

Revised October 2018

**MEDICAL STAFF BYLAWS
OF
ACENSION OUR LADY OF VICTORY HOSPITAL, INC.**

DEFINITIONS

1. **MEDICAL STAFF** means all Doctors of Medicine, Doctors of Osteopathy, Doctors of Dentistry and Doctors of Podiatry, who are graduates of accredited medical, osteopathic, dental or podiatric schools, and all advanced practice providers, duly licensed or certified, as applicable, to practice in the State of Wisconsin, and who are granted specific privileges to care for patients in Our Lady of Victory Hospital, Inc.
2. **GOVERNING BODY** means the Board of Directors of Our Lady of Victory Hospital, Inc.
3. **EXECUTIVE COMMITTEE** means the Executive Committee of the medical staff, unless specific reference is made to the Executive Committee of the Governing Body.
4. **HOSPITAL ADMINISTRATOR** means the individual appointed by the Governing Body, to act in its' behalf, in the management of the Hospital and who shall be the chief executive officer for purposes of Hospital administration.
5. **PROVIDER** means an appropriately licensed Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry or Doctor of Podiatry.
6. **MEDICAL STAFF OFFICER** shall refer to the officer of the medical staff.
7. **CLINICAL PRIVILEGE OR PRIVILEGES** means the permission granted to a provider, or other advanced practice provider, to provide those diagnostic, therapeutic, medical, surgical, dental or podiatric services, specifically delineated to him/her, which may or may not include permission to admit patients.
8. **HOSPITAL** refers to Our Lady of Victory Hospital, Inc. and applies to both the Hospital and clinic operation.
9. **ADVANCED PRACTICE PROVIDER** shall be used to describe those persons credentialed in accordance with these Bylaws to perform in their area of expertise in the Hospital, under the direction and supervision of a provider member of the medical staff, if required, or in collaboration with a provider member of the medical staff, if required, and shall include but not be limited to physician assistants (PAs), advanced practice nurse providers (APNPs), and certified registered nurse anesthetists (CRNAs).
10. **MEMBER(s)** of the medical staff shall mean the providers and advanced practice providers with clinical privileges at the Hospital.

ARTICLE I NAME

The name of this organization shall be the medical staff of Our Lady of Victory Hospital, Inc.

ARTICLE II PURPOSES AND RESPONSIBILITIES

II.1 Purpose. The purpose of this organization shall be:

- (a) To provide that all patients of the Hospital receive quality care;
- (b) To provide an appropriate educational setting that will maintain scientific standards and continuously advance professional knowledge and skill;
- (c) To initiate and maintain rules and regulations for medical staff self-governance;
- (d) To provide a mechanism for the medical staff to discuss issues concerning the medical staff and the Hospital with the Governing Body and Hospital Administrator;
- (e) To provide a mechanism for formulating recommendations for Hospital policy-making and planning procedures.

II.2 The Responsibilities of the Medical Staff are:

- (a) To provide an appropriate level of professional performance by all members of the medical staff authorized to practice in the Hospital through the appropriate delineation of clinical privileges and ongoing review and evaluation of each member's performance.
- (b) To participate in the Hospital's utilization review program.
- (c) To recommend to the Governing Body action with respect to appointments, reappointments, staff category, clinical privileges and corrective action.
- (d) To assure the Governing Body that appropriate clinical privileges have been delineated.
- (e) To account to the Governing Body for the quality and efficiency of patient care at the Hospital through regular reports and recommendations.
- (f) To initiate and pursue corrective action with respect to members when warranted.
- (g) To conduct all its affairs in a willing manner, with civility, dignity and respect, and free of unlawful discrimination because of age, sex, creed, national origin, race, handicap, disability, color, ancestry, religion, sexual orientation, mental status, newborn status, financial status, or any other unlawful factor.

ARTICLE III MEDICAL STAFF MEMBERSHIP

III.1 Nature of Medical Staff Membership. Membership on the medical staff of Our Lady of Victory Hospital, Inc. is a privilege which shall be extended only to professionally competent physicians, osteopaths, dentists, podiatrists and advanced practice providers, who continuously meet the qualification standards and requirements set forth in these Bylaws. Appointment to and membership on the medical staff shall confer on the provider or advanced practice provider only such clinical privileges and prerogatives as have been granted by the Governing Body in accordance with these Bylaws and Appendix A for advanced practice providers.

III.2 Basic Responsibilities of Individual Medical Staff Members. Each member of the medical staff shall:

- (a) Provide patient care within the parameters of their professional competence, as reflected in the scope of their clinical privileges.
- (b) Abide by the medical staff Bylaws and all other adopted standards, policies, rules and procedures of the Hospital and medical staff.
- (c) Discharge such staff, committee and Hospital functions for which he/she is responsible by staff status, assignment, appointment, election or otherwise.
- (d) Prepare and complete in a timely fashion the required medical, patient and Hospital records for all patients he/she admits or in any way provides care to in the Hospital.
- (e) Abide by the ethical principles of the provider's profession, and conform his/her hospital practices to the requirements of the Ethical and Religious Directives for Catholic Health Care Services of the United States Catholic Conference of Bishops that are promulgated by the local diocese.
- (f) Work with and relate to other providers, medical affiliates, members of professional review organizations and accreditation bodies in a manner essential for maintaining a hospital.
- (g) Accept committee and consultation assignments as may be required by these Bylaws, Rules and Regulations.
- (h) Discharge such other responsibilities as may be required by the medical staff, subject to the Governing Body's approval.

III.3 Qualifications for Membership.

- (a) Are either: (1) certified by a certifying board that is either a member of the American Board of Medical Specialties (ABMS) or recognized by the American Osteopathic Association (AOA), the American Board of Podiatric Medicine (ABPM), the American Board of Physician Specialists, or a Dental Specialty

Certifying Board in the practitioner's primary specialty with the exception of the emergency department of which can be board certified in family or internal medicine with 3 years emergency department experience; or (2) have completed all of the residency or other specialized training required for admission to the examination of such a certifying board and have an active application for certification to include meeting any minimum years in practice requirements followed by certification within five years of the date of completion of residency or specialized training. The governing body may waive this requirement in unusual circumstances, based on the favorable recommendation of the MEC, when the practitioner has extensive experience, qualifications and training.

- (b) Only providers and advanced practice providers licensed to practice in the State of Wisconsin and whose background, experience and training demonstrates, in the judgment of the Governing Body, that any patient treated by them in the Hospital will be given quality medical care, shall be qualified for membership on the medical staff. No provider or advanced practice provider shall be entitled to appointment to the medical staff, or to the enjoyment of particular privileges, merely by virtue of the fact that he/she is duly licensed to practice in this or in any other state, or by virtue of membership in any professional organization, or past or present privileges at another hospital. To qualify for membership or appointment on the medical staff, the individual must not be barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code.
- (c) The individual shall not be excluded from participation in any federally-funded health care program or barred from providing direct patient care in the Hospital under Wisconsin's caregiver misconduct laws.
- (d) The individual shall document their background, experience, training and demonstrated competency. All providers shall participate in and be subject to the performance improvement activities of the Hospital and the medical staff.
- (e) The individual shall document their adherence to the ethics of their profession and their good reputation.
- (f) The individual shall be required to establish their ability to work compatibly with other providers and members of the supporting staff.
- (g) As a part of their appointment and reappointment to the medical staff, or at any other time upon the request of the Governing Body, Credentialing Committee or Executive Committee, individuals must certify to their freedom from a physical or mental condition which would in any way impair their ability to exercise the clinical privileges requested or to care for patients, and the Governing Body may precondition appointment, reappointment, or the continuing exercise of any or all clinical privileges upon the provider undergoing a health examination by a physician acceptable to the Governing Body or upon submission of any other reasonable evidence of current health status that may be requested by the Executive Committee, Credentialing Committee or the Governing Body. The

presence of a physical or mental condition which can reasonably be accommodated shall not constitute a bar to the grant of medical staff membership or clinical privileges.

- (h) The individual must submit and maintain on file at all times current evidence of continued licensure, DEA registration (if applicable) and financial responsibility in amounts which shall be determined by the Governing Body after consultation with the Executive Committee, which responsibility may be satisfied by acceptable malpractice insurance coverage. This requirement may be satisfied by submitting copies of the provider's current license, DEA registration and insurance certificate each time these documents change or are updated.
- (i) As part of their appointment and reappointment to the medical staff, individuals have a continuing obligation to promptly notify the Hospital Administrator of, and to provide such additional information as may be requested regarding, each of the following:
 - (i) the revocation, limitation or suspension of his/her professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal governmental agency relating to his/her professional license, or the imposition of terms of probation or limitation by any state;
 - (ii) loss of staff membership or privileges at any hospital or other health care institution, whether temporary or permanent, including all suspensions;
 - (iii) cancellation or change of professional liability insurance coverage;
 - (iv) 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 peer review organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin;
 - (v) receipt of notice of the filing of any suit against the provider alleging professional liability in connection with the treatment of any patient in or at the Hospital; and
 - (vi) A provider must notify the Hospital of 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.
- (j) No person who is otherwise qualified, shall be denied privileges by reason of race, color, creed, handicap, disability, religion, sexual orientation, sex, or national origin or on the basis of any other criterion unrelated to the delivery of good patient care in the Hospital, to professional qualifications, to the Hospital's

purposes, needs and capabilities, to community need, or to my requirements set forth in these Bylaws.

- (k) As part of their appointment and reappointment to the medical staff, individuals have a continuing obligation to comply with federal and state laws and regulations applicable to the practice of their profession, including, but not limited to, proof of immunity against rubella, compliance with blood borne pathogen standards and annually submit results of tuberculosis testing.
- (l) An individual employed by the Hospital in a purely administrative capacity, with no clinical duties or privileges, is subject to the regular personnel policies of the Hospital and to the terms of his/her contract or other conditions of employment, and need not be a member of the medical staff. Conversely, a medical administrative officer, an individual who has both administrative and clinical duties, must be a member of the medical staff, achieving this status by the procedures provided in Article III. His/Her clinical privileges must be delineated in accordance with Article IV. The medical staff membership and clinical privileges of any medical administrative officer shall be contingent on his/her continued occupation of that position unless otherwise provided in an employment agreement, contract or other arrangement.

III.4 Ethics and Ethical Relationships.

- (a) By accepting membership on the medical staff, individuals specifically agrees to abide by the Rules and Regulations of the medical staff and the Code of Ethics of the individual's respective profession, and the Ethical and Religious Directives for Catholic Health Care Services.
- (b) All members of the medical staff shall pledge that they shall not receive from or pay to another individual, either directly or indirectly, any part of a fee received for professional services not actually rendered personally or at their direction.
- (c) The professional conduct of members of the medical staff shall at all times be governed by applicable Wisconsin and federal laws. In the event the provisions of these Bylaws or the Rules and Regulations promulgated hereunder shall not be in conformity with any Wisconsin or federal law or regulation, these Bylaws and Rules and Regulations may be amended by the Executive Committee and Governing Body, and as soon thereafter as may be practicable, such change shall be approved by the medical staff.

III.5 Conditions and Duration of Appointment

- (a) Initial appointment and reappointment to the medical staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments or revocation of appointments, only after there has been a recommendation from the medical staff acting through the Credentialing Committee as provided in these Bylaws.

- (b) Initial appointment and reappointment to the medical staff shall be for a period of two (2) years. During the initial appointment, the Medical Staff Officer may prescribe such additional monitoring, assessment, restrictions, limitations or reviews as it determines for safe patient care, as described further below.
- (c) Appointment to the medical staff shall confer on the appointee only such clinical privileges as have been recommended by the Credentialing Committee of the medical staff and granted by the Governing Body, in accordance with these Bylaws, Rules and Regulations and as set forth in the notice of appointment.
- (d) Every application for staff membership shall be signed by the applicant.

ARTICLE IV CATEGORIES OF THE MEDICAL STAFF

IV.1 The Medical Staff. The medical staff shall consist of Active, Courtesy and Advanced Practice Provider staff categories.

IV.2 Active Medical Staff.

- (a) The Active medical staff shall consist of those providers who regularly admit patients to, or are otherwise regularly involved in the care of patients in the Hospital, who are located close enough to the Hospital to provide proper care to their patients if the provider has admitting privileges, and who assume all the functions and responsibilities of membership on the Active medical staff.
- (b) New members of the Active medical staff must have attained acceptable qualifications in their field of practice according to current national standards and have an interest in the operation of the Hospital.
- (c) Members of the Active medical staff shall promote the quality of medical care in the Hospital, offer sound counsel to the Hospital Administrator and the Governing Body and participate in the internal governance of the medical staff according to these Bylaws.
- (d) Members of the Active medical staff shall:
 - (i) Be eligible to vote, hold office, and serve on all Hospital and medical staff committees;
 - (ii) Be eligible to serve on medical staff committees and attend committee meetings as provided in Article IX and X of these Bylaws.
- (e) Active medical staff members must be able to render continuous care and supervision of their patients either in person or through back-up arrangements with a qualified medical staff member or advanced practice provider with appropriate privileges, agree to accept staff committee assignments, and provide emergency care and emergency consultation within the scope of their privileges for patients admitted to the Hospital.

IV.3 The Courtesy Staff. The Courtesy medical staff shall consist of those providers qualified for staff appointment but who, on a limited or occasional basis, provide direct patient services to the Hospital, either in person or through telemedicine. A member of the Courtesy medical staff must have active staff privileges at another hospital and must provide documentation of that fact. The requirement to have active staff privileges at another hospital may be waived, for good cause, by the Credentialing Committee with the approval of the Governing Body. Members of the Courtesy medical staff shall be eligible to vote, hold office, serve on medical staff committees, and attend medical staff meetings. When a member of the Courtesy medical staff admits a patient to the Hospital and exercises his/her privileges, that Courtesy medical staff member agrees that they are responsible for the care of the patient until discharge and, if unavailable, will arrange for coverage of the patient with another appropriate member.

IV.4 Advanced Practice Clinician Staff. Advance practice clinicians may be granted clinical privileges on the medical staff in accordance with the procedures set forth in Article V. Advanced practice clinicians shall conform to the Bylaws, Rules and Regulations of the medical staff. If granted clinical privileges to do so and within the scope of their certification, license or other credentials, advanced practice clinicians may admit patients to the Hospital. Advanced practice clinicians are eligible to vote on all medical staff matters. Advanced practice clinicians may serve on and attend medical staff committee meetings.

IV.5 Telemedicine Staff.

Interpretive Telemedicine Privileges

Applicants based at distant sites whose practice at the Hospital will be limited to Interpretive Telemedicine only may apply for telemedicine Privileges through one of the following mechanisms, as selected by the Credentialing Committee either for the individual or for a designated class of applicants per policy decision of the Credentialing Committee:

- (a) If the applicant will be providing the Interpretive Telemedicine services pursuant to a written contract and the services are under the control of a JCAHO-accredited organization, by submission and processing according to these Bylaws of a telemedicine privileges application containing at least the following information (and verification of the information with either the distant JCAHO accredited site or a primary source):
 - (i) Medical Staff status at distant site and scope of clinical Privileges currently held.
 - (ii) Wisconsin licensure.

- (iii) Evidence of insurance meeting requirements for applicants for Medical Staff Membership.
 - (iv) Existence of any of the events or circumstances outlined in Article III.3.
 - (v) Request for the specific telemedicine Privileges desired.
 - (vi) Acknowledgment that the applicant is subject to these Bylaws in all respects in connection with the application for or exercise of clinical Privileges; or
- (b) By submission of the same application required of all other applicants for Medical Staff Membership or Clinical Privileges, to be processed pursuant to the application process described in these Bylaws.

Interactive Telemedicine Privileges

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

- (c) By submission of the same application required of all other applicants for Medical Staff Membership or Clinical Privileges, to be processed pursuant to the application process described in these Bylaws.
- (d) If the applicant is a Member of the Medical Staff of, or has been granted Clinical Privileges at, a distant site that is JCAHO-accredited, by submission of a copy of the most recently completed application for Medical Staff Membership or Clinical Privileges at the distant site, provided the applicant supplies any supplemental information required by the Hospital that is not contained on the distant hospital's form, with the information to be processed pursuant to the application process described in these Bylaws.
- (e) By submission and processing according to these Bylaws of a telemedicine privileges application containing at least the following information (with evidence that the information has been verified by the distant JCAHO-accredited site), along with verification by the JCAHO-accredited distant site that the applicant has been granted, at a minimum, the same privileges being requested at the Hospital as telemedicine privileges:
 - (i) Medical staff status at distant site and scope of Clinical Privileges currently held.
 - (ii) Wisconsin licensure.
 - (iii) Evidence of insurance meeting requirements for applicants for Medical Staff Membership.

- (iv) Existence of any of the events or circumstances outlined in Article III.3.
 - (v) Request for the specific telemedicine Privileges desired.
 - (vi) Acknowledgment that the applicant is subject to the Bylaws in all respects in connection with the application for or exercise of Clinical Privileges.
- (f) In processing requests for Clinical Privileges, the Hospital may rely upon credentialing information obtained and verified in accord with JCAHO standards by a JCAHO-accredited distant site where the applicant currently holds Medical Staff Membership or Clinical Privileges rather than directly obtaining primary source verification of the information supplied by the applicant.
- (g) Applicants for telemedicine Privileges may be granted Clinical Privileges without Medical Staff Membership and any of the rights, responsibilities and Prerogatives of such Membership.

IV.5 Initial Appointments; Monitoring. All initial appointments are subject to this Section. During the initial appointment period the member will be subject to review of their clinical performance by the Medical Staff Officer or designee. The member shall complete the Hospital's in-person new orientation program. Members may be subject to review, observation and proctoring requirements as defined by the member's department(s). Any observer must have unrestricted privileges for the procedure he or she is observing. At reappointment, the member must submit documentation that the member has satisfactorily met the requirements established by the Medical Staff Officer or the Credentialing Committee.

IV.6 Dental and Podiatric Staff Functions.

- (a) Dentists and podiatrists granted membership on the medical staff in accordance with the procedures set forth in Article V may be members of the Courtesy category of the medical staff if they qualify.
- (b) Patients admitted to the Hospital for dental or podiatric care shall be given the same medical appraisal as those admitted for other services. Admission of a dental or podiatric patient shall occur pursuant to the determination of the dentist or podiatrist and an assessment by a member of the medical staff with clinical privileges to medically oversee the patient or a physician approved by the medical staff. For the care of any medical problem that may be present on admission or that may arise during hospitalization of a dental or podiatric patient, a member of the medical staff with appropriate privileges shall be responsible for the medical care of the patient.
- (c) Dentists and podiatrists shall conform to the Bylaws, Rules and Regulations of the medical staff, including:
 - (i) Patients may be admitted for dental or podiatric services by a dentist or podiatrist after obtaining the concurrence of the admitting member.

- (ii) At the time of surgery admission, the name of the responsible staff member must appear on the appropriate forms. This member shall be responsible for pre- and post-operative medical care of the patient, except as otherwise provided in these Bylaws.
 - (iii) The dentist or podiatrist may discharge the patient after obtaining the concurrence of a member of the medical staff with appropriate privileges or in compliance with approved standing discharge orders.
 - (iv) Complete records, including dental, podiatric, and medical, shall be required on each patient and shall be part of the Hospital record.
- (d) Oral surgeons who have been granted clinical privileges to do so may admit and discharge patients without medical problems without first obtaining the concurrence of a physician member of the medical staff, but such oral surgeons must designate a member of the medical staff with appropriate clinical privileges to be responsible for the care of any medical problem that may arise. If granted clinical privileges to do so, oral surgeons may, in lieu of a member of the medical staff, perform the admission history and physical examination and assess the medical risks of the proposed surgical procedures on those patients admitted without medical problems.

ARTICLE V PROCEDURE FOR APPOINTMENT & REAPPOINTMENT

V.1 Application for Appointment.

- (a) All applications for appointment to the medical staff shall be in writing, shall be signed by the applicant and shall be submitted on forms prescribed by the Credentialing Committee and approved by the Governing Body. The Credentialing Committee acts on behalf of the medical staff under the authority granted to it by this authorization from the medical staff and the Executive Committee as a committee of the whole. The application shall require documentation of current licensure, relevant education and training and experience, and current competence as well as a summary of the applicant's current and previous institutional positions held and board certifications, if any. Detailed information concerning the applicant's professional qualifications shall include the names of at least two (2) persons who have had extensive experience in observing and working with the applicant, and who can provide adequate reference pertaining to the applicant's professional competence and ethical character, and shall include information as to the applicant's membership status and/or if clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, limited or not renewed, at any other hospital or institution, and shall indicate whether his/her membership in local, state or national medical societies, dental societies, podiatric societies, his/her DEA license or medical, dental or podiatric license or registration to practice in any profession, in any jurisdiction, has ever been suspended or terminated, whether the applicant has been reprimanded or otherwise disciplined by any state or federal governmental

agency relating to the practice of his/her profession, any previously successful or currently pending challenges to any licensure or registration of the applicant, and any professional liability actions resulting in a final settlement. This information will be obtained from a primary source when feasible. 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. Additionally, information as to past or pending involvement in any quality inquiry, sanction action or formal investigation by a Medicare peer review organization, the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin shall be included on the application. Information as to current physical and mental ability to safely perform the responsibilities of membership and to safely exercise the clinical privileges requested will also be required.

- (b) The Medical Staff Office may deny an application for appointment or reappointment to the medical staff or for clinical privileges without forwarding the application to the Credentialing Committee, if it determines that the applicant does not hold a valid Wisconsin license, does not have adequate professional liability insurance, is not eligible to receive payment from the Medicare or Medical Assistance Program or is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code, or that the Hospital has already granted by contract with another individual or entity the exclusive right to exercise the clinical privileges being applied for. Applicants who are administratively denied under this Section do not have a 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.
- (c) The applicant shall have the burden of producing adequate information for proper evaluation of his/her competence, character and ethics and other qualifications, and for resolving any doubts about such qualifications. Failure to adequately complete the application form, the withholding of requested information or providing of false or misleading information shall be a basis for denial of membership on or removal from the medical staff.
- (d) The completed application shall be submitted to the Hospital Administrator or designee. After collecting and verifying references and other materials deemed pertinent, he/she shall transmit the application and all supporting materials to the Credentialing Committee for evaluation. No appointment to the medical staff will be recommended, nor clinical privileges granted, until all specific information is available and has been verified.

- (e) The application form shall include a statement that the applicant has received and read the bylaws of the Hospital Governing Body, and the Bylaws, Rules and Regulations and Fair Hearing Plan of the medical staff and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges in all matters relating to consideration of his/her application. (Attachment A).
- (f) Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information including an appraisal by the Credentialing Committee and any consultants deemed appropriate by the Credentialing Committee. The applicant shall have the burden of establishing both qualifications and competency in the clinical privileges requested.
- (g) By applying for appointment or reappointment, each applicant signifies his/her willingness to appear and be interviewed. The applicant by signing the application authorizes the Hospital to consult with any and all members of medical staffs of other hospitals with which the applicant has been associated, as well as with others who may have information bearing on the competence, character, mental, physical and emotional stability, and ethical qualifications of the applicant and to inspect such records as shall be material to an evaluation of stated professional qualifications, and competence to carry out the clinical privileges requested as well as the applicant's moral and ethical qualifications and physical, mental and emotional health. By so applying, the applicant also releases all individuals who submit information at the request of the Hospital to facilitate the assessment of his/her qualifications for staff appointment and clinical privileges from any liability for their statements made in good faith and without malice and releases from any liability all representatives of the Hospital and its medical staff and medical staff committees for their acts performed in good faith and without malice in connection with evaluating the applicant.

V.2 Appointment Process.

- (a) The Hospital Administrator or his/her designee will obtain verifying information from the National Provider Data Bank, the appropriate state Boards of Medical Licensure or other relevant licensing board and related sources. If required, the applicant will authorize any special releases these agencies may require. Failure to timely receive information from the National Provider Data Bank shall not suspend processing of the application.
- (b) Within ninety (90) days after receipt of the completed application for membership, references, reports and other supporting data requested of the applicant, the Credentialing Committee, shall make a written recommendation to the Governing Body that the provider be appointed to the medical staff, under the terms of these Bylaws or that he/she be rejected for staff membership or that

his/her application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted which may, where appropriate, be qualified by probationary conditions.

- (c) In making a recommendation, the Credentialing Committee shall examine evidence of the character, professional competence, qualifications and ethical standing of the provider, and shall verify, through information obtained in references, given by the provider and from other sources available to the committee that the applicant meets and has established all necessary qualifications for staff membership and the clinical privileges requested as set forth in Articles III and IV of these Bylaws. The Credentialing Committee, through the Hospital Administrator, shall transmit its recommendation to the Governing Body, along with the completed application and all other documentation considered in arriving at its recommendation. All recommendations of the Credentialing Committee shall be included in the minutes of the Executive Committee at its next meeting following the date the recommendation is made.
- (d) While the recommendation and the appointment to the medical staff shall be based primarily on professional competence of applicants, the ability of the Hospital to provide adequate facilities and supportive services for the applicant and his/her patients; patient care needs for additional staff members with the applicant's skill and training shall also be considerations of the Governing Body in determining medical staff membership. To the extent the geographic location of the applicant and his/her practice affects the ability of the applicant to provide effective continuity of care for Hospital patients, it shall also be a consideration.
- (e) When the recommendation of the Credentialing Committee is to defer the application for further consideration, it must be followed-up within one hundred and twenty (120) days with a subsequent recommendation for appointment with specified clinical privileges or for rejection of staff membership. The Executive Committee may assume responsibility for the completion of processing applications when the Credentialing Committee has decided to defer and the Executive Committee may at that time extend the time period for it to render a decision, which decision shall be timely communicated to the applicant by the Hospital Administrator.
- (f) When the recommendation of the Credentialing Committee is adverse to the provider, either in respect to appointment or clinical privileges, the Hospital Administrator shall promptly so notify the provider by Certified Letter, within ten (10) working days. No such adverse recommendation need be forwarded to the Governing Body until after the provider has exercised or has waived his/her right to a hearing, as provided in the Fair Hearing Plan.
- (g) If, after the Credentialing Committee has considered the report and recommendation of the hearing committee and the hearing record, and if the Credentialing Committee's reconsidered recommendation is favorable to the provider, it shall be processed in accordance with Section V.2(c). If such

recommendation continues to be adverse, the Hospital Administrator shall promptly so notify the provider by Certified Mail, within ten (10) working days. The Hospital Administrator shall also forward such recommendation and documentation to the Governing Body, however, the Governing Body shall not take any action thereon until after the provider has exercised or has been deemed to have waived his/her rights to an appellate review, as provided in the Fair Hearing Plan.

- (h) At its next regular meeting, but not more than thirty (30) days after receipt of a favorable recommendation, the Governing Body or its Executive Committee, shall act on the matter. If the Governing Body's decision is adverse to the provider with respect to either appointment or clinical privileges, the Hospital Administrator shall notify him/her of such adverse decision within seven (7) days, by Certified Mail, and such adverse decision shall be held in abeyance until the provider has exercised or waived his/her rights under the Fair Hearing Plan of these Bylaws, and until there has been compliance with Section V.2(c). The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.
- (i) At its next regular meeting, after all the providers' rights under the Fair Hearing Plan have been exhausted or waived, the Governing Body shall act on the matter. The Governing Body's decision shall be conclusive, except that the Governing Body may defer final determination by referring the matter for further consideration at a joint meeting of the Governing Body and a committee of the medical staff. Any such referral shall state the reason therefore, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made, and may include a directive that an additional hearing will be conducted to clarify issues which are in doubt. At its next regular meeting, after receipt of such subsequent recommendation, and new evidence in the matter if any, the Governing Body shall make a decision either to appoint the provider to the staff or to reject him/her for staff membership. All decisions to appoint shall include delineation of the clinical privileges which the provider may exercise.
- (j) Whenever the Governing Body's decision shall be contrary to a medical staff committee recommendation, the Governing Body shall meet with the Credentialing Committee before making the final decision.
- (k) When the Governing Body's decision is final, it shall send notice of such decision through the Hospital Administrator, to the Medical Staff Officer and by Certified Mail, to the applicant.

V.3 Reappointment Process.

- (a) The Hospital Administrator will provide each staff member scheduled for reappointment with a reappointment application form at least sixty (60) days prior to expiration of the member's current appointment. Each staff member who desires reappointment shall submit his/her completed reappointment form to the

Hospital Administrator or designee within thirty (30) days of receipt. Failure without good cause to so return the form shall be deemed a voluntary resignation from the staff and shall result in automatic termination of membership at the expiration of the member's current term. A provider whose membership is 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 application form shall include all information necessary to update the information contained in the applicant's initial application for appointment since the last time such information was supplied.
- (c) All changes in medical staff category or scope of clinical privileges shall be subject to the procedures in these Bylaws applicable to initial appointments.
- (d) Prior to the last scheduled Governing Body meeting before expiration of the provider's current appointment, the Credentialing Committee shall complete its review of all pertinent information available on each provider scheduled for periodic appraisal for the purpose of determining its recommendations for reappointments to the medical staff and for the granting of clinical privileges for the ensuing two (2) years and shall transmit its recommendations, in writing, to the Governing Body. All recommendations of the Credentialing Committee shall be included in the minutes of the Executive Committee at its next meeting following the date the recommendation is made. In all cases where non-reappointment or a change in staff status or clinical privileges is recommended, the reasons for the recommendation shall be stated and documented. The Executive Committee may assume responsibility for the completion of processing applications when the Credentialing Committee has decided to not reappoint or a change in staff status and the Executive Committee may at that time extend the time period for it to render a decision, which decision shall be timely communicated to the applicant by the Hospital Administrator.
- (e) In arriving at recommendations for reappointment of each medical staff member and the assignment of privileges, specific consideration shall be given to the applicant's professional competency and clinical judgment in the treatment of patients, ethics and conduct, physical and mental capabilities, attendance at medical staff meetings and participation in staff affairs compliance with the Hospital Bylaws and the medical staff Bylaws, Rules and Regulations (including timeliness of medical record completion), cooperation with Hospital personnel, use of the Hospital's facilities for patients, relations with other staff members, and general attitude toward patients, the Hospital and the public. Reappointment policies include the periodic appraisal of the professional activities of each member of the medical staff and of all other individuals granted clinical privileges in the Hospital through the medical staff credentialing process, as well as periodic appraisal of physical and mental ability to safely exercise the limited privileges requested with or without accommodation.

- (f) The results of performance improvement activities, and the monitoring performed during a prior term of appointment shall be considered in the appraisal of the applicant's professional performance, judgment and technical and/or clinical skills.
- (g) Any medical staff committee report of all matters considered in each applicant's periodic reappointment appraisal must be made a part of the permanent files of the Hospital.
- (h) Factors considered in the periodic appraisal include, but are not limited to:
 - (i) Number of procedures performed or major diagnoses made;
 - (ii) Rates of undesirable outcomes, such as complications compared with those of others doing similar procedures; and
 - (iii) Findings and conclusions of review by peers
- (i) When the recommendation of the medical staff committee is negative, prior to any referral of the recommendation to the Governing Body for action, the provider involved should be notified of the negative recommendation, and given an opportunity either to utilize the procedural rights which are contained in these Bylaws or to accept the recommendation.

V.4 Modification of Membership Status or Privileges. A member of the medical staff may, either in connection with the reappointment process or at any other time, request modification of his/her staff category or clinical privileges by submitting a written application to the Hospital Administrator on the prescribed forms. The application shall be processed in the same manner as provided in Section V.2(c) above for reappointment. Any grant of new, extended or increased clinical privileges shall be subject to evaluation and monitoring as set forth in this Article V.

V.5 Reapplication After Adverse Action.

- (a) An applicant who has received a final adverse professional review action regarding appointment or clinical privileges or both 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 or until he/she completes training identified by the medical staff as a prerequisite for the privileges, whichever is shorter.
- (b) An applicant who has received a final adverse professional review action regarding appointment 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 that was 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 Article shall be processed as an initial application, but the applicant shall submit additional information as the Credentialing Committee or Governing Body may require in demonstration that the basis for the earlier adverse action no longer exists.
- (d) If the recommendation of the Credentialing Committee or the action proposed by the Governing Body upon reapplication under this Section V.5 continues to be adverse, the scope of the hearing 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.

V.6 Leave of Absence and Reappointment.

- (a) Any member of the medical staff may obtain a leave of absence from the medical staff for a period not to exceed his/her present term of appointment by submitting a written request to the Executive Committee and the Hospital Administrator. Failure of a provider to return or make application for extension of leave shall constitute a resignation from the medical staff, and shall not be subject to any hearing or appellate review. A request for medical staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointment.
- (b) Upon return from leave of absence, the provider will be required to submit a request for reinstatement in writing to the Hospital Administrator and the Credentialing Committee who will review the request and make recommendation to the Governing Body regarding reappointment/reinstatement to the medical staff.

V.7 Withdrawal of Privileges. Any member of the staff may voluntarily withdraw any clinical privilege at any time upon written notice to the Hospital Administrator and the Medical Staff Officer. Such action, unless as a result of disciplinary action or investigation or in lieu thereof, shall not create a right of hearing under the Fair Hearing Plan, nor generate any reporting requirements under state law or the Health Care Quality Improvement Act.

V.8 Time Periods for Processing. Applications for appointment or reappointment shall be considered in a timely and good faith manner by all individuals and groups who are required by these Bylaws to act on applications and, except for good cause, shall be processed within the time periods specified in these Bylaws. 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 applicant to have his/her application processed within those periods, nor to create a right for a staff member to be automatically reappointed for the coming term.

ARTICLE VI CLINICAL PRIVILEGES

VI.1 Clinical Privileges Restricted.

- (a) Every provider or advanced practice provider practicing at this Hospital, by virtue of medical staff membership or otherwise, shall in connection with such practice, be entitled to exercise only those Hospital specific clinical privileges granted to him/her by the Governing Body, except as provided in Sections VI.2 and VI.3 below.
- (b) Every application for appointment or reappointment must contain a specific request for clinical privileges that defines the scope of patient care services they may provide independently in the Hospital.
- (c) Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based on the direct observation of care provided, review of the records of patients treated in this or other hospitals, and review of the records as part of the Hospital's performance improvement activity.
- (d) Privileges granted to dentists shall be based on their education, training, experience and demonstrated competence and judgment. The scope and extent of surgical privileges that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges.
- (e) Privileges granted to podiatrists shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical privileges that each podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by podiatrists shall be under the overall supervision of an Active staff member.
- (f) There are professionals who are licensed by the State of Wisconsin who cannot practice independently, as directed by Wisconsin Statute. Services performed by these professionals may be required by the medical staff and Our Lady of Victory Hospital, Inc., and therefore, require monitoring by a member of the medical staff, to assure competence.
- (g) Privileges granted to advanced practice provider members shall be based upon their training, experience and demonstrated competence and judgment, within the scope of their license. Such individuals will provide medical or surgical care under the supervision of a provider who has been accorded privileges to provide such care in the Hospital. The scope of privileges granted to advanced practice provider members shall be specifically provided for in the Advanced Practice Provider Policy.

VI.2 Temporary Privileges. The granting of temporary privileges is not encouraged and shall be done only when deemed necessary or beneficial to the Hospital and patient needs. Privileges under this Section are limited as follows:

- (a) Providers applying for temporary privileges under this clause must be licensed in Wisconsin, and meet at least one of the following criteria:

- (i) be an Active staff member in good standing at another health care facility;
or
 - (ii) have a sponsor on the medical staff who is willing to assume responsibility for the provider.
- (b) Temporary privileges will not be granted to applicants for medical staff membership during the pendency of their applications, except in unusual circumstances. Applicants are to submit a completed application at least sixty (60) days in advance to allow full review prior to the contemplated date of beginning practice.
- (c) Temporary privileges may be granted to a provider only by the Hospital Administrator upon recommendation by the Medical Staff Officer. Such temporary privileges shall be limited by the medical staff to a specific number of patients or specific period of time in any staff year, after which the provider shall be required to apply for medical staff membership.
- (d) A provider who contemplates serving as locum tenens must complete an application as if he/she were applying for medical staff membership and must be reviewed, approved, and have privileges delineated by the Credentialing Committee, subject to the approval of the Governing Body. The provider engaging the locum tenens provider must, at least thirty (30) days prior to the period of temporary privileges requested, file a letter requesting temporary privileges for the locum tenens provider, acknowledging responsibility for his/her actions and quality of practice. Temporary privileges may be granted for the locum tenens provider for an initial period not to exceed sixty (60) days and may be extended for two (2) successive periods of thirty (30) days each.
- (e) All providers exercising temporary privileges shall do so under the supervision of an Active medical staff member who is responsible for admission and general care of the patient.
- (f) No provider is entitled to temporary privileges as a matter of right. A provider shall not be entitled to the procedural rights afforded by the Fair Hearing Plan because of his/her inability to obtain temporary privileges or because of any termination, modification or suspension of temporary privileges.
- (g) Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting provider's qualifications, ability and judgment to exercise the privileges requested. Special requirements of consultation and reporting may be imposed by the Credentialing Committee. Before temporary privileges are granted, the provider must acknowledge in writing that he/she has received 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.

- (h) Providers applying for temporary privileges under this Section must satisfy the requirements regarding professional liability insurance, health status and the Wisconsin caregiver background check.
- (i) Temporary privileges may be terminated or suspended at any time at the direction of the Hospital Administrator on the recommendation of the Medical Staff Officer. Any such action shall not be subject to the procedural rights afforded by the Fair Hearing Plan. The provider may be permitted to care for a patient then under his/her care until discharge of the patient if deemed necessary by the president of the medical staff. Where it is determined that the life or health of the patient would be endangered by the continued treatment by a provider whose temporary privileges have been terminated, the president of the medical staff shall assign a member of the medical staff to assume responsibility for the care of the patient until the patient is discharged from the Hospital.

VI.3 Emergency Privileges. In the case of an emergency, any provider, regardless of department or medical staff status, clinical privileges, or lack thereof, shall be permitted to provide any type of patient care necessary as a life-saving measure or to prevent serious harm, as long as the care provided is within the scope of the individual's license. When an emergency situation no longer exists, the provider must request the necessary privileges and/or medical staff membership to continue to treat the patient. In the event such privileges or staff membership are denied, or he/she does not desire to request privileges or medical staff membership, the patient shall be assigned to an appropriate member of the medical staff. For the purpose of this Section, an emergency is defined as a condition in which serious, permanent harm would result to a patient whose life is in immediate danger, and any delay in administering treatment would add to that danger.

ARTICLE VII IMMUNITY FROM LIABILITY

VII.1 Conditions. Any act, communication, report, recommendation or disclosure, with respect to any individual, performed or made in good faith and without malice 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. Such privileges shall extend to members of the medical staff, administration and Governing Body, the Hospital Administrator 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 who have supplied information to or received information from an authorized representative of the Governing Body or of the medical staff and includes, but is not limited to, individuals, health care facilities, governmental agencies, peer review organizations and any other person or entity with relevant information. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation or disclosure, even where the information involved would otherwise be deemed privileged. Such immunity shall apply to all acts, communications, reports, or disclosures performed or made in connection with this or any other health care institution's activities related to, but not limited to:

- (a) applications for appointment or clinical privileges;
- (b) monitoring of members of the staff during the term of initial appointment or of any other provider or medical affiliate under the monitoring protocol established by the medical staff;
- (c) periodic reappraisals for reappointment or clinical privileges;
- (d) corrective action, including suspension;
- (e) hearings and appellate reviews;
- (f) medical care evaluations;
- (g) utilization reviews;
- (h) profiles and profile analysis;
- (i) malpractice loss prevention; and
- (j) other Hospital, departmental, service or committee activities related to quality patient care and interprofessional conduct.

The acts, communications, reports, recommendations and disclosures referred to in this Section may relate to an individual's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care. 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 Hospital Administrator 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. To reaffirm the immunity intended by this Section, each individual shall, upon request of the Hospital, execute releases acknowledging the immunity and protection set forth in this Section in favor of the individuals and organizations involved in the operations and administration of the medical staff, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state. Execution of such releases is not a prerequisite to the effectiveness of this Section. The consents, authorizations, releases, rights, privileges and immunities provided under Article V of these Bylaws for the protection of this Hospital's providers, other 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.

ARTICLE VIII OFFICERS

VIII.1 Officer of the Medical Staff. The Medical Staff Officer shall be the sole officer of the medical staff.

VIII.2 Qualifications for the Medical Staff Officer. The Medical Staff Officer must be a physician member of the Active medical staff at the time of nomination and election, and must remain a member in good standing during his or her term of office. Failure to maintain such status shall immediately create a vacancy in the office. The Medical Staff Officer shall be a provider with demonstrated competence in his or her field of practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of Hospital and medical staff activities. The Medical Staff Officer shall be elected by the Active, Courtesy, and APC staff members after nomination by the Hospital Administrator.

VIII.3 Terms of Office. The Medical Staff Officer shall serve until removed from office by the Hospital Administrator.

VIII.4 Duties of the Medical Staff Officer. The Medical Staff Officer shall:

- (a) Serve as chief administrative officer of the medical staff and act in coordination and cooperation with the Hospital Administrator in all matters of mutual concern within the Hospital.
- (b) Be responsible for the enforcement of the medical staff Bylaws, Rules and Regulations, and for implementations of sanctions, where these are indicated, and for the medical staff's compliance with procedural safeguards in all instances where corrective action has been requested against a provider.
- (c) Establish, together with the medical staff and administration, the type and scope of services required to meet the needs of the patients and the Hospital.
- (d) Participate in making recommendations to the medical staff for the establishment of criteria for clinical privileges in the Hospital.
- (e) Make recommendations for clinical privileges for each member of the Hospital medical staff.
- (f) Serve as an Ex-Officio (non-voting) member of the Governing Body.
- (g) Make recommendations regarding the sufficient number of qualified and competent persons to provide care or services, and for space and other resources needed by the departments.

- (h) Oversee the continuous assessment and improvement of the quality of care and services within the Hospital and implement and maintain quality control programs as appropriate.

ARTICLE IX COMMITTEES

IX.1 Composition of the Executive Committee. The Executive Committee shall be a standing committee and shall consist of the Officer of the Medical Staff, and members of the Active or Courtesy medical staff or APC staff selected by the Medical Staff Officer to serve as additional voting members. Medical Staff members delegated by a committee member to attend a meeting shall have proxy vote. The Executive Committee shall have no more than 7 voting members. The Executive Committee shall operate as a committee of the whole and receive and act upon the reports of all other medical staff committees.

- (a) The Medical Staff Officer shall be chair of the Executive Committee.
- (b) The Hospital Administrator shall be an Ex-Officio member without vote, and other representatives may attend with the permission of the voting members.

Membership Requirements. All practitioners eligible for appointment to the MEC must:

- (a) Demonstrate ability to establish professional and collegial relationships;
- (b) Be committed to the mission, vision, values and strategic plan of the Hospital;
- (c) Demonstrate commitment to the continuous performance improvement activities of the Medical Staff and the Hospital
- (d) Be respected by their peers; and
- (e) Be aware of and willing to enforce compliance with these Bylaws, the Medical Staff Code of Conduct and Conflict of Interest Policy and the Ethical & Religious Directives for Catholic Health Care Services. This enforcement applies only to the Hospital proper and not to other locations and programs not under the Hospital's control or ownership.

Replacement of Members. In the event of any vacancy, for any reason, the Chair of the governing body, or his or her designee, shall promptly fill the position with a qualified physician after consultation with the President (and the CAO. MEC members appointed in this fashion shall have a term equal to the remainder of the term of the member they are replacing.

Removal of Members. The governing body also retains the prerogative to remove a member of the MEC at any time. The MEC will recommend to the governing body and Medical Staff, subject to ratification of the Medical Staff, a replacement to complete the

remainder of the term for elected members of the MEC removed in this manner and for other vacancies in the elected members of the MEC.

- (a) The Active staff members may also remove any at large member of the MEC, if 15% of the Active staff members sign a petition calling for the removal of an MEC member, and a two-thirds majority of all the eligible staff members vote for removal. Any resulting vacancy shall be filled by an election or appointment of a replacement in a manner as determined by the Chief Medical Officer, subject to governing body approval. A person so removed shall not be eligible for re-election for a period of two years following removal.
- (b) Reasons for removal of a member of the MEC include but are not limited to:
 - (i) failure to adequately discharge or carry out with good faith objectivity the duties of the position;
 - (ii) actions contrary to the philosophies, policies or mission of the Hospital; and
 - (iii) failure to meet the conditions of and qualifications for membership on the Medical Staff.
- (c) The terms of the selected MEC members shall be two years unless the members are selected to fill a vacancy. Office terms also may be shorter than two years to achieve appropriate staggering of terms as determined by the Medical Staff Officer and the governing body.

IX.2 Duties and Responsibilities of the Executive Committee. The Executive Committee is empowered to act on behalf of the medical staff and to coordinate the activities and general policies of the committees as indicated by the medical staff Bylaws, Rules and Regulations. The Executive Committee is a major component in the Hospital's program organized and operated to help improve the quality of health care in the Hospital and its activities will be conducted in a manner consistent with the provisions of secs. 146.37 and 146.38 of the Wisconsin Statutes. The quality improvement ("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 relating to improving the quality of health care and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee including, but not limited to, participating in monitoring plans. The Executive Committee shall generally meet quarterly and maintain a permanent record of its proceedings and actions.

This committee shall be responsible:

- (a) to be regularly involved in medical staff management, including the enforcement of medical staff Bylaws, Rules and Regulations, policies and committee affairs;

- (b) to coordinate the activities and general policies of the various committees, as required;
- (c) to make recommendations to the governing body related to the appointment of medical staff members;
- (d) 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;
- (e) to fulfill the medical staff's accountability to the Governing Body for the medical care rendered to the patients in the Hospital, including quality, performance improvement and efficiency;
- (f) to consider amendments to the Bylaws, Rules and Regulations of the medical staff as necessary for the proper conduct of its work;
- (g) to perform such other functions as may from time to time be delegated by the medical staff or the Governing Body;
- (h) to provide recommendations to (the Executive Committee of the Governing Body and) the Governing Body on all matters relating to corrective actions.

IX.3 Credentialing Committee. The Credentialing Committee shall meet at least monthly and be composed of the Medical Staff Officer, who shall act as Chair of the Credentialing Committee, and no more than two (2) Active, Courtesy, or APC staff members selected by the Medical Staff Officer to serve as additional voting members. The Credentialing Committee is responsible for reviewing and evaluating the qualifications of each applicant for initial appointment, reappointment or modification of appointment, and for clinical privileges, and for submitting recommendations to the Governing Body on the qualifications of each applicant for staff membership or particular clinical privileges with respect to appointment, staff category, clinical privileges and special services. Medical staff clinical privileges will be reviewed on a periodic basis to assure that privileges and credentials are commensurate with the provider's or advanced practice provider's actual practice and abilities. The Active medical staff acts through the Credentialing Committee for purposes of the activities described above, and the Credentialing Committee acts for the medical staff on all recommendations as described above and all recommendations of the Credentialing Committee to the Governing Body shall be reported to and included in the minutes of the next meeting of the Executive Committee. The Credentialing Committee is a major component in the Hospital's program organized and operated to help improve the quality of health care in the Hospital and its activities will be conducted in a manner consistent with the provisions of secs. 146.37 and 146.38 of the Wisconsin Statutes. The quality improvement ("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 all committees of the Medical Staff relating to improving the quality of health care and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the

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

IX.4 Peer Review Steering Committee. A subcommittee of the Medical Executive Committee will act as the Peer Review Steering Committee. Additional participants in the peer review process will be selected by the Medical Staff Officer. The work of all practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate by the Medical Staff Officer. The peer review body will consider and record the views of the person who care is under review. Recommendations and outcomes will be submitted by the Quality department for review by the Peer Review Steering Committee.

- (a) In the event of a conflict of interest or circumstances would suggest a biased review, the Medical Staff Officer will replace, appoint, or determine who will participate in the process so that bias does not interfere in the decision-making process.
- (b) The Peer Review Steering Committee will make recommendations on the need for external peer review to the Medical Executive Committee. External peer review will take place under the following circumstances if deemed appropriate by the MEC or Board of Directors. No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the MEC or Board of Directors. Circumstances requiring external peer review include:
 - (i) Litigation – when dealing with a potential lawsuit
 - (ii) Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly impact a practitioner's membership or privileges
 - (iii) Lack of internal expertise – when no one on the medical staff has adequate expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as described above. External peer review will take place if the potential for conflict of interest cannot be appropriately resolved by the MEC or Board of Directors.
- (c) New technology – when a medical staff member requests permission to use new technology or perform a procedure new to Our Lady of Victory Hospital and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.
- (d) Miscellaneous issues – when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the MEC or Board of Directors

may require external peer review in any circumstances deemed appropriate by either bodies.

- (a) If the results of individual case reviews for a physician exceed thresholds established by the Medical Staff described below, the Medical Staff Officer will review the findings to determine if further intensive review is needed to identify a potential pattern of care. Thresholds are:
 - (i) Any single egregious case
 - (ii) Within any 12-month period of time, any one of the following criteria:
 - (iii) 3 cases rated care physician inappropriate
 - (iv) 5 cases rated either physician care controversial or inappropriate
 - (v) 5 cases rated as having documentation issues regardless of care rating
- (b) In the event a decision is made by the Board of Directors to investigate a practitioner's performance or circumstances warrant the evaluation of one or more providers with privileges, the MEC or its designee shall appoint a panel of appropriate medical professionals to perform the necessary peer review activities.
- (c) Peer review will be conducted by the medical staff in a timely manner. The goal is for routine cases to be completed within 90 days of the data the chart is reviewed by Quality Improvement Specialist and/or Care Coordinators. Complex cases are to be completed within 120 days. Exceptions may occur based on case complexity or review availability.
- (d) Direct oversight of the peer review process is delegated by the MEC to the subcommittee of the MEC acting as the Peer Review Steering Committee. The responsibilities of the subcommittee related to peer review are described in the Medical Staff Bylaws. The Peer Review Steering Committee will report to the MEC at least annually.
- (e) All matters relating to the peer review process are treated in strict confidence. All activities relating to the performance improvement process will be held in confidence to the extent permitted by law. Peer review case study activities are conducted pursuant to Sections 146.37 & 146.38 of the Wisconsin Statutes regarding the peer review of health care providers. All Our Lady of Victory Hospital employees receive the corporate confidentiality policy and are required to sign a confidentiality agreement annually.

IX.5 Other Committees. The medical staff, through the decision of the Medical Staff Officer, shall establish such committees as are required for medical staff operations and function. The Medical Staff Officer shall appoint committee members to all standing, special, ad hoc and multi-disciplinary medical staff committees, except the Executive Committee,

and act as chair of all medical staff committees, including the Executive Committee. The Medical Staff Officer may appoint any provider or advanced practice provider member of the medical staff to serve on any committee. The Hospital Administrator, at his or her discretion, shall be an ex officio member on all standing, special, ad hoc and multi-disciplinary medical staff committees.

- IX.6 Reports.** The Medical Staff Officer shall ensure a written report of conclusions, recommendations, actions taken and the results of actions taken are monitored and reported to the Executive Committee.

ARTICLE X COMMITTEE MEETINGS

- X.1 Meetings.** The Medical Staff Officer shall determine the necessity and frequency of committee meetings, and shall set forth how and when such meetings shall occur. The meetings may occur by telephonic or other electronic means. The Executive Committee and the Credentialing Committee shall meet as needed, as determined by the Medical Staff Officer, but the Executive Committee shall meet no less than quarterly and the Credentialing Committee shall meet no less than monthly. A quorum for a meeting shall be those present in person or electronically at the meeting, so long as the Medical Staff Officer and Hospital Administrator are present in person or electronically during the entire meeting.
- X.2 Minutes.** The Medical Staff Officer or designee shall be responsible for preparing and maintaining the minutes of all committee meetings, including a record of the attendance of members and the vote taken on each matter, as applicable.

ARTICLE XI MEDICAL STAFF MEETINGS

- XI.1 Regular Meetings.** The medical staff shall meet at least annually. Additional regular meetings may be held as necessary as determined by the Medical Staff Officer. The Executive Committee, as a committee of the whole, may designate any of its meetings as the annual meeting of the medical staff provided that the Medical Staff Officer sends notice, electronically or by other reasonable means, not less than three (3) business days before the meeting.
- XI.2 Special Meetings.** The Medical Staff Officer or the Executive Committee may call a special meeting of the medical staff. Any member of the Active staff may at any time file a request with the Medical Staff Officer that a special meeting of the medical staff be called, which shall be called if approved by the Medical Staff Officer.
- XI.3 Time and Place.** The Medical Staff Officer shall designate the time and place for all regular and special meetings.
- XI.4 Notice.** Notice of a regular meeting, either written or oral, shall state the place, date and hour of the meeting and be given to all medical staff members not less than three (3) days before the time of such meeting. Notice of a special meeting shall be by special notice, i.e. written notification sent by Certified or Registered Mail, Return Receipt Requested, or hand delivered to the addressee, to each member of the medical staff, stating the place,

day and hour of any special meeting and the reason for the meeting, at least three (3) normal business days prior to the meeting. No business shall be transacted at any special meeting except that stated in the notice calling that meeting.

XI.5 Quorum. Quorum shall consist of however many medical staff members participate in the regular or special meeting. All action shall be taken by simple majority vote.

XI.6 Eligibility to Vote. Only members in good standing of the Active, Courtesy, or Advanced Practice Clinician staff shall be eligible to vote for all matters which are presented for vote at the annual or a special meeting of the medical staff.

ARTICLE XII ADOPTION AND AMENDMENT OF BYLAWS

XII.1 Medical Staff Responsibility. The Active 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, 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, Rules and Regulations 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.

XII.2 Methodology. Medical staff Bylaws may be adopted, amended, or repealed by the following combined action:

- (a) Medical Staff. A proposed amendment of the Bylaws must be circulated to the medical staff at least five (5) days in advance of a regular or special meeting of the medical staff. The proposed Bylaws may then be acted upon at the regular or special meeting of the medical staff. A proposed change in Bylaws will be passed if a majority of all active members of the medical staff present at the meeting votes in the affirmative. A written proxy shall be accepted for voting on Bylaws changes; and
- (b) Governing Body. The Governing Body shall act no later than thirty (30) days after the vote of the medical staff on the proposed amendment. The affirmative vote of the majority of the Governing Body shall be final. The Governing Body may not adopt a bylaw amendment by unilateral action. Unilateral action for these purposes would be the adoption of a proposed amendment without notice to the Executive Committee and medical staff and further without providing reasonable time for response and recommendation. If the medical staff fails to exercise its responsibility and authority after notice from the Governing Body to such effect, including a reasonable period of time for response, the Governing Body may resort to its own initiative in formulating or amending these Bylaws. In such event, medical staff recommendations and views shall be carefully considered by the Governing Body during its deliberations and in its actions.

ARTICLE XIII RULES & REGULATIONS

The medical staff shall adopt such Rules and Regulations as may be necessary to implement more specifically, the general principles founded in these Bylaws, subject to the approval of the Governing Body. These shall be related to the proper conduct of the medical staff organization, activities of the medical staff, and the level of practice that is to be required for each provider in the Hospital. Such rules and regulations may be amended or repealed at any meeting of the medical staff, Executive Committee, or Credentials Committee without previous notice by a majority vote of those active or courtesy medical staff or APC present in person at the meeting or by written proxy. Such changes shall be effective when approved by the Governing Body.

ARTICLE XIV ADOPTION

These Bylaws, together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the Active or Courtesy medical staff or APC and shall replace any previous Bylaws, Rules and Regulations, and shall become effective when approved by the Governing Body of the Hospital. The Rules and Regulations may also be changed as provided in Article XIII.

ARTICLE XV REVIEW OF BYLAWS

These Bylaws, Rules and Regulations and Fair Hearing Plan shall be reviewed on a 2-year basis by a committee appointed by the Medical Staff Officer. Recommendations will be presented to the medical staff for action as provided for in Article XII of these Bylaws.

ARTICLE XVI HISTORY AND PHYSICAL EXAMINATIONS

A medical history and physical examination (“H&P”) must be performed and documented by a provider or advanced practice provider with appropriate privileges, no more than thirty (30) days before or twenty-four (24) hours after admission or registration (inpatient or outpatient), but in all cases prior to surgery or a procedure requiring anesthesia services. If the H&P is performed within thirty (30) days prior to the patient’s admission or registration, a provider advanced practice provider with appropriate privileges must complete and document an updated examination of the patient, including any changes in the patient’s condition, within twenty-four (24) hours after the patient’s admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia services. A provider may delegate the performance of an H&P to an individual in accordance with state law and if the individual receiving the delegation does not have appropriate privileges, the provider must countersign the H&P and accept full responsibility for the H&P. Refer to the medical staff policies for more information regarding H&P documentation requirements.

APPENDIX A

ADVANCED PRACTICE PROVIDER POLICY

I. GENERAL

- A. Each individual in these categories will present his or her qualifications for review by the medical staff in accord with the procedures as set forth for the appointment of providers to the medical staff. If approved, the Governing Body may grant such individual privileges, including the ability to admit patients if within state scope of practice, as restricted by Articles II and III of this Policy.
- B. As a condition of appointment and the exercise of clinical privileges as an advanced practice provider, each individual must meet the following conditions:
 - 1. Only advanced practice providers licensed in the State of Wisconsin who can document their background, experience, training, and demonstrated competence, their adherence to the ethics of their profession, their good reputation and their ability to work with other physicians and dentists and members of the supporting staff, and the capability 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 Our Lady of Victory Hospital will be given quality care, shall be qualified for advanced practice provider privileges.
 - 2. As part of their appointment and reappointment to the medical staff, providers must certify biennially, or at any other time upon request of the Governing Body, Credentialing Committee or the Executive Committee, the ability to perform the privileges requested with or without reasonable accommodation.
 - 3. Each advanced practice provider must submit and maintain on file at all times current evidence of continued licensure; DEA registration, if applicable; and financial responsibility in amounts which shall be determined by the Governing Body after consultation with the Executive Committee. The requirement of financial responsibility may be satisfied by acceptable professional liability insurance coverage and, for those providers eligible to do so, participation in the Wisconsin Patients Compensation fund. This requirement may be satisfied by submitting copies of the provider's current license, DEA registration and insurance certificate each time these documents change or are updated.
 - 4. As part of their appointment and reappointment to the medical staff, providers have a continuing obligation to promptly notify the Hospital Administrator of, and to provide such additional information as may be requested regarding, each of the following:

- a. the revocation, limitation or suspension of his or her professional license or DEA registration, or the imposition of terms of probation or limitation of any state;
 - b. loss of staff membership or privileges at any hospital or other health care institution;
 - c. cancellation or change of professional liability insurance coverage;
 - d. receipt of a quality letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation, or the filing of charges, by a Medicare peer review organization, the Department of Health and Human Services, of any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin; and
 - e. receipt of notice of the filing of any suit against the provider alleging professional liability in connection with the treatment of any patient in or at Our Lady of Victory Hospital.
5. Optometrists licensed by the State of Wisconsin. A physician member of the medical staff shall be responsible for the admission and care of any medical problem that may be present at the time of admission, or that may arise during hospitalization and discharge.
- C. Independent advanced practice providers shall:
1. Exercise independent judgment in their areas of competence,
 2. Possess a documented collaboration or supervision (as appropriate under law) relationship with an Active or Courtesy member of the medical staff;
 3. Record reports and progress notes on the patients' records and write orders for treatment to the extent established in the Rules and Regulations of the medical staff, provided that such orders are within the scope of his or her license, certificate or other legal credential;
 4. Not admit or discharge patients to or from Our Lady of Victory Hospital, unless granted clinical privileges to do so; and
 5. Be required, as a condition of continued privileges, to attend meetings involving the clinical review of patient care in which they participated.
- D. Applications for clinical privileges as an independent advanced practice provider shall be processed in accordance with the procedures set forth in Article VI of the medical staff Bylaws for the grant of clinical privileges. An individual applying for clinical privileges as an Independent Advanced practice provider must be

recommended to the Credentialing Committee by an Active or Courtesy member of the medical staff or have as a reference such a member of the medical staff.

II. REMOVAL OF ADVANCED PRACTICE PROVIDERS

- A. Advanced practice providers who are members of the medical staff shall have the same duties and prerogatives of staff members; however, advanced practice providers who are not members of the medical staff have none of the duties or prerogatives of staff members.
- B. The Hospital administration or upon recommendation of a committee of the medical staff, to suspend or terminate any or all of the privileges or functions of any advanced practice provider or category of affiliate. Only if such advanced practice provider is a member of the medical staff shall he or she be entitled to the review and appeal procedures of the medical staff Bylaws. Where such advanced practice provider is not a member of the medical staff, the following applies:
 1. The advanced practice provider who is terminated or curtailed shall be told the reasons for such action, and if they so request, shall be entitled to have such action reviewed by the Credentialing Committee. At any review meeting, the individual shall be present and allowed to fully participate.


Revised June 2017

ADOPTED by the active Medical Staff of Our Lady of Victory Hospital; revised September 25, 2018.



Medical Staff Officer

Approved by the Board of Directors on October 4, 2018.



Hospital President
Our Lady of Victory Hospital

