.

The Committee will send a recommendation to the Board of Directors on each Applicant for Medical Staff appointment and/or clinical privileges, as applicable. Such reports relative to staff appointment and delineation of clinical privileges shall include a consideration of the recommendations from the Service Chairman in which the Applicant requests privileges;

to review reports that are referred by the Quality Improvement Committee and by the president of the Medical Staff;

to arrive at a decision regarding the performance of a Practitioners and Allied Health Professionals and formulate a recommendation to the Board of Directors. or other referring committee;

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, reappointments, and the assignment of

Practitioners and Allied Health Professionals to the various Services as provided in Section 4 of these Bylaws.

The Medical Executive Committee shall meet monthly and/or as necessary and within sixty (60) days after receiving a completed application for membership on a Medical Staff and/or a request for clinical privileges. The Medical Executive Committee shall maintain a permanent record of its proceedings and actions.

- (b) **Provider's Health Committee:** The Provider's Health Committee shall consist of no fewer than three physician members of the Medical Staff representing various specialties, when practicable. Members will be appointed by the Medical Staff president and may serve an unlimited number of two-year terms. Long term service on the committee is encouraged so as to provide continuity and development of expertise. Its purpose is primarily to maintain and improve the quality of care of patients and to assist in the maintenance of appropriate standards of personal performance, and its duties shall include those duties outlined in the Medical Staff policy on Provider's Health.

11.2 Multi-disciplinary Committees Involving Medical Staff

The Medical Staff and other Providers, as appropriate, shall participate in the assessment and improvement of professional standards throughout the Hospital by maintaining representation on multi-disciplinary committees which relate to the quality of care rendered to patients. The Infection Control, Quality Improvement and Emergency Department Committees shall be joint committees of both the Hospital and Ministry Sacred Heart Hospital, an affiliated facility operated as a critical access hospital in Tomahawk, Wisconsin. Notwithstanding the joint structure of the committees, each hospital's obligations and opportunities for improvement shall be addressed. Members of the Hospital Medical Staff and other Providers, as applicable, shall be assigned to these committees by the president of the Medical Staff, who shall, with the president of Ministry Sacred Heart Hospital Medical Staff, also appoint a Chairman of each committee. Chairmen of multi-disciplinary committees may serve an unlimited number of consecutive two-year terms. Multi-disciplinary committees shall meet monthly unless otherwise specified in policy, and shall maintain a permanent record of their proceedings and actions. These committees include but are not limited to:

- (a) Infection Control Committee
- (b) Quality Improvement Committee
- (c) Emergency Department Committee
- (d) Utilization Review Committee.
- (f) Pharmacy and Therapeutics Committee:

(1) The Medical Staff shall participate in the maintenance and improvement of high professional standards through the Hospital by

participating on committees which address pharmacy and therapeutics functions. The initial pharmacy and therapeutics evaluation function for the Hospital is delegated to the Ministry Pharmacy and Therapeutics Committee. Membership on this committee shall consist of active Medical Staff members representing different specialties of practice, from one or more Ministry hospitals or Ministry Medical Group, including a representative of Hospitals Medical Staff. Membership will also include representatives of pharmacy, nursing service, and administration. The chair of the committee will be approved by the Hospital Medical Executive Committees. A Ministry pharmacist shall act as secretary for the committee.

(2) The Ministry Pharmacy and Therapeutics Committee shall:

(i) Be responsible for the development and recommendation and, following approval by the Hospitals, the maintenance of a formulary and policies and procedures regarding the continued evaluation, appraisal, selection, procurement, storage, distribution, use, safety, security and all other matters relating to drugs in the Hospitals 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 President of the Medical Staff or the Executive Committees; and

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

(3) Drug Formulary

The Hospitals will maintain a listing for drugs (i.e., a drug formulary) which are routinely stocked and available. All drugs and medications on the Hospitals formulary shall be those listed in the latest edition of the United States Pharmacopoeia or American

Hospital Formulary Service or other accepted drug compendium or its update and approved by the Pharmacy and Therapeutics Committee. Use of drugs not approved for formulary status (e.g., “non-formulary”) will be managed according to Hospital policy and procedure. Investigational drugs may be administered in the Hospital consistent with Hospital policy. Controlled drugs, antibiotics, anticoagulants and corticosteroids ordered without a time limit will be subjected to a stop date approved by the Pharmacy and Therapeutics Committee. Drugs shall not be stopped without notifying the attending Practitioner.

(i) Use of a patient’s home medications is generally not allowed except in the following circumstance: if the drug in question is non-formulary medication for which the pharmacy does not stock a therapeutic substitute or which cannot be procured within a reasonable amount of time. In such situations, the medication(s) must be positively identified by a pharmacist as to the identity of the drug and its appropriateness, including drug stability and storage. Medications that cannot be identified or verified, or are out of date and appear to be stored inappropriately, will not be used under any circumstances. If a patient’s home medications are not used, patients are encouraged to return the medications to home. Storage of patient’s own medication during hospital stay is done in accordance with Hospital policy

11.3 Special Committees

The Medical Executive Committee may establish such other special 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 optimum patient care in the Hospital, and may provide for Medical Staff and, as applicable, Allied Health Professional 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 president of the Medical Staff may appoint members of the Medical Staff and, as applicable, Allied Health Professionals to special committees.

11.4 Medical Staff Functions

As appropriate for the Hospital, the president of the Medical Staff will appoint Medical Advisors to oversee Medical Staff Functions such as Pharmacy & Therapeutics, Continuing Medical Education, ICU/CCU/CPR, and Tissue as may be required for effective and efficient operation of the Hospital and for the proper discharge of the Medical Staff’s responsibility for assuring optimum patient care. Medical Advisors shall serve in that capacity until such time as they are replaced by a new appointee. Activity summaries of these Medical Staff functions will be presented to the appropriate Medical

Executive Committee(s) and/or Quality Improvement Committee(s) on a quarterly basis for discussion/action as appropriate.

11.5 Peer Review Protection

Medical Staff committees are a major component 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 the committee and include activities of the individual members of Medical Staff committees as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committees (including, but not limited to, participating in monitoring plans) including, but not limited to, Hospital administration and the Governing Body. Medical Staff committees may also be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act and a "review body" as that term is used in the Wisconsin Statutes.

11.6 Removal from Committees

Committee members may be removed from their appointed positions at the discretion of the president of the Medical Staff. Permissible bases for removal include but are not limited to loss of good standing, failure to appropriately discharge committee responsibilities, lengthy service on the committee, and the committee member's request to resign from the committee.

SECTION 12 MEETINGS

12.1 Staff Meetings

There shall be regular meetings of the general Medical Staff as determined by the Medical Staff. An annual meeting of the Medical Staff shall be scheduled once per year.

12.2 Special Meeting

Special meetings of the Medical Staff may be called at any time by the Governing Body, the president of the Medical Staff, the Medical Executive Committee, or at the written request of not less than five members of the Provisional/Active/Affiliated Medical Staff. Such a meeting shall be convened within ten (10) days of the receipt of the formal written request for a special meeting. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Notice of a special meeting shall be given to each member of the Medical Staff in writing or by telephone at least forty-eight (48) hours before the time set for the special meeting.

12.3 Attendance at Meetings

Each member of the Active/Affiliated and Provisional Medical Staff categories shall be encouraged to attend meetings of the Medical Staff, their assigned Service, and assigned

committees, but attendance at any specified frequency is not required unless specified as criteria for membership in their assigned Service. Nonetheless, attendance records will be maintained.

If requested, Practitioners must be present at meetings scheduled to present the clinical course of a patient he/she attended whose record is being discussed for peer review.

12.4 Quorum and Voting

Unless otherwise set forth in these Bylaws, those members of the Provisional, Active, and Affiliated Medical Staff who are present and entitled to vote at general Medical Staff and Service meetings, but no fewer than two members, shall constitute a quorum. A quorum must be present in order for any vote to be called. When called, votes will be tabulated numerically – for, against, and abstaining – and entered into the minutes of the meeting. Unless otherwise set forth in these Bylaws, every question shall be decided by a plurality vote of those present at the meeting and eligible to vote.

12.5 Minutes

Minutes of each regular and special meeting of the Hospital’s Medical Staff, and its Committees or Services, shall be prepared and shall include a record of attendance of members and the action taken on each matter. The minutes shall be signed by the presiding officer and copies shall be submitted to those in attendance for approval, and the minutes shall, thereafter, be forwarded to the Medical Executive Committee. The Medical Staff Services Office and each committee and Service shall maintain a permanent file of the minutes of each meeting. All Medical Staff members may have access to meeting minutes that are not otherwise privileged and confidential, upon sufficient notice to the Medical Staff president, committee or Service Chairman, as applicable.

SECTION 13 BYLAWS, RULES, REGULATIONS AND POLICIES

13.1 Medical Staff Responsibility

The Medical Staff shall adopt such Bylaws, Rules and Regulations and policies as may be necessary for the proper conduct of its work and to implement more specifically the general principles set forth in these Bylaws.

SECTION 14 ADOPTION AND AMENDMENT OF BYLAWS

14.1 Medical Staff Responsibility

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the Governing Body, Medical Staff Bylaws, Rules and Regulations, Policies and amendments thereto, which shall be effective when approved by the Governing Body. Such responsibility and authority shall be exercised in

good faith and in a reasonable, timely and responsible manner, so as to have Bylaws of generally recognized quality, to provide a basis for acceptance by accreditation agencies, to comply with supervising licensing authorities, and to provide a system of ongoing effective professional review.

Upon adoption by the Board of Directors, the Medical Staff Rules and Regulations and associated policies will be incorporated by reference and become art of the Medical Staff Bylaws.

14.2 Methodology

- (a) The Medical Staff Bylaws, Rules and Regulations and policies shall be reviewed periodically and revised as necessary. The review shall be undertaken by a committee (if applicable) appointed by the president of the Medical Staff and any proposed amendments and revisions shall be recommended to the Medical Executive Committee. The Medical Executive Committee will consider the recommendation and bring proposals to the Medical Staff.
- (b) Medical Staff Bylaws may be adopted, amended or repealed by: the affirmative vote of two-thirds of the Provisional, Active, and Affiliated Staff eligible to vote on this matter who are present at a meeting at which a quorum is present, provided at least ten (10) days' written notice, accompanied by the proposed Bylaws and/or alterations, has been given of the intention to take such action, and provided at least 10% of all Provisional, Active, and Affiliated Staff Members entitled to vote are present in person or by written proxy; and the affirmative vote of a majority of the Governing Body.
- (c) In addition to the amendment process for the Bylaws set forth herein, the Medical Staff may, upon a vote of the Medical Staff using the methodology described in this subsection (b) above, recommend amendments to the Bylaws directly to the Governing Body, provided that the recommendation is first communicated to the Medical Executive Committee. The timing and method of presentation to the Governing Body will be consistent with the Hospital's corporate bylaws.

14.3 Effective Date

These Bylaws, together with the appended Rules and Regulations and Fair Hearing Plan, shall be adopted at any regular meeting of the Hospital's Provisional, Active, and Affiliated Staff, shall replace any previous Bylaws, Rules and Regulations, and Fair Hearing Plan 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.

**SECTION 15 OTHER
GOVERNANCE
CONSIDERATIONS**

15.1 Periodic Review

The Medical Staff Bylaws, Fair Hearing Plan and Rules and Regulations of the Hospital shall be reviewed and revised as necessary to reflect the Hospital's current practices with respect to Medical Staff organization and functions, The review shall be undertaken by a committee (if applicable) appointed by the president of the Medical Staff, presented to the Medical Executive Committee and any proposed amendments or revisions shall be adopted by the Medical Staff and Governing Body as provided herein.

15.2 Conflict Resolution

In the event the Medical Staff has a concern regarding the Medical Staff Bylaws, Rules and Regulations, associated policies, Service Rules and Regulations, or any other conflict that cannot be resolved or otherwise appropriately managed through existing processes, representative members of the Active Medical Staff may request an opportunity to meet with the Executive Committee. If the members remain unsatisfied, they may prepare and present the issue at a regularly scheduled Medical Staff meeting. If the issue is supported by the Medical Staff, as evidenced by a vote of the Medical Staff using the methodology described in Section 14.214.2(b), such issue may proceed directly to the Governing Body according to the Hospital's policies and administrative process.

15.3 Automatic Amendment to Conform to Law

The professional conduct of members of the Medical Staff and Allied Health Professionals shall at all times be governed by applicable Wisconsin and federal laws. In the event that the provisions of these Bylaws or the Rules and Regulations promulgated hereunder shall not be in conformity with any applicable Wisconsin or federal law or regulation, these Bylaws and Rules and Regulations shall be deemed automatically amended to comply with such law or regulation. As soon thereafter as may be practicable, such change shall be made in writing in the Bylaws or Rules and Regulations consistent with the procedures herein.

15.4 General Provisions

Technical or insignificant deviations from the procedures set forth in these Bylaws will not be grounds for invalidating the action taken. At any time, limits set forth in these Bylaws may be extended or accelerated by mutual agreement of the Provider Medical Executive Committee, Governing Body, or President. The time periods specified in these Bylaws for action by the Medical Executive Committee, Governing Body, President, or any other committees, are to guide those bodies in accomplishing their tasks and will 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.

15.5 Governing Law

These Bylaws shall be governed by, and construed in accordance with the Health Care Quality Improvement Act of 1986 and, to the extent not inconsistent therewith, Sections 146.37 and 146.38 of the Wisconsin Statutes, and to the extent not so governed, with the other laws of the State of Wisconsin without giving effect to its conflict of laws principles.