MEDICAL STAFF BYLAWS

OF

OUR LADY OF VICTORY HOSPITAL, INC.

02/06/97 Approved by Medical Staff
02/19/97 Approved by Board of Directors

Amendment to Appendix B Approved:
11/06/97 by Medical Staff
11/19/97 by Board of Directors

Amended Bylaws Approved:
03/05/98 by Medical Staff
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5/3/07 by Medical Staff
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Medical Staff Bylaws Reviewed and Revised
5/7/09 by Medical Staff
6/17/09 by Board of Directors

PREAMBLE

WHEREAS, **Our Lady of Victory Hospital, Inc. is a nonprofit Corporation, organized under the laws of the State of Wisconsin, and**

WHEREAS, **their purpose is to serve as a Critical Access hospital with Medicare skilled swing beds, providing care, treatment and education, and**

WHEREAS, **it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authorities of the Hospital's Governing Body, and that the cooperative efforts of the Medical Staff, the Chief Executive Officer and the Governing Body, are necessary to fulfill the Hospital 's obligations to their patients .**

THEREFORE, **the physicians, dentists and podiatrists practicing in these institutions hereby organize themselves into a Medical Staff in conformity with these Bylaws.**

DEFINITIONS

1. The term **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, duly licensed to practice in the State of Wisconsin, and who are granted specific privileges to attend patients in Our Lady of Victory Hospital, Inc.

2. The terms **GOVERNING BODY, BOARD OF DIRECTORS, GOVERNING BOARD**, means the Board of Directors of Our Lady of Victory Hospital, Inc.

3. The term **EXECUTIVE COMMITTEE** means the Executive Committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Governing Body.

4. The term **CHIEF EXECUTIVE OFFICER** means the individual appointed by the Governing Body, to act in its' behalf, in the management of the Hospital .

5. The term **PRACTITIONER** means an appropriately licensed Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry or Doctor of Podiatry.

6. The term **CHIEF OF STAFF** shall refer to the President of the Medical Staff.

7. The term **CLINICAL PRIVILEGE OR PRIVILEGES** means the permission granted to a practitioner, or other allied health professional, 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. The term **MEDICAL STAFF YEAR** means a two (2) year period from January 1 to December 31.

9. The term **EX-OFFICIO** means serves as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means with voting rights.

10. The term **SPECIAL NOTICE** means written notification sent by Certified or Registered Mail, Return Receipt Requested, or hand delivered to the addressee.

11. The term **HOSPITAL** refers to Our Lady of Victory Hospital, Inc. and applies to both the Hospital and clinic operation.

12. The term **ALLIED HEALTH PROFESSIONAL** 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 member of the Medical Staff.

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 admitted or treated in any of the facilities, departments and services of the Hospital receive quality care;

(b) To provide an acceptable level of professional performance of all practitioners authorized to practice in the Hospital through appropriate delineation of the clinical privileges that each practitioner may exercise in the Hospital, and through an ongoing review and evaluation of each practitioner's performance in the Hospital;

(c) To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;

(d) To initiate and maintain rules and regulations for the self-governance of the medical staff;

(e) To provide a means whereby issues concerning the medical staff and the Hospital may be discussed by the Medical staff, with the Governing Body and Chief Executive Officer;

(f) To provide a means or method by which members of the medical staff can formulate recommendations for the Hospital's policy-making and planning procedures.

II.2 **The Responsibilities of the Medical Staff are:**

(a) To provide an appropriate level of professional performance of all members of the medical staff authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each member may exercise in the Hospital and through an ongoing review and evaluation of each member's performance in the Hospital.

(b) To provide a continuing education program fashioned, at least in part, on the needs demonstrated through patient care audit and other quality assessment and improvement programs.

(c) To provide a utilization review program to allocate inpatient medical and health services based upon determinations of individual medical, social and emotional needs consistent with sound health care resources utilization management.

(d) To provide an organizational structure that allows continuous monitoring and improvement of patient care practices.

(e) To participate in ongoing measurement, assessment and improvement of both clinical and non-clinical process and the resulting patient outcomes.

(f) To recommend to the Governing Body action with respect to appointments, reappointments, staff category, clinical privileges and corrective action..

(g) To assure the Governing Body that appropriate clinical procedures have been delineated.

(h) To account to the Governing Body for the quality and efficiency of patient care rendered to patients at the Hospital through regular reports and recommendations.

(i) To initiate and pursue corrective action with respect to members when warranted.

(j) To develop, administer, and seek compliance with these Bylaws, Rules and Regulations of the medical staff, and other patient care related Hospital and medical staff policies and procedures.

(k) To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.

(l) To conduct all its affairs involving the medical staff, patients, and employees in a willing manner and an atmosphere of civility, dignity and respect, 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.

(m) To carry out such other responsibilities as may be delegated by the Governing Body.

ARTICLE III MEDICAL STAFF MEMBERSHIP

III.1 **<u>Nature of Medical Staff Membership.</u>** 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 and podiatrists, 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 practitioner only such clinical privileges and prerogatives as have been granted by the Governing Body in accordance with these bylaws.

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 principle of the practitioner's profession, and conform his/her hospital practices to requirements of the Ethical and Religious Directives for Catholic Health Care Services of the United States Catholic Conference of Bishops are promulgated by the local diocese.

(f) Work with and relate to other practitioners, medical affiliates, members of professional review organizations and accreditation bodies in a manner essential for maintaining a hospital.

(g) Pledge not to receive from or pay to another practitioner, either directly or indirectly, any part of any fee received for professional services not actually rendered personally or at his/her direction.

(h) Provide for continuous care and supervision of patients, and refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner who is not qualified to undertake the responsibility and who is not adequately monitored.

(i) Promptly notify the Chief Executive Officer of revocation, limitation or suspension of his/her professional license or DEA registration, or the imposition of terms of probation or limitation of practice by any state, or of his/her loss of staff membership or privileges at any hospital or other health care institution, or of the cancellation of his/her professional liability insurance coverage, or of the commencement of a formal investigation, or the filing of charges by the Department of Health and Human Services, or any law enforcement agency, or health regulatory agency of the United States of the State of Wisconsin.

(j) Promptly notify the Chief Executive Officer within fifteen (15) days of receipt of notice of the filing of any suit against the practitioner alleging professional liability.

(k) Accept committee and consultation assignments as may be required by these Bylaws, Rules and Regulations.

(l) Discharge such other responsibilities as may be required by the medical staff, subject to the Governing Body’s approval.

III.3 <u>Qualifications for Membership.</u>

(a) Only practitioners licensed to practice medicine, dentistry or podiatry 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 practitioner shall be entitled to membership of the medical staff, or to the enjoyment of particular privileges, merely by virtue of the fact that he/she is duly licensed to practice medicine, dentistry or podiatry in this or in any other state, or by virtue of membership in any professional organization, or past or present privileges at another hospital. To qualify for membership on the Medical Staff, the individual must not be barred from providing services under Chapter HFS 12 of the Wisconsin Administrative Code.

(b) Practitioner 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.

(c) Practitioners shall document their background, experience, training and demonstrated competency. All practitioners shall participate in and be subject to the performance improvement activities of the Hospital and the medical staff.

(d) Practitioners shall document their adherence to the ethics of their profession and their good reputation.

(e) Practitioners shall be required to establish their ability to work compatibly with other practitioners and members of the supporting staff.

(f) As a part of their appointment and reappointment to the medical staff, or at any other time upon the request of the Governing Body or Executive Committee, practitioners 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 practitioner 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 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.

(g) Practitioners 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 practitioner's current license, DEA registration and insurance certificate each time these documents change or are updated.

(h) As part of their appointment and reappointment to the medical staff, practitioners have a continuing obligation to promptly notify the Chief Executive Officer 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; and

(v) receipt of notice of the filing of any suit against the practitioner alleging professional liability in connection with the treatment of any patient in or at the Hospital.

(vi) A practitioner 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.

(i) 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.

(j) As part of their appointment and reappointment to the medical staff, practitioners 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.

(k) The Governing Body shall solely determine whether to select or reject medical staff based on the limitations of facilities, services, staff, support capabilities or any qualified practitioner in accord with criteria of a medical staff development plan or due to the existence of any contracts for exclusive provision of clinical services, shall be made by the Governing Body.

(l) The foregoing qualifications shall not be deemed exclusive by other qualifications and conditions deemed by the Hospital and the medical staff to be relevant in considering an applicant's application for exercising privileges in the Hospital.

(m) <u>Administrative and medical administrative officers.</u> A practitioner 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, a practitioner 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 <u>Ethics and Ethical Relationships.</u>

(a) By accepting membership on the medical staff, a practitioner specifically agrees to abide by the Rules and Regulations of the medical staff and the Code of Ethics of the American Medical, Dental, Osteopathic or Podiatry Association, whichever is applicable, 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 practitioner, either directly or indirectly, any part of a fee received for professional services not actually rendered personally or at their direction. Further, all members shall pledge that they will provide continuous care for their patients, and refrain from delegating the responsibility for diagnosis or care of

hospitalized patients to a practitioner who is not qualified to undertake the responsibility and who is not adequately supervised. The member must agree to furnish the Hospital with a current list of alternates, and when the member is unavailable, he or she must notify the Hospital of alternative clinical coverage to be provided by a medical staff member with comparable privileges of the attending member.

(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 shall be deemed automatically amended to comply with such law or regulation. As soon thereafter as may be practicable, such change shall be made in writing in the Bylaws or Rules and Regulations.

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 as provided in these bylaws.

(b) Initial appointments shall be for a period of six (6) months. Reappointments shall be made through the Practitioner's birth month of the remainder of a medical staff year. Thereafter, reappointments shall be made for a period of not more than one medical staff year, and such period of reappointment shall commence on the date of the medical staff member's birthday. The medical staff year is a two-year period commencing in odd numbered years (i.e. 1997-99, 1999-01, etc.) Example: Dr. Smith is initially appointed and received medical staff privileges in November, 1996. He is granted initial appointment for six months (through April, 1997). Dr. Smith's birthday is in the month of February. He would need to be reappointed to the medical staff in February, 1999 for one medical staff year expiring in February, 2001.

(c) Appointment to the medical staff shall confer on the appointee only such clinical privileges as have been recommended by the Medical Executive 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 and shall contain the applicants acknowledgement of every medical staff members' obligation to provide continuous care and supervision of his/her patients, to abide by the medical staff bylaws, rules and regulations and to accept committee assignments and to accept consultation assignments.

ARTICLE IV CATEGORIES OF THE MEDICAL STAFF

IV.1 **The Medical Staff**. The medical staff shall consist of Honorary, Active and Courtesy/Consulting Staff categories.

IV.2 **The Active Medical Staff.**

(a) The Active medical staff shall consist of those practitioners who regularly admit patients to, or are otherwise regularly involved in the care of patients in the Hospital, who are located close enough to the Hospital to provide proper care to their patients, and who assume all the functions and responsibilities of membership on the active medical staff. "Regularly" as used for a qualification, shall be determined by the Governing Body, but envisions staff members whose principal hospital affiliation is Our Lady of Victory Hospital.

(b) New members of the Active medical staff must have completed the provisional status set forth in Section VI.2, or served on the Courtesy/Consulting medical staff and have been regularly involved in the care of twelve (12) or more patients at the Hospital. This requirement may be waived in unusual circumstances by the Executive Committee and with approval of the Governing Body. They must have attained acceptable qualifications in their field of practice according to current national standards and have an active interest in the operation of the Hospital.

(c) Members of the active medical staff shall promote the quality of medical care in the Hospital, offer sound counsel to the Chief Executive Officer 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 required 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, 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.4 **The Courtesy/Consulting Staff.** The Courtesy/Consulting medical staff shall consist of those practitioners qualified for staff appointment but who, on a limited or occasional basis, provide direct patient services to the Hospital or who provide necessary consultations in areas of subspecialty. Practitioners who have been regularly involved in

the care of twelve (12) or more patients at the Hospital on an inpatient or outpatient basis in any calendar year shall apply for Active medical staff status at the direction of the Medical Executive Committee. A member of the Courtesy/Consulting 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 Executive Committee with the approval of the Governing Body. Members of the Courtesy/Consulting medical staff shall not be eligible to vote or hold office but may be permitted to serve on medical staff committees and attend medical staff meetings. Courtesy/Consulting medical staff members shall pay dues as established by the Medical Executive Committee.

IV.5 **<u>The Honorary Medical Staff.</u>** The Honorary Medical Staff shall consist of those practitioners who are not active in the Hospital and who are honored by Emeritus positions. These may be former members of the Active medical staff who have retired from active hospital services, or members of outstanding reputation. Honorary Staff members shall have no assigned duties and they shall not have privileges to admit or treat patients in the hospital. Honorary Staff members shall not be eligible to vote or hold office, but may serve on medical staff committees, except the Executive and Credentialing Committees.

IV.6 **<u>Appointments, Provisional.</u>** All initial appointments to the medical staff shall be provisional for a period of six (6) months. Reappointment to the provisional status may not exceed one (1) full medical staff year, at which time, the failure to advance an appointee from provisional to regular staff status shall be deemed a termination of his/her staff appointment. A provisional appointee, whose membership is so terminated shall have the rights accorded by these bylaws to a member for the medical staff who has failed to be reappointed.

IV.7 **<u>Dental and Podiatric Staff Functions.</u>**

(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/Consulting 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 an Active physician member of the Medical Staff 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, an Active physician member of the Medical Staff 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 physician.

(ii) Surgical procedures performed by dentists and podiatrists shall be done under the overall supervision of the chief of surgery or his/her designee.

(iii) At the time of surgery admission, the name of the responsible Active staff member must appear on the appropriate forms. This physician shall be responsible for pre- and post-operative medical care of the patient, except as provided in section (iv) below.

(iv) The dentist or podiatrist may discharge the patient after obtaining the concurrence of the an Active physician member of the Medical Staff or in compliance with approved standing discharge orders.

(v) Complete records, both 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 physician member of the medical staff with appropriate clinical privileges to be responsible for the care of any medical problem that may arise. If granted clinical privileges to do so, oral surgeons may, in lieu of a physician member of the medical staff, perform the admission history and physical examination and assess the medical risks of the proposed surgical procedures on those patients admitted without medical problems.

ARTICLE V PROCEDURE FOR APPOINTMENT & REAPPOINTMENT

V.1 <u>Application for Appointment.</u>

(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 Executive Committee and approved by the Governing Body. 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 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 HFS 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 Credentials 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 HFS 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 Chief Executive Officer. After collecting and verifying references and other materials deemed pertinent, he/she shall transmit the application and all supporting materials to the credentials

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 Executive Committee and any consultants deemed appropriate by the Executive 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 <u>Appointment Process.</u>

(a) The Chief Executive Officer or his/her designee will obtain verifying information from the National Practitioner 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 Practitioner 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 Credentials Committee shall make a written recommendation to the medical staff that the practitioner be provisionally appointed to the medical staff, 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 Credentials Committee shall examine evidence of the character, professional competence, qualifications and ethical standing of the practitioner, and shall verify, through information obtained in references, given by the practitioner 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 Article) of these Bylaws. The Credentials Committee shall transmit its recommendation to the medical staff, along with the completed application and all other documentation considered in arriving at its recommendation. A majority vote of the medical staff is required for action on the recommendation.

(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 Medical Executive Committee is favorable to the practitioner, the Chief Executive Officer shall promptly forward it along with all supporting documentation, to the Governing Body. A majority vote of the Governing Body is required for action on the recommendation.

(f) When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed-up within ninety (90) days with a subsequent recommendation for provisional appointment with specified clinical privileges or for rejection of staff membership.

(g) When the recommendation of the Medical Executive Committee is adverse to the practitioner, either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the practitioner by Certified Letter, within ten (10) working days. No such adverse recommendation need be forwarded to the Governing Body until after the practitioner has exercised or has waived his/her right to a hearing, as provided in the Fair Hearing Plan.

(h) If, after the Medical Executive Committee has considered the report and recommendation of the hearing committee and the hearing record, and if the Medical Executive Committee's reconsidered recommendation is favorable to the practitioner, it shall be processed in accordance with section V.2.(e). If such recommendation continues to be adverse, the Chief Executive Officer shall promptly so notify the practitioner by Certified Mail, within ten (10) working days. The Chief Executive Officer shall also forward such recommendation and documentation to the Governing Body, however, the Governing Body shall not take any action thereon until after the practitioner has exercised or has been deemed to have waived his/her rights to an appellate review, as provided in the Fair Hearing Plan.

(i) 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 practitioner with respect to either appointment or clinical privileges, the Chief Executive Officer 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 practitioner 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(e). The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

(j) At its next regular meeting, after all the practitioners' 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 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 provisionally the practitioner to the staff or to reject him/her for staff membership. All decisions to appoint shall include delineation of the clinical privileges which the practitioner may exercise.

(k) Whenever the Governing Body's decision shall be contrary to the medical staff recommendation, the Governing Body shall meet with the Medical Executive Committee before making the final decision.

(l) When the Governing Body's decision is final, it shall send notice of such decision through the Chief Executive Officer, to the chairman of the Medical Executive Committee, and by Certified Mail, to the applicant.

V.3 Reappointment Process.

(a) The Chief Executive Officer will provide each staff member scheduled for reappointment with a reappointment application form at least 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 Chief Executive Officer 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 practitioner 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 including, without limitation:

(i) Changes in medical staff membership or clinical privileges at any other hospital or institution, including, without limitation, any revocation, suspension, reduction, limitation, denial or non-renewal thereof, whether voluntary or involuntary;

(ii) Suspension or revocation of licensure or registration (state, district or DEA) or any reprimand or imposition of sanctions related thereto or suspension or revocation of membership or imposition of other sanctions by any local, state or national professional society;

(iii) Any malpractice claims, suits, settlements or judgments, whether pending or finally determined and any refusal or cancellation of professional liability insurance;

(iv) Any additional training, education or experience relevant to the privileges sought on reappointment;

(v) Any criminal conviction or pending criminal charges and provide updated information regarding any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient/resident or has misappropriated the property of any patient/resident. Applicants must submit a fully completed Background Information Disclosure from with the completed application;

(vi) Current evidence of licensure and DEA registration and of professional liability insurance coverage; and

(vii) Documentation of the health assessment required under state regulations on persons providing direct patient services in the Hospital and reporting

of any adverse findings relevant to the applicant's exercise of clinical privileges, and current physical and mental ability to safely perform the responsibilities of membership and to safely exercise clinical privileges requested with or without accommodation.

(c) All promotions in or 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 practitioner's current appointment, the credentials committee shall complete its review of all pertinent information available on each practitioner 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 years and shall transmit its recommendations, in writing, to the Executive Committee. 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.

(e) The results of performance improvement activities, and the monitoring performed during a term of provisional appointment, if applicable, shall be considered in the appraisal of the applicant's professional performance, judgment and technical and/or clinical skills.

(f) Any Credentials 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.

(g) 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

(h) Prior to the last scheduled Governing Body meeting before the expiration of the practitioner's current appointment, the Executive Committee shall make its recommendations to the Governing Body concerning the reappointment or nonreappointment and the continuation or alteration of privileges for the ensuing two years of each member of the medical staff scheduled for reappraisal. 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. Reappointments to the medical staff with delineation of privileges, shall be made biannually by the Governing body.

(i) When the recommendation of the Executive Committee is negative, prior to any referral of the recommendation to the Governing Body for action, the practitioner 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 Chief Executive Officer on the prescribed forms. The application shall be processed in the same manner as provided in section V.2(e) above for reappointment. Any grant of new, extended or increased clinical privileges shall be subject to evaluation as set forth in Article V and to monitoring as set forth in section e.

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 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 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 medical staff or

Governing Body may require in demonstration that the basis for the earlier adverse action no longer exists.

(d) If the recommendation of the medical staff or the action proposed by the Governing Body upon reapplication under section V.5 continues to be adverse, the scope of the hearing to which the practitioner is entitled shall be limited to consideration of the sufficiency of the additional information submitted in demonstration that the basis for the earlier adverse action no longer exists.

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 Chief Executive Officer. Failure of a practitioner 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 practitioner will be required to submit a request for reinstatement in writing to the Chief Executive Officer and the credentials committee who will review the request and make recommendation to the Executive Committee and 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 Chief Executive Officer and the president of the medical staff. 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 <u>Clinical Privileges Restricted.</u>

(a) Every practitioner 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.3 and VI.4 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 the Active Medical Staff, to assure competence. They shall be part of the overall Hospital Performance Improvement Plan, which is accountable and reports to the Medical Staff Executive Committee. These professionals are not Members of the Medical Staff, however, are monitored by the Medical Staff.

(g) Privileges granted to Allied Health Staff shall be based upon their training, experience and demonstrated competence and judgment, within the scope of their license. This individual will provide medical or surgical care under the supervision of a practitioner who has been accorded privileges to provide such care in the Hospital. The scope of privileges granted to Allied Health Staff shall be specifically provided for in the Allied Health Practitioner Policy.

VI.2 Provisional Appointments and New Clinical Privileges: Monitoring Protocol.

(a) During the term of any provisional appointment to the medical staff, it will be the responsibility of the chief of the medical staff to provide or arrange to orient the practitioner, and establish and oversee a monitoring protocol.

(b) The initial cases in which a member of the provisional staff admits and treats, or participates as a non-admitting practitioner, and the initial cases in which any medical staff member exercises new or increased clinical privileges, shall be reviewed by means of the monitoring protocol. The process shall recommend to the Executive Committee in advance either a fixed number of cases or a fixed time period in which all cases will be reviewed for the individual member subject to review according to the volume of cases in which the practitioner is expected to participate so that a sufficient number of cases will have been performed for the Executive Committee to make a determination about the need for continued review. At the conclusion of the cases or period of time set by the Executive Committee, the Executive Committee shall recommend that the monitoring be terminated or that an additional period of monitoring be established. The Executive Committee may extend the monitoring of a practitioner for an additional period, with no further action being required by the Governing Body, and, the practitioner shall not be entitled to a hearing or review under the Fair Hearing Plan on the decision to attend monitoring for one additional period. Any decision to extend the monitoring protocol beyond the term of the next renewal appointment following the initial provisional appointment or of the first grant of the new or increased clinical privileges must be ratified by the Governing Body, and the decision is subject to review in accord with the Fair Hearing Plan.

(c) During the provisional appointment, the monitoring protocol shall afford the Hospital and the practitioner the following:

(i) The ability to establish pretreatment consultation requirements.

(ii) A current review of the clinical abilities of a practitioner.

(iii) A resource person or committee with whom the practitioner can or must seek consultation.

(iv) A resource in the form of the monitoring committee with whom other staff members or Hospital personnel may confer concerning the provisional appointee.

(v) A basis for recommending privileges at the completion of the provisional appointment.

VI.3 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) Practitioners applying for temporary privileges under this clause must be licensed in Wisconsin, and meet at least one of the following criteria:

(1) be an active staff member in good standing at another health care facility; or

(2) have a sponsor on the medical staff who is willing to assume responsibility for the practitioner.

(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 practitioner only by the Chief Executive Officer after recommendation by the President of the medical staff, allowing him to attend or consult upon specific patients in the Hospital, provided an Active or Provisional Active staff member is responsible for admission and general care of the patient. 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 practitioner shall be required to apply for medical staff membership.

(d) A practitioner 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 Executive Committee, subject to the approval of the Governing Body. The practitioner engaging the locum tenens practitioner must, at least thirty (30) days prior to the period of temporary privileges requested, file a letter requesting temporary privileges for the locum tenens practitioner, acknowledging responsibility for his/her actions and quality of practice. Temporary privileges may be granted for the locum tenens practitioner 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 practitioners exercising temporary privileges shall do so under the supervision of an Active medical staff member.

(f) No practitioner is entitled to temporary privileges as a matter of right. A practitioner shall not be entitled to the procedural rights afforded by the Fair

Hearing Plan because of his/her inability to obtain temporary privileges or because of any termination, modification or suspension of temporary privileges.

(g) Temporary privileges may be terminated or suspended at any time at the direction of the Chief Executive Officer on the recommendation of the president of the medical staff. Any such action shall not be subject to the procedural rights afforded by the Fair Hearing Plan. The practitioner 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 practitioner 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.

(h) Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested. Special requirements of consultation and reporting may be imposed by the Medical Executive Committee. Before temporary privileges are granted, the practitioner 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.

(i) Practitioners applying for temporary privileges under this section must satisfy the requirements regarding professional liability insurance, health status and the Wisconsin caregiver background check.

VI.4 Emergency Privileges.

In the case of an emergency, any practitioner, to the degree permitted by his or her license, and regardless of department or staff status, or lack of it, shall be permitted to provide any type of patient care necessary, as a life-saving measure, or to prevent serious harm, regardless of medical staff status or clinical privileges, as long as the care provided is within the scope of the individual license. When an emergency situation no longer exists, the medical staff member must request the necessary privileges, to continue to treat the patient. In the event such privileges are denied, or he/she does not desire to request privileges, 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.

The following shall be express conditions to any individual's application or reapplication for, or exercise of, clinical privileges or medical staff membership at the Hospital:

(a) 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.

(b) Such privileges shall extend to members of the medical staff, administration and Governing Body, the Chief Executive Officer 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.

(c) There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation or disclosure, even where the information involved would otherwise be deemed privileged.

(d) 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:

(i) Applications for appointment or clinical privileges;

(ii) Monitoring of members of the provisional staff or of any other practitioner or medical affiliate under the monitoring protocol established by the medical staff,

(iii) Periodic reappraisals for reappointment or clinical privileges;

(iv) Corrective action, including suspension;

(v) Hearings and appellate reviews;

(vi) Medical care evaluations;

(vii) Utilization reviews;

(viii) Profiles and profile analysis;

(ix) Malpractice loss prevention; and

(x) Other Hospital, departmental, service or committee activities related to quality patient care and interprofessional conduct.

(e) The acts, communications, reports, recommendations and disclosures referred to in this section may relate to an individual's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

(f) 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 Chief Executive Officer 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.

(g) 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 specified in section O, 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.

(h) The consents, authorizations, releases, rights, privileges and immunities provided under Article O of these bylaws for the protection of this Hospital's practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial 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 Officers of the Medical Staff

The officers of the medical staff shall be:

(a) President
(b) Secretary-Treasurer

VIII.2 Qualifications for Officers.

Officers must be members of the Active medical staff at the time of nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The officers shall be practitioners with demonstrated competence in their fields of practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of Hospital and medical staff activities.

VIII.3 Election of Officers.

(a) Officers shall be elected at the annual meeting of the medical staff. Only members of the Active medical staff shall be eligible to vote.

 (i) A majority vote will be required for election of officers.

 (ii) A quorum of the medical staff must be present at the time of election of officers. A quorum shall constitute fifty-percent (50%) of the Active medical staff.

(b) Nominations may be made from the floor at the time of the meeting. Individuals must receive a second and further must indicate a willingness to serve, if elected.

VIII.4 Terms of Office.

All officers shall serve a one (1) Medical Staff Year from the election date. Officers shall take office on the first day of the medical staff year and may be reelected for one (1) additional consecutive term.

VIII.5 Vacancies in Office.

Vacancies in office during the medical staff year, except for the presidency, shall be filled by appointment by the Executive Committee of the medical staff. If there is a vacancy in the office of president, a special election shall be held to fill that vacancy. This shall be accomplished at the next regular staff meeting. Special notice will be sent to all members of the medical staff seven (7) days prior to the meeting, notifying them of the special election.

VIII.6 Duties of the President.

(a) The president shall serve as chief administrative officer of the medical staff.

(b) Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the Hospital.

(c) Call, preside at and be responsible for the agenda of all general meetings of the medical staff.

(d) Serve as the chair of the medical staff Executive Committee.

(e) 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 practitioner.

(f) Appoint committee members to all standing, special and multi-disciplinary medical staff committees, except the Executive Committee.

(g) Represent the views, policies, needs and grievances of the medical staff to the Governing Body and the Chief Executive Officer.

(h) Establishes, together with the medical staff and administration, the type and scope of services required to meet the needs of the patients and the Hospital.

(i) Document and implement policies and procedures which guide and support the provision of services in the Hospital.

(j) Participates in making recommendations to the medical staff for the establishment of criteria for clinical privileges in the Hospital.

(k) Makes recommendations for clinical privileges for each member of the Hospital medical staff.

(l) Provides continuing surveillance of the professional performance of all individuals with clinical privileges in the Hospital.

(m) Leads the assessment and improvement of both clinical and nonclinical processes and the resulting patient outcomes.

(n) Receive and interpret the policies of the Governing Body to the medical staff and report to the Governing Body on the performance and improvement of quality; with respect to the medical staff's designated responsibility to provide medical care.

(o) Be responsible for the education activities of the medical staff, subject to the policies of the Governing Body.

(p) Shall serve as an Ex-Officio (non-voting) member of the Governing Body.

(q) Be a spokesperson for the medical staff in its external, professional and public relation matters.

VIII.7 Secretary-Treasurer.

(a) The secretary-treasurer shall be a member of the Executive Committee of the medical staff.

(b) The secretary-treasurer will keep accurate and complete minutes of all medical staff meetings, call medical staff meetings on order of the president, attend to all correspondence and perform such other duties as ordinarily pertain to this office. If there are funds he/she shall also act as Treasurer taking responsibility over those funds if so present

VIII.8 Eligibility for Reelection.

(a) A staff member who has served as president may not serve more than two (2) consecutive Medical Staff Year terms.

(b) A staff member who has served as Secretary-Treasurer may not serve more than two (2) consecutive Medical Staff Year terms.

VIII.9 Resignation & Removal from Office.

(a) Resignation. Any general staff officer may resign at any time, giving written notice to the Executive Committee. Such resignation takes effect on the date of receipt or at any later time specified in it.

(b) Removal. Removal of a general staff officer may be affected by the board acting on its own initiative, or by a two-thirds (2/3) vote by secret ballot of the members of the staff eligible and qualified to vote for staff officers; such vote being taken at a special meeting called for that purpose.

Permissible basis for removal of a general staff officer include, with limitation:

(i) failure to perform the duties of the position held, in a timely and appropriate manner;

(ii) failure to satisfy, continuously, the qualifications of that particular position;

(iii) if the officer is currently under corrective action proceedings.

ARTICLE IX COMMITTEES

IX.1 Composition of the Executive Committee.

The Executive Committee shall be a standing committee and shall consist of all active members of the medical staff, in good standing. The Executive Committee shall operate as a committee of the whole.

(a) The president of the medical staff shall automatically be chair of the Executive Committee.

(b) The Chief Executive Officer shall be an Ex-Officio member without vote, and he/she shall sit with the committee at all times.

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 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 monthly and maintain a permanent record of its proceedings and actions. The majority of the Executive Committee members must be fully licensed physicians who are members of the active medical staff.

This committee shall be responsible:

(a) to represent the medical staff and to act on its behalf as needed under such limitations as may be imposed by these bylaws;

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

(c) to coordinate the activities and general policies of the various committees, as required;

(d) to receive and act upon committee reports;

(e) to implement policies of the medical staff;

(f) 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;

(g) to provide liaison between medical staff and the Chief Executive Officer and the Governing Body;

(h) to recommend action to the Chief Executive Officer on matters of a medico-administrative nature;

(i) to make recommendations to the Governing Body, including long-range planning;

(j) to fulfill the medical staff's accountability to the Governing Body for the medical care rendered to the patients in the hospital. The Executive Committee shall monitor all medical care performance improvement activities, make recommendations to the Governing Body on the organization, if such activities, and be responsible for taking any necessary and appropriate action or delegating the responsibility for such action to the appropriate medical staff or multidisciplinary committee or group;

(k) to ensure that the medical staff is kept abreast of the accreditation status of the hospital.

(l) to provide for the preparation and presentation of all the programs of all meetings either directly or through delegation to a program committee or other suitable agent;

(m) to report at each general staff meeting;

(n) to review the credentials of all applicants and to make recommendations for medical staff membership and delineation of clinical privileges;

(o) to review periodically all information available regarding the performance and clinical competence of medical staff members and others with clinical privileges;

(p) to consider amendments to the Rules and Regulations of the medical staff as necessary for the proper conduct of its work;

(q) to be responsible for making recommendations to the Governing Body relating to the structure of the medical staff, the mechanism used to conduct, work at and revise the performance improvement activities of the medical staff, the mechanisms used to review credentials and delineate individual clinical

privileges; the mechanisms by which memberships on the medical staff may be terminated; and the mechanism for fair hearing procedures;

(r) to have overall responsibility for all medical staff accreditation policy and procedure specific functions of this responsibility may be delegated to appropriate medical staff members and committees; and

(s) to perform such other functions as may from time to time be delegated by the medical staff or the Governing Body.

(t) to provide recommendations to (the Executive Committee and) the Governing Body on all matters relating to the appointment, reappointment, staff category, clinical privileges and corrective actions by:

(i) reviewing and evaluating the qualifications of each applicant for initial appointment, reappointment or modification of appointment, and for clinical privileges;

(ii) reviewing and evaluating the qualifications of each allied health professional applying for clinical privileges;

(iii) submit recommendations on the qualifications of each applicant for staff membership or particular clinical privileges and of each allied health professional; such recommendations shall be with respect to appointment, staff category, clinical privileges and special services.

(u) Account to the Governing Body and to the staff for the overall quality and efficiency of patient care in the Hospital.

IX.3 Performance Improvement Activities.

The Medical Staff has a leadership role in organization’s performance improvement activities by providing leadership for the process measurement, assessment and improvement. These processes include , though are not limited to, those within the:

- Medical Assessment and treatment of patients;
- Use of Medications;
- Use of blood and blood components;
- Use of operative and other procedures;
- Accurate, timely and legible completion of patients’ medical record.

Performance Improvement is carried out through various committees within the facility, all of which report directly to the Executive Committee. Committees are as follows:

(a) Credentialing Committee.

Professional staff clinical privileges outlined in the bylaws will be reviewed on a periodic basis, with input from Performance Improvement activities, which will be used to assure that privileges and credentials are commensurate with the professional's actual practice and abilities.

(b) Surgical Committee.

Surgical case review is performed every other month by members of the Surgical Committee, to continuously improve the selection and performance of surgical and invasive procedures.

(i) Blood Usage Review is evaluated by members of the Surgical Committee, on a monthly basis, with the focus on the most important blood/blood components, by the Pathologist member.

(ii) Tissue Review.
An intensive evaluation is completed every other month, performed for cases in which there are major discrepancies between preoperative and pathological diagnoses, by the Pathologist member.

One physician is elected Chairman, two other medical staff members participate.

(c) Pharmacy & Therapeutics

Pharmacy & Therapeutics committee meets quarterly to develop and approve policies and procedures relating to the selection, distribution, handling, use and administration of drugs; develops and monitors a drug formulary; and to provide definition and review of all significant untoward drug reactions and medication errors. (Not a committee – a review process)

(i) Drug Usage Evaluation (DUE) is reviewed by the Pharmacy &Therapeutics Committee on a quarterly basis.

(d) Infection Control.

Infection Control Committee meets at least quarterly and shall consist of at least two physicians; one of whom is an active staff member and presides as chairman, and a designated Pathologist. The purpose of the Infection Control Committee shall be to prevent, investigate and control Hospital/Swing Bed acquired infections.

(e) Safety/Risk Management Committee.

The Safety/Risk Management Committee meets quarterly to monitor and evaluate facility-wide safety practices in an effort to minimize safety hazards to patients, employees and visitors, while providing a system to control all risk factors involved. The Medical Staff actively participates, as appropriate, in Safety/Risk Management Committee activities, related to the clinical aspects of patient care and safety. The President serves as Chairman of the Safety/Risk Committee.

(f) Utilization Review/Discharge Planning.

The Utilization Review Program addresses over-utilization, under-utilization and inefficient scheduling of resources. There is a written, formal Utilization Review Plan.

(g) Ethics Committee.

The Ethics Committee meets quarterly and is designed to consider and discuss ethical issues arising in patient care, and to provide guidance in addressing ethical concerns within the framework of the institution's philosophy. The Chief Executive Officer serves as Chairman, with one active medical staff member appointed by the Chief of Staff.

(h) Emergency Room Committee.

The Emergency Room Committee meets to monitor and evaluate the quality and appropriateness of emergency services furnished at the Hospital. One medical staff physician is elected Chairman and one PA-C or NP appointed. The Committee meets quarterly.

IX.4 Composition of Committees.

Each designated Committee shall consist of at least:

(a) Medical Staff representatives, appointed for a term of two years. As provided for in these bylaws, he/she may repeat a term of service for at least one additional two-year period.

(b) Chief Executive Officer and/or VP Nursing and Clinical Services.

(c) Recording Secretary assigned by Health Information Management.

(d) All appropriate personnel.

IX.5 Responsibilities of Physician Clinical Services Director.

(a) All clinically related activities of the clinical services.

(b) All administratively related activities of the clinical services.

(c) Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the clinical services.

(d) Recommendations to the Medical Staff of the criteria of the clinical privileges in the clinical services.

(e) Recommending clinical privileges for each member of the clinical services.

(f) Development and implementation of policies and procedures that guide and support the provision of services;

(g) Recommendations for a sufficient number of qualified and competent persons to provide care or services;

(h) The continuous assessment and improvement of the quality of care and services;

(i) The maintenance of quality control programs as appropriate.

(j) Recommendations for space and other resources needed by the department.

IX.6 Reports.

A written report of conclusions, recommendations, actions taken and the results of actions taken are monitored and reported to the Executive Committee.

IX.7 Service on Committees.

It shall be mandatory for each active staff member to serve in a committee function unless he/she can demonstrate some very compelling reason, satisfactory to the chief of the medical staff, why he/she should not function as a member of a committee. Committee members, in the event of malfeasance, may be removed from that committee by simple majority vote of the active staff and/or Executive Committee.

ARTICLE X COMMITTEE MEETINGS

X.1 Regular Meetings.

Committees may, by resolution, provide the time for holding regular meetings without notice, other than such resolution.

X.2 Special Meetings.

A special meeting of any committee may be called by or at the request of the chairman, or by the president of the medical staff.

X.3 Notice of Meetings.

Written or oral notices, stating the place, date and hour of any special meeting or of any regular meeting, not held pursuant to resolution, shall be given to each member of the committee not less than three (3) days before the time of such meeting, by the person(s) calling the meeting.

X.4 Quorum.

Fifty (50%) of the actual medical staff members of a committee shall constitute a quorum at any meeting.

X.5 Manner of Action.

The action of a majority of the members present at a meeting in which a Quorum is present shall be the action of the committee. Action may be taken without a meeting by unanimous consent in writing, signed by each member entitled to a vote.

X.6 Rights of Ex-Officio Members.

Persons serving under these bylaws as Ex-Officio members of a committee shall have all rights and privileges of regular members except that they shall not be counted in determining the existence of a Quorum.

X.7 Minutes.

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of the members and the vote taken on each matter. The minutes shall be signed by the presiding officer and a copy forwarded to the Executive Committee. Each committee shall maintain a permanent file of minutes of each meeting.

X.8 Attendance Requirement.

Each committee member shall be required to attend not less than fifty (50%) percent of all meetings of his/her assigned committee(s) for each year. The failure to meet the foregoing attendance requirements, unless excused by the committee chairman for good cause shown, shall be grounds for corrective action leading to the revocation of the membership in the same manner and to the same effect as provided in section VIII.9, of these bylaws. Committee chairpersons shall report such failures to the president of the staff for action.

ARTICLE XI MEDICAL STAFF MEETINGS

XI.1 Regular Meetings.

Staff meetings shall be held at a minimum of ten (10) times per year, to review and evaluate the medical performance of the staff, quality review of activities and to consider and act upon committee requests.

XI.2 Annual Meeting.

The first meeting in each calendar year shall be considered the annual meeting at which any election of officers for the ensuing period shall be conducted.

XI.3 Time and Place.

The chief of staff shall by standing resolution, designate the time and place for all regular staff meetings. Notice of the original resolution and any changes thereto will be given to each staff member in the same manner as provided in section X.3 for notice of a special meeting.

XI.4 Special Meetings.

The president of the staff, the Executive Committee and any member of the active staff, with prior approval of the president of the medical staff, may at any time file a request with the president that a special meeting of the medical staff be called. The president of the staff shall designate the time and place of any such special meeting.

XI.5 Notice.

Notice of the special meeting shall be by special notice 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.6 Quorum.

The presence of fifty (50%) percent of the total membership of the active medical staff, at any regular or special meeting, shall constitute a Quorum. The Active Staff membership shall be defined at each January meeting.

XI.7 Attendance Requirements.

Each member of the active medical staff shall be required to attend the regular annual meeting of the medical staff and at least seventy-five percent (75%) or more of all other regular medical staff meetings, in each staff year. A member who is compelled to be absent from any regular staff meeting shall report to the president of the medical staff

his/her reason for such absence. Unless excused for cause by the president of the medical staff, the failure to meet the foregoing annual attendance requirements shall be grounds for corrective action, leading to the revocation of medical staff membership. Reinstatement of staff members whose membership has been revoked because of absence from staff meetings shall be made only upon application, and all such applications shall be processed in the same manner as applications for original appointment.

XI.8 Regular Meeting Agenda.

The Agenda at any regular medical staff meeting shall be:

(a) Call to Order

(b) Approval of Executive Committee Meeting Minutes

(c) Review and Approval of Sub-Committee Meeting Minutes

(d) Monitoring and Evaluating Issues

(e) Continuity of Service Review

(f) Old Business

(g) New Business

(h) President's Report

(i) Adjournment

Xl.9 Special Meeting Agenda.

The Agenda at special meetings of the medical staff shall be:

(a) Reading of the Notice calling the meeting.

(b) Transaction of the business for which the meeting was called.

(c) Adjournment.

X1.10 Eligibility to Vote.

Only members in good standing of the Active Staff shall be eligible to vote for the election of officers, or for any other matters which are presented for vote at a general 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 Active Medical Staff at least five (5) days in advance of a regular monthly meeting of the medical staff. The proposed bylaws may then be acted upon at the regular monthly meeting of the medical staff provided a quorum is present. A proposed change in bylaws will be passed if a majority of all members of the active staff entitled to vote 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 active 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 and 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, as well as in body, the level of practice that is to be required for each practitioner in the Hospital. Such rules and regulations may be amended or repealed at any regular meeting at which a quorum is present, and without previous notice, or at any special meeting on notice, by a two-thirds (2/3) vote of those present, of the Active medical staff. Such changes shall be effective when approved by the Governing Body.

ARTICLE XIV ADOPTION

These bylaws, together with the appendant Rules and Regulations, shall be adopted at any regular or special meeting of the active medical staff and shall replace any previous Bylaws, Rules and Regulations, and shall become effective when approved by the Governing Body of the Hospital.

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 president of the medical staff. Recommendations will be presented to the medical staff for action as provided for in Article XII of these bylaws.

APPENDIX A

Physician Assistant Role & Responsibility
OUR LADY of VICTORY HOSPITAL

I. A Physician Assistant must hold a current certificate from the Wisconsin Medical Examining Board to practice as a Physician Assistant in Wisconsin.

II. The Physician Assistant Practice:

A. The entire practice of any Physician Assistant shall be under the supervision of a licensed physician.

B. A physician Assistant's practice may not exceed his/her educational training or experience and may not exceed the scope of practice of the supervising physician. A task assigned by the supervising physician, to the Physician Assistant, may not be delegated by the Physician Assistant, to another person.

C. Patient Services: A Physician Assistant may perform the following services:

1. Obtain a personal medical history and perform an appropriate physical examination and record and present pertinent data, concerning the patient, in a manner meaningful to the supervising physician. This means a patient of any age, in any setting.

2. Perform or assist in performing, routine diagnostic studies as appropriate, for a <u>specific</u> practice setting

3. Perform routine therapeutic procedures, including injections, immunizations, suturing and care of wounds, as the protocol form.

<u>Examples:</u>

a. Injections
b. CPR
c. Intravenous lines
d. Suturing and wound care including the administration of local anesthesia
e. Apply, adjust and remove casts, splints, and traction devices, including skeletal traction.
f. Order I.V. fluids, scheduled medications as described in WI Code Chapter 8, and routine medications described in the <u>Federal Substance Act of 1970</u>.
g. Order routine laboratory work, x-ray, diet therapy, and rehabilitation therapy, as appropriate for a specific practice setting.

h. Perform emergency evaluation and treatment in life-threatening situations and immediately reporting to the supervising physician.
i. Assist supervising physician in surgery.
j. Make patient rounds and record progress in patient record.
k. Perform patient assessment and treatment in the Emergency Room, as appropriate for the specific practice setting. Notification of the supervising physician would be per existing backup (Emergency Room physician protocols; i.e. admissions, transfers, codes, fractures.) Availability of supervising physician will be according to State Regulation (in person or within fifteen (15) minutes of contact by telephone, 2-way radio or television communication.
l. Provide patient education/counseling including:

    (1) diet
    (2) disease
    (3) modes of treatment
    (4) normal development
    (5) pre/past outpatient teaching
    (6) rehabilitation
    (7) facility referrals to community agencies, after consultation with supervising physician
    (8) write take home prescriptions in compliance with supervising physician's written protocols.

4. Instruct and counsel a patient on physical and mental health, including diet, disease, treatment and normal growth and development.

5. Assist the supervising physician in a hospital or facility, by assisting in surgery, making patient rounds, recording patient progress notes, compiling and recording detailed narrative case summaries and accurately writing or executing standing orders or other specific orders, following consultation with and at the direction of the supervising physician.

6. Assist in the delivery of services to a patient by reviewing the monitoring treatment and therapy plans.

7. Perform independently, evaluative and treatment procedures necessary to provide an appropriate response, in life-threatening emergency situations.

8. Facilitate referral of patients to other appropriate community health care facilities and resources.

9. Prepare written prescriptions, order drugs per supervising physician protocols.

(The direction given is spelled out in a protocol agreement, drawn up by the supervising physician(s) with the aid of the Physician Assistant. This spells out the conditions under which the Physician Assistant may order medication.)

Attach copy of the following
Wisconsin Administrative Code Section:

MEDICAL EXAMINING BOARD

Chapter Med 8

PHYSICIAN'S ASSISTANTS

APPENDIX B

ALLIED HEALTH PRACTITIONER POLICY

I. GENERAL

A. Allied Health Professionals shall consist of those health care professionals who participate in patient care and are not employees of Our Lady of Victory Hospital, Inc.

B. Allied Health Professionals shall be divided into two (2) categories; independent Allied Health Professionals and dependent Allied Health Professionals.

C. 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 practitioners to the Medical Staff. If approved, the Governing Body may grant such individual privileges as restricted by Articles II and III of this Policy.

D. As a condition of appointment and the exercise of clinical privileges as an Allied Health Professional, each individual must meet the following conditions:

1. Only Allied Health Professionals 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 Allied Health Professional privileges.

2. As part of their appointment and reappointment to the Medical Staff, practitioners must certify biennially, or at any other time upon request of the Governing Body or the Executive Committee, the ability to perform the privileges requested with or without reasonable accommodation.

3. The practitioners 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 practitioners eligible to do so, participation in the Wisconsin Patients Compensation fund. This requirement may be satisfied by submitting copies of the

practitioner'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, practitioners have a continuing obligation to promptly notify the Chief Executive Officer 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 practitioner 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.

B. In the event that other personnel not holding degrees of M.D., D.O., D.S.C., D.P.M. or DDS, ask for privileges in restricted areas, i.e., other allied health professional areas, privileges shall be restricted to the area of competence of the individual allied health professional person in question and this shall be approved through the Credentials Committee, Executive Committee and Medical Staff on an individual basis as the need arises.

C. Independent Allied Health Professionals shall:

   1. Exercise independent judgment in their areas of competence, provided that an Active or Courtesy/Consulting member of the Medical Staff shall have the ultimate responsibility for patient care;
   2. Participate directly in the management and care of patients under the general supervision or direction of an Active or Courtesy/Consulting 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.
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 clinical privileges as an Independent Allied Health Professional 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 Allied Health Professional must be recommended to the Credentials Committee by an Active or Courtesy/Consulting member of the Medical Staff or have as a reference such a member of the Medical Staff.

III. DEPENDENT ALLIED HEALTH PROFESSIONALS

A. This category of Allied Health Professionals shall consist of certified physician assistants and those clinical technicians who are employees of a clinic or employees of a member or members of the Medical Staff and who perform a major portion of their professional responsibilities within Our Lady of Victory Hospital.

B. The employer of the individual who is seeking approval as a dependent Allied Health Professional shall present a written statement of the clinical duties and responsibilities of said individual to the Credentials Committee and the Executive Committee for their review and approval prior to allowing the individual to perform any professional responsibilities within Our Lady of Victory Hospital. The individual applicant shall supply information regarding his or her qualifications, including professional training, experience, and current competence, to the Credentials Committee for processing in accordance with the procedure for processing applications for privileges set forth in Article VI of the Bylaws.

C. The staff physician's application and biennial reapplication to have his or her Allied Health Professional work in Our Lady of Victory Hospital must be approved by the Credentials Committee and the Executive Committee of the Medical Staff prior to consideration by the Governing Body.

D. The staff physician who requests permission to have his/her dependent Allied Health Professional work in Our Lady of Victory Hospital is responsible for the acts of that person. The physician is also responsible for anything that may happen to his employee, i.e., needle stick, blood in the eye, acquired immune disease, hepatitis. The acts of the Allied health Professional will be imputed to the physician. It is the further responsibility of the employer of the dependent Allied Health Professional to acquaint said individual with the applicable Rules and Regulations of the Medical Staff and Our Lady of Victory Hospital personnel

with whom said individual shall have contact at the Our Lady of Victory Hospital. The dependent Allied Health Professional's employer shall furnish evidence of professional liability insurance coverage for such individuals.

E. All physician members of a partnership or corporation, holding Medical Staff privileges at Our Lady of Victory Hospital, who wish to use the same Allied Health Professional must sign the initial application. Physician members of a partnership or corporation may interchange Allied Health Professionals employed by the same partnership or corporation, if such Allied Health Professionals have been granted permission in accord with this credentialing policy to work within Our Lady of Victory Hospital. In all circumstances, each physician member of a partnership or corporation engaging in such interchange shall be responsible for maintaining appropriate supervision of Allied Health Professionals.

F. Allied Health Professionals working in Our Lady of Victory Hospital shall meet all applicable statutory and regulatory requirements imposed by the State of Wisconsin.

G. No Allied Health Professional shall be allowed to do anything within Our Lady of Victory Hospital that requires skill, training and experience of a physician.

H. If the Medical Staff membership of the employer is terminated for any reason or if the employer's clinical privileges are curtailed to the extent that the professional services of said individual within Our Lady of Victory Hospital are no longer necessary or permissible to assist the employer, the clinical duties and responsibilities of such individual with Our Lady of Victory Hospital shall be terminated.

IV. PROCESSING OF APPLICATIONS OF STAFF PHYSICIANS FOR PERMISSION FOR THEIR ALLIED HEALTH PROFESSIONAL TO WORK IN OUR LADY OF VICTORY HOSPITAL

A. A staff physician submits to the Medical Staff Office an application at least 30 days prior to the first anticipated date of work of the Allied Health Professional to work in Our Lady of Victory Hospital. Approval of credentialing review may take more than thirty (30) days and the applying physician should plan accordingly.

B. Such application shall include:

1. Details of the Allied Health Professional's credentials, references, training and any licensure or certification and, if applicable, evidence of U.S. Drug Enforcement Administration registration.
2. Evidence of professional liability insurance coverage.
3. A detailed job/position description identifying specific duties, tasks, responsibility and authority of Allied Health Professional.

4. All Allied Health Professional Staff will be re-credentialed every two (2) years.

V. REMOVAL OF ALLIED HEALTH PROFESSIONALS

A. Allied Health Professionals are not members of the Medical Staff and, accordingly, have none of the duties or prerogatives of staff members.

B. Our Lady of Victory Hospital retains the right, either through the Administration or upon recommendation of the Executive Committee, to suspend or terminate any or all of the privileges of functions of any Allied Health Profession or category of affiliate, without recourse on the part of such person or others to the review and appeal procedures of the Medical Staff Bylaws.

1. Independent Allied Health Professionals who are terminated or curtailed shall be told the reasons for such action, and if they so request, shall be entitled to have such action reviewed by the Executive Committee or a committee duly appointed by the Executive Committee. At any review meeting, the individual shall be present and allowed to fully participate.
2. Where a dependent Allied Health Professional is terminated or curtailed, the employer shall be notified as to the reasons for such action and be afforded an opportunity of review by the Executive Committee.

RULES AND REGULATIONS

Our Lady of Victory Hospital
Stanley, Wisconsin

A. <u>Admission and Discharge of Patients</u>

1. A patient may be admitted to the hospital only by a member of the active or courtesy/consultant staff, or by a practitioner approved for provisional appointment to the Medical Staff.

2. A member of the active medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for special instructions and for transmitting reports of the patient's condition to referring practitioners and to individuals designated by the patient and/or the responsible parties.

3. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

4. A patient to be admitted on an emergency basis, who does not have a private practitioner, may select any available practitioner in the applicable service to attend them. Where no such selection is made, a member of the active staff on duty, in the appropriate service, will be assigned to the patient on a rotation basis.

5. Each member of the active medical staff who does not reside within a thirty (30) mile radius of the hospital shall name a member of the medical staff who is a resident in the area, who may be called to attend their patients in an emergency or until they arrive. In case of failure to name such practitioner, the chief of the medical staff or chief of the service concerned shall have the authority to call any member of the active staff.

6. Responsibility of the admitting practitioner includes the provision for continuous care of their patient(s) at all times, by themselves or another credentialed member of the staff. In the event of inability to contact the attending practitioner or designee, the chief of staff or chief of the service concerned will be contacted; any one of which shall have the authority to call any member of the active staff in such an event. At the earliest time, the involved practitioner shall be approached by the chief of staff. Should this measure fail, disciplinary action will be carried out.

7. The admitting practitioner, to the best of their knowledge, shall be responsible for giving such information as may be necessary to assure the protection of the

patient from self-harm and to assure the protection of others, whenever their patient may be a source of danger.

a. any patient known or suspected of being suicidal must be identified to nursing personnel upon admission;

b. psychiatric consultation must be sought for potentially suicidal patients;

c. the patient with a primary psychiatric diagnosis should not be admitted to Our Lady of Victory Hospital, Inc. because of the lack of accommodations for this particular type of patient, and should be referred/transferred to the nearest appropriate facility, immediately following medical stabilization.

8. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay for disease categories as identified by the Utilization Review Plan of this hospital, and approved by the medical staff. This documentation must contain:

   a. an adequate written record for the reason for continued hospitalization; a simple reconfirmation of the patient's diagnosis is not sufficient.

   b. the estimated period of time a patient will need to remain hospitalized;

   c. discharge planning.

   Upon request of the Utilization Review Physician Advisor, the attending practitioner must provide justification for the necessity of continued hospitalization of any patient, including the estimated number of days of anticipated stay, and the reason thereof. This report must be submitted within twenty-four (24) hours of receipt of such request.

9. Hospital admissions and the assignment of beds shall be based upon the following priorities:

   a. <u>emergency admissions</u> – all admissions classified as an emergency by the admitting practitioner. For the purpose of this section, emergency is defined as a condition where danger to life, serious injury or permanent harm is imminent and any delay in administering treatment would add to that danger.

   b. <u>urgent admissions</u> – this category includes those so designated by the attending practitioner and shall be reviewed as necessary by the chief of staff or designee, to determine priority when all such admissions for a specific day are not possible.

c. <u>pre-operative admissions</u> – this includes all patients already scheduled for surgery who are not included in the above categories.

d. <u>routine and other elective admissions</u> – this includes all other routine or elective admissions which are not included in the above categories.

10. Patients shall be discharged only on an order by an attending practitioner. Should the patient leave the hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident shall be made in the patient's medical record.

11. The physician is responsible to adhere to any Advance Directive, Living Will or Power of Attorney for Healthcare for each patient, if any of the above documents are contained in the patient's chart.

12. In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or their qualified designee, within a reasonable time. Policies with respect to the deceased shall conform to local law. Nursing policy for death in the hospital is:

    a. death is verified by an R.N.
    b. R.N. checks for apical pulse
    c. R.N. checks for palpable or doppler blood pressure
    d. R.N. checks absence of respirations
    e. R.N. charts the time above.

13. In the event that the question of death or extraordinary prolongation of same, or refusal of treatment, sub-Ethics Committee support group may be consulted, which will be an Ethics Committee. It shall be an ad hoc committee and will be composed of at least one or more physicians, a clergy member, the chief executive officer, a member of the hospital board, representation from nursing service, and legal council, if necessary.

14. Any patient with an order to "do not resuscitate" or "no code blue", must have that order written on the record, as well as evidence of patient/family consultation.

B. <u>Medical Records</u>

1. A medical record is initiated and maintained for every individual assessed or treated at Our Lady of Victory, Inc.

2. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include: identification data, specific complaint, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory and radiology services

and other provisional diagnoses, medical and surgical treatment, operative reports, pathological report findings, progress notes, final diagnosis, condition on discharge, summary or discharge note and autopsy report, when performed.

3. a. A complete admission history and physical examination shall be completed within 24 hours of admission on all inpatients.

   b. If a patient is readmitted within 30 days for the same condition (diagnosis), there shall be a reference to the previous history with an interval note, and any pertinent changes in physical findings shall be recorded.

   c. PAME – Pre-Anesthesia Medical Exam for outpatient surgicals. A history and physical must have been completed in the past 30 days with no intervening illness, operation or cause for substantial change in Hgb or body chemistries. A physician note confirming that none of these has occurred in the interval must be charted within 24 hours prior to surgery. At a minimum, heart and lung assessment must be documented. Beyond 30 days, the physician will need to complete a new H & P.

4. When the history and physical exam are not recorded prior to an emergency surgery, or a special diagnostic or therapeutic procedure, there should be a progress note indicating the provisional diagnosis and that there were no contraindications for the procedure.

5. The attending practitioner shall countersign, time, and date to authenticate the history, physical examination and post-operative note when they have been recorded by another individual.

6. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care. Progress notes shall be written at least daily on acute care patients.

7. Consultation shall show evidence of pertinent findings on examination of the patient, the consultant's opinion and recommendation. This report shall be a part of the patient's record. A limited statement such as "I concurred" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation noted shall, except in emergency situations as verified in the record, be recorded prior to the operation.

8. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated with a signature.

9. Symbols and abbreviations may be used only when they have been approved by the medical staff. A official record of approved abbreviations shall be kept on file

in the record room. All verbal and telephone orders should be authenticated, signed, timed and dated, within 48 hours of receipt.

10. Final diagnosis shall be in full, without the use of symbols or abbreviations, and signed by the responsible practitioner at the time of discharge, on all patients.

11. At the time of discharge from inpatient care, a discharge summary concisely summarizes the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the patient's condition on discharge and any specific instructions given to the patient and/or family.

    A final progress note is substituted for the discharge summary only for those patients with problems and interventions of a minor nature, who require less than a forty-eight (48) hour period of hospitalization.

12. Written consent of the patient or designee is required for the release of medical information to persons not otherwise authorized to receive this information.

13. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with court orders, subpoena or statute.

14. All original records are the property of the hospital and shall not otherwise be removed. In the case of readmission of a patient, all previous records shall be available for use by the attending practitioner. This shall apply whether the patient is attended by the same practitioner or another. Unauthorized removal of records from the hospital shall constitute grounds for suspension of the practitioner for a period to be determined by the executive committee of the medical staff.

15. A medical record shall not be permanently filed until it is completed by the responsible practitioner.

16. The medical record shall be complete at the time of discharge, including progress notes, final diagnosis and discharge summary. If the record still remains incomplete thirty (30) days following discharge, without all essential reports received and placed on the record, the chief of staff shall notify the practitioner that their privileges to admit patients to the hospital shall be suspended three (3) days from the date of that notice, and such practitioner shall remain suspended until the record(s) have been completed.

C. **General Conduct of Care**

1. A general "Consent Form", signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission.

2. All orders for treatment must be in writing. For inpatients and outpatients, a verbal order shall be considered to be in writing if dictated to a duly licensed/certified clinical professional (e.g. licensed registered nurse, licensed practical nurse, licensed pharmacist, respiratory therapist, registered physical therapist, registered occupational therapist, registered speech therapist, certified radiology technician, certified laboratory technician), functioning within their space of competence, and signed by the appropriately authorized person to whom dictated, and indicating the name of the ordering practitioner. The ordering practitioner shall authenticate (sign) such orders within forty-eight (48) hours indicating the date and time of such authenticating signature. All verbal orders shall be verified and documented as RBV (Read Back Verify).

3. The practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until verified by the nurse.

4. All previous orders are canceled when the patient transfers to surgery, or another service (e.g. special care unit, to medical, from another service, etc.).

5. All drugs and medications administered to patients shall be those listed in latest edition of the United States Pharmacopoeia National Formulary, American Hospital Formulary Service of the AMA Drug Evaluations and facility drug formulary, Drugs from bonafide clinical investigations may be exceptions. These shall be used in full accordance with the statement of principles involved in the use of investigational drugs in hospitals and all regulations of the Federal Drug Administration.

6. Drug Stop Order Acute Care – there will be an automatic drug stop order of seven (7) days on all sedatives; seven(7) days on all antibiotics, unless the duration is specified. There will be an automatic stop order of five (5) days on all oxytocins and narcotics of Class II drugs. If the order expires at night, the nurse shall notify the practitioner the next morning. The physician must rewrite the order if they are to be continued.

7. Drug Stop Order Swing Bed- the automatic stop orders will be extended to 30 days, except for antibiotics: Antibiotics will have a 14 day stop order.

8. Any qualified practitioner with clinical privileges in this hospital may be called for consultation, within their area of expertise.

9. If a nurse has any reason to doubt or question the care provided to any patient, or believes that appropriate consultation is needed and has not been obtained, they may call this to the attention of their supervisor, who in turn may refer the matter to the attending physician. If not satisfied, they may then refer to the VP Clinical Services (or designee). If warranted, the VP Clinical Services may bring the

matter to the attention of the chief of staff or appropriate department Medical Director

D. General Rules Regarding Surgical Care

1. Surgery is performed only after a history, physical examination and the pre-operative diagnosis have been completed and recorded in the patient's medical record. Any indicated diagnostic tests must also be completed and reported in the medical record. In unusual emergency situations in which there is inadequate time to record the history and physical examination prior to surgery, a brief note, including the pre-operative diagnosis, is recorded prior to surgery.

2. Patients scheduled for elective surgery should be admitted no later than one (1) - two (2) hours prior to surgery. To the extent possible, patients scheduled for surgery should have their required pre-operative laboratory work-up and history and physical completed at least 24-48 hours in advance, to insure the availability of compatible blood and to aid the operating room team in completing the appropriate anesthesia and nursing assessments. Guidelines for laboratory work, as approved by the Medical Director of Anesthesia, will be followed.

3. Except in cases of emergency, all surgery should be scheduled with the operating room supervisor or unit clerk well in advance of the desired date. Elective surgeries should be performed Monday through Friday from 0700 to 1700. Emergency surgeries are performed when surgeon in on-call.

4. Emergency cases will be given priority over all other scheduled or elective cases.

5. A patient admitted for dental care or podiatric care is a dual responsibility involving the dentist or podiatrist and a physician member of the medical staff.

    a. Dentist/Podiatrist responsibility:

        1. a detailed dental or podiatric history justifying hospital admission or outpatient status.

        2. a detailed description of the examination of the oral cavity and pre-operative diagnosis, or a detailed description of the examination of the foot and pre-operative diagnosis

        3. a complete operative report describing the findings and techniques. In the case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments shall be sent to the hospital pathologist for examination.

4. progress notes, as are pertinent to the patient's condition, relative to that specialty.

b. Physician's Responsibility:

1. medical history pertinent to the patient's general health by an Active physician member of the Medical Staff or a physician approved by the Medical Staff.

2. a physical examination to determine the patient's condition prior to anesthesia and surgery by an Active physician member of the Medical Staff or a physician approved by the Medical Staff.

3. if anesthesia is used, a physician shall be immediately available in the hospital or adjacent clinic to assist in an emergency situation.

4. the patient's medical care while hospitalized or in an outpatient status.

c. The discharge of the patient shall be on the order of the dental or podiatric member of the medical staff.

6. Written, signed, informed surgical consent shall be obtained prior to the operative procedure, except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The risks/benefits associated with a surgical procedure are discussed with the patient prior to documenting informed consent (definition listed below under a.) and includes consideration of at least alternate options (if they exist), the need for and risks of blood transfusions and available alternatives, as well as anesthesia options with attendant risks. In an emergency situation involving a minor or unconscious patient in which a consent for surgery cannot be immediately obtained from parents, guardian or responsible party, these circumstances should be fully explained on the patient's medical record.

a. Informed Consent –
- Potential benefits & risk
- Potential problems related to recuperation
- The likelihood of success
- The possible results of non-treatment
- Any significant alternatives

7. Every surgical patient shall have a pre-anesthetic evaluation within 24 hours before surgery, a pre-anesthesia visit by anesthesia, and an anesthetic record and post-anesthesia follow-up examination, with findings recorded within 48 hours after surgery.

8. Specimens removed during a surgical procedure are sent to the pathologist for evaluation, when indicated. Their authenticated report shall be made a part of the patient's medical record.

10. Operative reports are dictated or written in the medical record immediately after surgery and describe the findings, the technical procedure used, the specimens removed, the post-operative diagnosis and the name of the primary surgeon and any assistants.

11. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible following surgery.

12. When the operative report is not placed in the medical record immediately following surgery (within six (6) hours), an operative progress note is entered in the medical record immediately after surgery to provide pertinent information for any individual required to attend the patient.

13. The patient is discharged from post-anesthesia care area by the use of discharge criteria.

E. <u>Emergency Services</u>

1. The medical staff shall adopt a method of providing medical coverage in the emergency service area. This shall be in accordance with the hospital's basic plan for the delivery of such services, including delineation of clinical privileges for all physicians who render emergency care.

2. Physicians of the active staff should provide emergency care to the limit of their experience and expertise for their patients when needed. If for some reason the scheduled ER physician knows they will not be available, they should make arrangements for another credentialed practitioner to provide care until he is available. The scheduled ER physician will be notified of any patient seeking emergency services. Upon notification the ER physician will:

    a. Provide an appropriate medical screening examination to determine the presence or absence of an emergency medical condition.
    b. Treat the patient within the capabilities of Our Lady of Victory Hospital, and/or
    c. Stabilize the medical condition of the patient, within the capabilities of Our Lady of Victory Hospital prior to discharge or transfer.

3. The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a procedure manual, relating specifically to this outpatient facility. The contents of such manual shall be revised as necessary by representatives of the medical staff, nursing staff and facility administration

4. An appropriate medical record shall be kept for every patient receiving emergency services and be incorporated in the patient's hospital record, if such record exists. The record shall include:

    a. adequate patient identification;

    b. information concerning the time of the patient's arrival, means of arrival and by whom transferred;

    c. pertinent history of injury or illnesses, including details relative to first aid or emergency care given the patient prior to their arrival;

    d. description of significant clinical, laboratory and roentgenological (x-ray) findings;

    e. diagnosis;

    f. treatment given;

    g. condition of the patient on discharge or transfer; and final disposition, including instructions given to the patient, family member or care giver staff, relative to necessary follow-up care;

    h. documentation indicating if patient left against medical advise;

    i. authorization by the patient or legally authorized representative;

    j. a copy of the record of emergency services provided is available to the practitioner or medical organization responsible for the follow-up care of the patient.

5. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

6. There will be a quarterly review of selected emergency room medical records by the Emergency Room committee to evaluate the quality of emergency medical care.

7. There should be a plan for the care of mass casualties at the time of any major disaster based upon the hospital's capacities in conjunction with other emergency facilities in the community. It shall be formulated by involvement of members of the medical staff, hospital administration and other departments of the hospital and approved by the medical staff and the governing body.

8. The disaster plan will make provision within the hospital for:

a. availability of basic utilities and supplies including gas, water and essential medical and supportive materials, and food;

b. an efficient system of notifying and assigning personnel;

c. unified medical command under the direction of a designated physician;

d. conversion of all useable space in clearly defined areas for efficient triage, patient observation and immediate care;

e. prompt transfer when necessary, and after preliminary medical services have been rendered to a facility most appropriate for administering definitive care;

f. a special disaster medical record such as an appropriately designed tag that accompanies the casualty as they are moved.

g. procedures for the prompt discharge or transfer of patients in the hospital who can be moved without jeopardy;

h. maintaining security in order to keep relatives and curious persons out of the triage area; and

i. the establishment of a public information center and assignment of a qualified public relations liaison; advance arrangements with communication media will assist in providing and organizing the dissemination of information.

9. The disaster plan will be rehearsed as needed, preferably as part of a coordinated drill in which other community emergency service agencies will participate.

F. <u>Allied Health Staff</u>

1. Definition – an Allied Health Professional is an individual other than a licensed physician , dentist or podiatrist who exercises independent judgment within the areas of their professional competence and who is qualified to render medical or surgical care under the supervision of a practitioner who has been accorded privileges to provide such care in the hospital.

2. Qualifications – only an Allied Health Professional holding a license, certificate or such other credentials as may be required by applicable state law, and who satisfies the basic qualifications are eligible to provide specified services in the hospital. The medical executive committee and the chief executive officer may establish additional qualifications required as a member of any particular category of Allied Health Professionals.

3. Position descriptions – written guidelines for the performance of specified services by the Allied Health Professional will be developed by the medical executive committee and the chief executive officer, with input where applicable from the physician director of the clinical service involved. For each category of Allied Health Professionals, such guidelines must include:

   a. specification of the classes of patients that may be seen, that is only those of the employer/physician, only those who have been referred to or from a particular clinical service, or any referred by a physician or other authorized practitioner;

   b. a description of the services to be provided and the procedures to be performed, including the equipment or special procedures or protocols that specific tasks may involve; responsibility for charting services provided in the patient's medical record.

   c. definition of the degree of assistance that may be provided to a practitioner in the treating of patients on hospital premises and any limitations thereon.

4. Evaluation of individual Allied Health Professional applications – an application for specified services for an Allied Health Professional is submitted and processed in the same manner as provided for clinical privileges. The Board may delegate to the chief executive officer the authority to act for it on any such applications from specific categories of Allied Health Professionals. An Allied Health Professional is individually assigned to a service appropriate to their professional training and is subject to a provisional period and formal periodic reviews as determined for each category. An Allied Health Professional is not entitled to any procedural rights provided for in the Fair Hearing Plan.

5. Obligations of the Allied Health Professionals – each Allied Health Professional shall retain appropriate responsibility within their area of professional competence for the care and supervision of each patient in the hospital for whom they are providing service and shall participate as appropriate in the qualify assurance program activities.

6. Reappointment process – reappointment for staff privileges shall be accomplished in a similar manner to those of the medical staff. A statement regarding health status will also be required, as well as continuing education credits.

G. <u>Medical Staff Meetings</u>

1. The annual meeting of the medical staff shall take place during the month of December, or if the December Executive Meeting is not held, at the next monthly meeting (January). Notice regarding time and place shall be called to the office of each member of the staff at least one (1) week in advance.

2. The president of the medical staff shall call regular monthly meetings of the staff at least ten (10) times each year. Notice regarding time and place are listed for the staff in such a way that they are apprised of the meeting at least one (1) week prior to the meeting.

CORRECTIVE ACTION PROCEDURES

AND

FAIR HEARING PLAN ADDENDUM

TO THE BYLAWS OF THE MEDICAL STAFF

OF

OUR LADY OF VICTORY HOSPITAL

Stanley, Wisconsin

CORRECTIVE ACTION PROCEDURES
AND
FAIR HEARING PLAN ADDENDUM

VICTORY MEDICAL CENTER, INC.
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DEFINITIONS

The following Definitions apply to the provisions of this Fair Hearing Plan:

1. Appellate Review Body – The group designated under this Plan to hear a request for Appellate Review, properly filed and pursued by the practitioner.

2. Ad Hoc Committee of the Medical Staff (or Hearing Committee) – Medical staff appointees hearing testimony and reporting evidentiary findings following adverse action by the Executive Committee of the medical staff or the Hospital Governing Body.

3. Parties – The Practitioner who requested the Hearing or Appellate Review and the body or bodies upon those adverse recommendations or actions a Hearing or Appellate Review is predicated.

4. Practitioner – The applicant or staff member, against whom an adverse action has been recommended or taken.

5. Special Notice – Written notification, sent by Certified or Registered Mail, return Receipt Requested.

6. Investigating Committee – Group of physicians appointed by the President of the Medical Staff for information and fact-finding purposes in preliminary stage of corrective action to reduce or suspend clinical privileges.

7. Governing body – The Governing Body of Our Lady of Victory Hospital, Inc.

8. Executive Committee – The Executive Committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Governing Body.

ARTICLE I CORRECTIVE ACTION

1.1 **General.** Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be disruptive to the operation of the Hospital, corrective action against such practitioner may be requested by any officer of the medical staff, by the chief executive officer or by the governing body. All requests for corrective action shall be in writing, shall be made to the chief of staff and shall be supported by reference to specific activities or conduct which constitutes the grounds for the request. If the practitioner involved is the chief of staff, the secretary-treasurer of the medical staff shall assume the chief of staff's position in this matter.

1.2 **Grounds for Request.** Conduct or activity upon which the request for corrective action may be based shall include, but not be limited to:

(a) Conduct or activity by a practitioner considered to lower the standards or aims of the medical staff or Hospital or which is disruptive to the operations of the Hospital.

(b) Conduct involving moral turpitude.

(c) Conviction of a crime relating to medical practice or medical ethics.

(d) Unethical practice.

(e) Incompetence.

(f) Failure to keep adequate records.

(g) Revocation, suspension or limitation of practitioner's license by the State Medical Examining Board or Dental Examining Board or voluntarily by practitioner.

(h) Loss or limitation of practitioner's narcotic (DEA) license.

(i) Exercising privileges while the practitioner's professional ability is impaired, whether through illness, accident, addictions or from any other source.

(j) Significant misstatement in, or omission from, any application for membership or privileges or any misrepresentation in presenting the practitioner's credentials.

(k) Violation of the Bylaws, Rules and Regulations of the Medical Staff, Hospital Bylaws, AMA Code of Ethics, or State of Wisconsin Rules.

(l) Conviction of a felony.

1.3 **Investigating Committee** Whenever the corrective action could be a reduction or suspension of clinical privileges, the chief of staff shall appoint an investigating

committee of physicians. The investigation should include an interview with the practitioner involved, who should be informed of the general nature of the charges that have been brought and that this may result in corrective action. The practitioner shall be permitted to discuss and explain the conduct. The practitioner's appearance at the interview shall not constitute a formal hearing and is considered preliminary in nature and not subject to procedural rules. A record of the interview shall be made.

1.4 **Opportunity for Interview.** Prior to making of the investigating committee report, the practitioner against whom the corrective action has been requested, shall have an opportunity for an interview with the investigating committee. At such interview, he/she shall be informed of the general nature of the charges against him/her and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in the Fair Hearing Plan shall apply hereto. A record such interview shall be made by the investigating committee and included in its' report to the chief of staff.

1.5 **Reports of Investigating Committee.** Within fourteen (14) days after the receipt of the request for corrective action, the investigating committee shall make a report of its' investigation to the chief of staff. Within thirty (30) days following receipt of the request for corrective action, the investigating committee shall report to the chief of staff recommendations for corrective actions involving reduction or suspension of clinical privileges, who shall forward recommendations to the Executive Committee of the medical staff.

1.6 **Appearance before Executive Committee of the Medical Staff.** The affected practitioner shall be permitted to make an appearance before the Executive Committee of the medical staff, prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in the Fair Hearing Plan, with respect to hearings, shall apply hereto. A record of such appearance shall be made by the Executive Committee.

1.7 **Action of Executive Committee of the Medical Staff.** The action of the Executive Committee of the Medical Staff, on a request for corrective action, , may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation or requirement for consultation, to recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed Summary Suspension of clinical privileges be terminated, modified or sustained, or to recommend that the practitioner's staff membership be suspended or revoked. Notice to the physician shall be in accord with section 4.4 of the Fair Hearing Plan.

1.8 **Appeal of Executive Committee Decision.** Any recommendation by the Executive Committee of the medical staff for reduction, suspension or revocation of clinical privileges or for the suspension or expulsion from the medical staff shall entitle the affected practitioner to procedural rights provided for in the Fair Hearing Plan. When the Executive Committee of the medical staff has made an affirmative recommendation for

reduction, suspension, revocation or expulsion in the matter, the procedure to be followed shall be as provided in Article IV of the Fair Hearing Plan, notwithstanding the summary suspension provisions of Article II.

ARTICLE II SUMMARY SUSPENSION

2.1 **Initiation of Summary Suspension.** Any one of the following; the chief of staff, chief executive officer and the Executive Committee of either the medical staff or the governing body, shall each have the authority whenever action must be taken immediately, in the best interest of patient care in the Hospital, to suspend summarily all or any portion of the clinical privileges of a practitioner and such summary suspension shall become effective immediately. The affected practitioner shall be notified of such action immediately by the staff member of body, suspending his/her privileges.

2.2 **Right to Expedited Appearance before Executive Committee of the Medical Staff.** A practitioner whose clinical privileges have been summarily suspended for more than fifteen (15) days shall be entitled to request that the Executive Committee of the medical staff hold a conference on the matter within thirty (30) days of the date of the written request.

2.3 **Appeal of Executive Committee of the Medical Staff Decision.** The Executive Committee of the medical staff will recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such conference, the Executive Committee of the medical staff does not recommend immediate termination of the summary suspension, the affected practitioner may proceed as outlined in Article IV this Fair Hearing Plan.

2.4 **Alternative Practitioners.** Immediately upon the imposition of the summary suspension, the chief of staff shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner, still in the Hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of such an alternative practitioner.

ARTICLE III AUTOMATIC SUSPENSION

3.1 **Failure to Complete Medical Records.** A temporary suspension in the form of withdrawal of the practitioner's admitting and elective surgical privileges effective until medical records are completed, shall be imposed automatically after warning of delinquency for failure to complete medical records. The medical records director shall notify the physician who is delinquent, the chief executive and the chief of staff, if the medical records are not completed within thirty (30) days after discharge of the patient from the Hospital. The physician shall have one (1) week in which to complete the record shall be given. At the end of three (3) days, notice of temporary suspension shall be given to the physician, the chief of staff and administration, and shall be in effect until the records are complete.

3.2 **Governing Body Action.** Action by the State Board of Medical Examiners or Dental Examining Board revoking or suspending a practitioner's license or placing him/her on probation shall automatically suspend all of his/her Hospital privileges. A practitioner whose DEA number is revoked or restricted or voluntarily surrendered shall automatically be divested of the right to prescribe medications controlled by such number. Further, all the practitioner's clinical privileges, which require the ability to prescribe such medications, shall be automatically suspended.

3.3 **Felony conviction.** An automatic suspension of all privileges of a practitioner shall be imposed upon notification received by the chief executive officer of the conviction of a practitioner of a felony. The Executive Committee may, upon request of the affected practitioner, convene to review the matter and shall submit a recommendation to the governing body regarding the continuation of the membership and privileges of the practitioner.

3.4 **State of Federal Action.** An automatic suspension of all privileges may be imposed upon a practitioner's failure to notify the chief executive officer within (5) days of receipt by the practitioner of an initial sanction notice of a gross and flagrant violation, or of the commencement of a formal investigation or the filing of charges, by a Medicare 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.

3.5 **Failure to Supply Information or Documentation.** An automatic suspension may be imposed upon a practitioner's failure without good cause to supply information or documentation requested by any of the following: the chief executive officer or his designee, the Executive Committee or the governing body. A suspension shall be imposed only if:

(a) the request for information or documentation was in writing;

(b) The request was related to evaluation of the practitioner's current qualifications for membership or clinical privileges;

(c) the practitioner failed to either comply with the request or to satisfactorily explain his/her inability to comply; and

(d) the practitioner was notified in writing that failure to supply the requested information or documentation within fifteen (15) days from receipt of the notice would result in automatic suspension. Any automatic suspension of any portion or all of the practitioner's privileges shall remain in effect until the practitioner supplies the information or documentation sought or satisfactorily explains his/her failure to supply it.

3.6 **General Misconduct.** An automatic suspension of all privileges may be imposed by the chief executive officer for misconduct that does not directly involve clinical issues.

Misconduct not involving clinical issues can consist of, but is not limited to: sexual harassment or abuse of others; drug, alcohol or other addiction; criminal, fraudulent or other improper business conduct.

3.7 **National Practitioner Data Bank.** A practitioner whose appointment or reappointment is conditioned upon subsequent receipt of a National Practitioner Data Bank report that does not contradict information known at the time of appointment or reappointment shall be automatically suspended upon receipt of a Data Bank report that does contradict that information.

3.8 **Failure to Self-Report.** Each practitioner shall have the duty to notify the chief executive officer of any action regarding himself/herself that may constitute a cause for automatic suspension under this section. Failure to report such action will result in automatic suspension.

3.9 **No Deemed Professional Review Action.** Automatic suspension activated pursuant to this section shall not be a professional review action and thus not give rise to any right of hearing or appellate review, including the maintaining of any suspension instituted as a result of Medical or Dental Examining board or DEA action.

3.10 **Enforcement.** It shall be the duty of the chief of staff to cooperate with the chief executive officer in enforcing all automatic suspensions.

ARTICLE IV HEARING PREREQUISITES

4.1 **Necessity for Adverse Action.** When a practitioner receives special notice of an adverse recommendation made by the Executive Committee of the medical staff or the Hospital Governing Body, he/she is entitled, upon timely and proper request, to a hearing before an Ad Hoc Hearing Committee of the Medical Staff. If the Executive Committee.

4.2 **Where Deemed Adverse.** A recommendation or action listed in section 4.3 is adverse only when it has been:

(a) recommended by the Executive Committee of the medical staff, or

(b) taken by the Hospital Governing Body, under consideration, where no prior right to request a hearing existed or where contrary to a prior recommendation.

4.3 **Triggering Events for Hearing by Ad Hoc Hearing Committee of the Medical Staff.** The following recommendations or actions, if deemed adverse under section 4.2, entitle the practitioner to a hearing by the Ad Hoc Hearing Committee of the medical staff upon timely and proper request;

(a) denial of initial staff appointment,

(b) denial of reappointment,

(c) suspension of staff membership,

(d) revocation of staff membership,

(e) denial of requested appointment to or advancement in staff category,

(f) reduction in staff category,

(g) suspension or limitation of the right to admit patients or any other membership prerogative directly related to a practitioner's provision of patient care,

(h) denial or restriction of requested clinical privileges,

(i) reduction in clinical privileges,

(j) suspension of clinical privileges,

(k) revocation of clinical privileges, or

(l) individual application of or individual changes in mandatory consultation requirement.

4.4 Notice of Adverse Executive Committee Recommendation or Action. The chief executive officer promptly gives the practitioner special notice of an adverse recommendation or action by the Executive Committee of the medical staff taken pursuant to section 1.7 of the Corrective Action Procedures. The notice:

(a) advises the practitioner of the recommendation or action and his right to request a hearing pursuant to the provisions of the medical staff bylaws and this Fair Hearing Plan;

(b) specifies that the practitioner has thirty (30) days after receiving a notice within which to submit a request for a hearing, and that the request must satisfy the conditions of section 4.5;

(c) stated that failure to request a hearing within that time period and in the proper manner, constitutes a waiver of right to any hearing or appellate review on the matter that is the subject of this notice;

(d) states that any higher authority required or permitted under this Plan to act on the matter following the waiver, is not bound by the adverse recommendation or action that the practitioner has accepted by virtue of the waiver, but may take any action whether more or less severe, if deemed warranted by the circumstances; and

(e) states that upon receipt of this hearing request, the practitioner will be notified of the date, time and place of the hearing and the grounds on which the adverse recommendation or action is based.

4.5 **Request for Hearing.** The practitioner has thirty (30) days after receiving a notice under section 4.4 to file a written request for a hearing. This request must be delivered to the chief executive officer either in person or by Certified or Registered Mail. If the practitioner wishes to be represented by an attorney at the hearing, his request for hearing must so state.

4.6 **Waiver by Failure to Request a Hearing.** A practitioner who fails to request a hearing within the time and in the manner specified in section 4.5 waives his or her right to any hearing or appellate review to which he or she might otherwise be entitled. Such waiver applies only to matters that were the basis for the adverse recommendation or action triggering this section 4.4 notice.

4.7 **Notice and Effect of Waiver.** The chief executive officer promptly sends the practitioner special notice of each action taken under any of the following sections and notifies the president of the staff of each such action. The effect of a waiver is as follows:

(a) After adverse recommendation by the Executive Committee of the medical staff, a waiver constitutes acceptance of the recommendation which then becomes and remains effective pending the decision of the Governing Body. The Governing Body considers the adverse recommendation as soon as practicable following the waiver. The Governing Body's action has the following effect:

(i) if the Governing Body agrees in all respects with the Executive Committee's recommendation, it then becomes effective as a decision of the Governing Body; or

(ii) if the Governing Body changes the Executive Committee's recommendation, if on the basis of the same information and material considered by the Executive Committee in formulating its recommendation, the Governing Body proposes different action, the matter is submitted to Joint Conference, as provided in Section 9.1 of this Plan. The Governing Body's action after receiving the Joint Conference recommendation, becomes effective as the decision of the Governing Body.

(b) After adverse action by the Governing Body, a waiver of an Appellate Review hearing constitutes acceptance of the Governing Body action which then becomes the final decision of the Governing Body.

4.8 **Additional Information Obtained Following Waiver.** If the source of the additional information referred to in this section is the practitioner or an individual or group

functioning, directly or indirectly on his behalf, the provision of this section shall not apply unless the practitioner demonstrates to the satisfaction of the Governing Body that the information was not reasonably discoverable in time, with presentation to and consideration by the party taking the initial action, or by the hearing committee if the practitioner's waiver is in connection with an Appellate Review.

(a) <u>When Received by the Governing Body.</u> If the Governing Body acquires or is informed of additional information that is directly relevant to the matter at issue that was not available to the Governing Body, the matter is reconsidered by the Governing Body. Favorable Governing Body action following a reconsideration becomes effective as a decision of the Governing Body. If the Governing Body action following reconsideration is still adverse, it is deemed a new adverse recommendation under section 4.2 and the matter is processed as such.

(b) <u>When received by the Executive Committee of the Medical Staff.</u> When the Executive Committee of the medical staff acquires or is informed of additional relevant information not available to or considered by the Executive Committee, this will be again reconsidered within the set time limit.

(i) <u>Executive Committee of the Medical Staff follow-up – recommendation adverse.</u> An adverse Executive Committee of the medical staff recommendation following reconsideration is deemed a new adverse recommendation under section 4.2 and the matter proceeds as such.

(ii) <u>Executive Committee of the Medical Staff recommendation – favorable.</u> A favorable Executive Committee of the medical staff recommendation following reconsideration is immediately forwarded to the governing body by the chief executive officer. The effect of the governing body recommendation is as follows:

a. <u>Governing body favorable.</u> Favorable governing body action becomes the decision of the Governing Body.

b. <u>Governing body adverse:</u> If the governing body's action is adverse, the matter is submitted to a Joint Conference as provided in section 9.1. A favorable Governing Body action after receiving the Joint Conference recommendation becomes its final decision. Adverse Governing Body action is deemed a new adverse action for section 4.2 and the matter proceeds as such.

4.9 **<u>Notice of the Time and Place of Hearing.</u>** The chief executive officer immediately delivers a timely and proper request to the president of the medical staff or the chairman of the Governing Body, dependent upon whose recommendation or action prompted the hearing request. Within fifteen (15) days after receiving such request, the president of the staff or chairman of the Governing Body, as appropriate, must schedule and arrange for a hearing. At least ten (10) days prior to the hearing, the chief executive officer sends the

practitioner special notice with the time, place and date of the hearing. The hearing date must not be less than ten (10) nor more than thirty (30) days after the chief executive officer receives a hearing request, provided however that a hearing for the practitioner who is under suspension, then in effect must be held as soon as the arrangements may reasonably be made, but not later than ten (10) days after the chief executive officer receives a hearing request.

4.10 **<u>Statement of Issues in Advance.</u>** The notice of hearing must contain a concise statement of the practitioner's alleged act or omission; a list, by number, of the specific or representative patients' records in question; list of witnesses, if any, expected to testify on behalf of the body whose action prompted the request for hearing; and/or other reasons or subject matter forming the basis for an adverse action or recommendation which is the subject of the hearing; and the names of individuals on the hearing committee.

4.11 **<u>Appointment of Ad Hoc Hearing Committee of the Medical Staff.</u>**

(a) <u>By Medical Staff.</u> A hearing occasioned by an adverse Executive Committee of the medical staff recommendation is conducted by a hearing committee appointed by the president of the staff and composed of at least three (3) members of the medical staff. The president designates one of the appointees as chairperson of the committee.

(b) <u>By the Governing Body.</u> A hearing occasioned by an adverse action of the Governing Body is conducted by a hearing committee appointed by the chairman of the Governing Body and composed of five (5) persons including at least two (2) medical staff members when feasible. The chairman designates one of the appointees as chairman of the committee.

4.12 **<u>Service on Hearing Committee.</u>** A medical staff or Governing Body member is not disqualified from serving on a hearing committee merely because he participated in investigating the underlying matter or issue or because he has heard of the case or has knowledge of the facts involved, or what he supposes the facts to be. Only under extreme circumstances shall a member of the body whose adverse recommendation or action occasioned a hearing serve on the hearing committee. However, such individuals may appear before the committee if requested by either of the parties concerned. In any event, all members of a hearing committee shall be required to consider and decide the case with good faith objectivity. Physicians who are in direct economic competition with affected practitioner shall not serve on the Hearing Committee. If a committee of medical staff members cannot be constituted, the Governing Body may direct the hearing to be held before a Hearing Officer or a committee of staff members of other affiliated hospitals.

ARTICLE V HEARING PROCEDURE

5.1 **Required Personal Appearance.** The personal presence of the practitioner is required. A practitioner who fails without good cause to appear and proceed at the hearing waives his or her rights in the same manner and with the same consequences as provided in sections 4.6, 4.7 and 4.8, if applicable.

5.2 **Presiding Officer.** The hearing officer is appointed under section 10.1, or if not appointed, the hearing chairman is the presiding officer. This officer maintains decorum and assures that all participants have a reasonable opportunity to present relevant oral and documentary evidence. The officer determines the order of procedure during the hearing and makes all rulings on matters of law, procedure and the admissibility of evidence.

5.3 **Representation.** A practitioner may be accompanied and represented at the hearing by a member of the medical staff in good standing or by a member of his or her local professional society. The Executive Committee or the Governing Body, depending upon whose recommendation or action prompted the hearing, shall appoint an individual to represent it. Representation by either party by an attorney at law is governed by section 10.2 of this Plan.

5.4 **Rights of Parties.** During a hearing, each party may:

(a) call and examine witnesses;

(b) introduce exhibits;

(c) cross-examine any witness on any matter relevant to the issue;

(d) impeach any witness;

(e) rebut any evidence; and

(f) request that the record of the hearing be made by use of a court reporter or an electronic recording unit.

If the practitioner does not testify on his or her own behalf, he or she may be called and examined as if under cross-examination.

5.5 **Procedure and Evidence.**

(a) The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or representation of evidence. Any relevant matter, upon which responsible persons customarily rely in the conduct of serious affairs, may be considered regardless of the admissibility of such evidence in a

court of law. Each party is entitled prior to or during the hearing, to submit memoranda concerning any issue of law or fact and those memoranda become part of the hearing records. The president officer may, but is not required to, order that oral evidence may be taken only on oath or affirmation, administered by any designated person entitled to notarize documents in the State of Wisconsin.

(b) The Ad Hoc Hearing Committee of the Medical Staff shall be entitled to consider any pertinent material contained on file in the Hospital and all other information that can be considered, pursuant to the medical staff bylaws in connection with applications for appointment or reappointment to the medical staff or for clinical privileges. The Ad Hoc Hearing Committee shall be entitled to conduct independent review, research and interviews, but may utilize the products of such in its decision only if the parties are aware of such and have the opportunity to rebut any information so gathered.

(c) The Ad Hoc Hearing Committee of the medical staff may meet without the presence of the parties to deliberate and/or establish procedures. The Hearing Committee may require that the parties submit written, detailed statements of the case to the committee and to each other. Such statements of the case may consist of a rendering of all the facts of the case. If so, the hearing can consist of clarification and explanation of the written statements of the case. If a party is ordered by the Hearing Committee to supply a detailed statement of the case and fails to do so, the committee can conclude that such failure constitutes a waiver of the party’s case.

(d) If the Ad Hoc Hearing Committee of the medical staff determines to require the parties to submit written statements of the case, notice to that effect shall be provided to both parties at least ten (10) days prior to any scheduled hearing. The written statements of the case shall be supplied both to the committee and to the other party at least forty-eight (48) hours prior to the commencement of the hearing.

(e) Statements from members of the medical staff, nursing or other Hospital staff, other professional personnel, patients or others may be distributed to the Hearing Committee of the medical staff and the parties in advance of or at the hearing. Such shall be made a part of the record of the hearing and given such credence as may be appropriate. These statements must be available to all parties. When time and distance allow, the authors of the statements should be available at the hearing for questioning by either party if so requested.

5.6 **Official Notice.** In reaching a decision, the Ad Hoc Hearing Committee may take official notice either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration,, or of any facts that may be judicially noted by the courts of the State of Wisconsin. Parties present at the hearing must be informed of the matters to be noticed

and these matters must be noted in the hearing record. Any party shall be given the opportunity, on a timely request, to request that a matter be officially noticed and to rebut any officially noticed matter by evidence or written or oral presentation of authority, in a manner to be determined by the Hearing Committee. The Hearing Committee is also entitled to consider all other information that can be considered under the medical staff bylaws, in connection with credentialing matters or anything on file with the Hospital.

5.7 **Burden of Proof.** When a hearing relates to section 4.3(a), 4.3(e), ?, or 4.3(h), the practitioner has the burden of proving, by clear and convincing evidence, that the adverse action or recommendation lacks any substantial factual basis, or that the basis or conclusions drawn therefrom are either arbitrary, unreasonable or capricious. Otherwise, the body whose adverse action or recommendation occasioned the hearing has the initial obligation to present evidence and support thereof, but the practitioner, thereafter, is responsible for supporting, by a preponderance of evidence, his challenge that the adverse action or recommendation lacks any substantial factual evidence or that the basis or conclusions drawn therefrom are either arbitrary, unreasonable or capricious.

5.8 **Hearing Records.** A record of the hearing must be kept that is of sufficient accuracy to permit any informed and valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Ad Hoc Hearing Committee of the medical staff may select the method to be used for making its records such as a court reporter, electronic recording unit, detailed transcription or minutes of the proceedings.

5.9 **Postponement.** The request for postponement of the hearing may be granted by the Ad Hoc Hearing Committee of the medical staff only upon a showing of good cause and only if the request is made as soon as is reasonably practical.

5.10 **Presence of Hearing Committee Members and Vote.** A majority of the Ad Hoc Hearing Committee of the medical staff must be present throughout the hearing and deliberation. If a Hearing Committee member is absent from any part of the proceedings, he may not participate in the deliberation or decision.

5.11 **Recesses and Adjournment.** The Ad Hoc Hearing Committee may recess and reconvene the hearing without additional notice without the convenience of the participants or for the purpose of obtaining new and additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall, at a time convenient to itself, conduct this deliberation outside the presence of the parties. Upon conclusion of its deliberation, the hearing shall be adjourned.

ARTICLE VI HEARING COMMITTEE REPORT AND FURTHER ACTION

6.1 **Hearing Committee Report.** Within fifteen (15) days after final adjournment of hearing, the Ad Hoc Hearing Committee of the medical staff makes a written report of its

findings and recommendations, with specific reference to the hearing record and other documentation considered, and forwards the report along with the record and other documentation, to the body whose adverse action occasioned the hearing.

6.2 Action on Hearing Committee Report. Within ten (10) days after receiving the Ad Hoc Hearing Committee's report, the body whose adverse recommendation or action occasioned a hearing considers it and affirms, modifies or reverses its recommendation or action, transmits the result together with the hearing record, the hearing committee report and all other documentation considered to the chief executive officer.

6.3 Notice of Result. The chief executive officer promptly sends a copy of the result to the practitioner by special notice, to the president of the staff , to the Executive Committee and to the Governing Body.

6.4 Effect of Favorable Result.

(a) Adopted by the Governing Body. If the Governing Body's results under section 6.2 are favorable to the practitioner, it becomes the final decision of the Governing Body.

(b) Adopted by the Executive Committee of the Medical Staff. If the Executive Committee of the medical staff's result is favorable to the practitioner, the chief executive officer promptly forwards it, together with all supporting documentation, to the Governing Body which may adopt or reject the result in whole or in part, or refer the matter back to the Executive Committee of the medical staff for further reconsideration. Any referral back shall state the reason, set a time limit within which a subsequent recommendation must be made, and may include a directive for an additional hearing. After receiving a subsequent recommendation and any new evidence, the Governing Body takes action. Favorable action by the Governing Body becomes effective as a decision of the Governing Body and the matter proceeds as provided in section 6.4(a) above.

6.5 Effect of Adverse Result. If the governing Body's action is adverse, a special notice informs the practitioner of his right to request an Appellate Review by the Governing Body. The chief executive officer promptly sends the practitioner special notice informing him of each action taken under this section. If the result of the Executive Committee of the medical staff or the Governing Body under section 6.2 continues to be adverse to the practitioner, the special notice shall inform him of his right to request an Appellate Review by the Governing Body, as provided in Article VII of this Plan.

ARTICLE VII INITIATION AND PREREQUISITES OF APPELLATE REVIEW

7.1 Request for Appellate Review. The practitioner has fifteen (15) days after receiving special notice under section 6.3, to file written request for an Appellate Review. The request must be delivered to the chief executive officer, in person or by Certified or

Registered Mail, and may include a request for a copy of the hearing committee report, record, and other material favorable and unfavorable, if not previously forwarded, but was considered in taking the adverse recommendation or action. If the practitioner wishes to be represented by an attorney in the Appellate Review appearance, it will be granted under section 8.4; his request must so state.

7.2 **Waiver by Failure to Request Appellate Review.** A practitioner who fails to request an Appellate Review within the time and manner specified, waives any right to a review. The waiver has the same force and effect as provided in section 4.6, 4.7, and 4.8, if applicable.

7.3 **Notice of Time and Place for Appellate Review.** The chief executive officer delivers a timely and proper request to the chairperson of the Governing Body. As soon as practicable, the Governing Body schedules and arranges for an Appellate Review which shall be not less than fifteen (15) days nor more than thirty (30) days after the chief executive officer received the request, provided, however, that an Appellate Review for a practitioner who is under suspension that is in effect shall be held as soon as the arrangements for it may reasonably be made but not later than fifteen (15) days after the chief executive officer received the request. At least ten (10) days prior to the Appellate Review, the chief executive officer sends the practitioner special notice of the time, place and date of the review. The time may be extended by the Appellate Review Body for good cause and if the request is made as soon as is reasonably practical.

7.4 **Appellate Review Body.** If an Executive Committee recommendation occasions the Appellate Review, the Governing Body serves as the Appellate Review Body. If the Governing Body action occasions the review, the Appellate Review is conducted by the Governing Body.

ARTICLE VIII APPELLATE REVIEW PROCEDURE AND FINAL ACTION

8.1 **Nature of Proceedings.** The proceedings by the Appellate Review Body shall not be a new or an additional hearing, but shall be in the nature of an appellate review based upon the hearing record, the Ad Hoc Hearing Committee's report and all subsequent results and actions, the written statements, if any, provided below and any other material that may be represented and accepted under section 8.5.

8.2 **Written Statements.** The practitioner may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he or she disagrees, and the reasons for disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the Appellate Review Body through the chief executive officer at least ten (10) days prior to the scheduled date of the review, except if the time limit is waived by the Review Body. A similar statement may be submitted by the group whose adverse action occasioned the review and, if submitted, the chief executive officer shall provide a copy to the practitioner at least five (5) days prior to the scheduled day of the Appellate Review.

8.3 **Presiding Officer.** The chairperson of the Appellate Review Body is the presiding officer. He or she determines the order of procedure during the review; makes all required rulings and maintains decorum.

8.4 **Oral Statements.** The Appellate Review Body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their position. Any party or representative appearing is required to answer questions put by any member of the Appellate Review Body.

8.5 **Consideration of New or Additional Matters.** New or additional matter or evidence, not raised or presented during the original hearing, or in the hearing report and not otherwise reflected in the records, may be introduced at the Appellate Review only at the discretion of the reviewing body and as the reviewing body deems appropriate, only if the party requesting consideration of the matter or evidence shows that it could not have been discovered in time for the initial hearing. The requesting party shall provide, through the chief executive officer, a written substantive description of the matter or evidence to the Appellate Review Body and party at least three (3) days prior to the scheduled date of review.

8.6 **Powers.** The Appellate Review Body has all the powers granted to the hearing committee and any additional powers that are reasonably appropriate to or necessary for the discharge of its responsibility.

8.7 **Presence of Members and Vote.** A majority of the Appellate Review Body must be present throughout the review and deliberation. If a member is absent from any part of the proceedings, that member shall not be permitted to participate in the deliberation or the decision.

8.8 **Recesses and Adjournments.** The review body may recess and reconvene the proceedings without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. At the conclusion of the oral statements, if allowed, the Appellate Review shall be closed. The review body shall then, at a time convenient to itself, conduct its deliberation outside the presence of the parties involved. The Appellate Review shall be adjourned at the conclusion of those deliberations.

8.9 **Action Taken.** The Appellate Review Body may affirm, modify or reverse the adverse result or action or, at its discretion, may refer the matter back to the hearing committee for further review and recommendation to be returned to it within fifteen (15) days and in accordance with its instructions. Within ten (10) days after receipt of such recommendation, after referral, the review body shall take action.

(a) Review Body in Accord with Executive Committee of the Medical Staff. If the Review Body's decision is in accord with the Executive Committee of the medical staff's last recommendation in the matter, if any, it is immediately

effective. If the Governing Body acted as the review body, its action is the final decision in the matter.

(b) Review Body Not in Accord with Executive Committee of the Medical Staff's. If the Review Body's action has the effect of changing the Executive Committee of the medical staff's last recommendation, if any, the matter may, at the discretion of the Governing Body, result in a joint meeting of the Governing Body and the Executive Committee to permit the Governing Body to explain its actions.

ARTICLE IX JOINT CONFERENCE COMMITTEE

9.1 Joint Conference Review. Within ten (10) days of its receipt of a matter referred to it by the governing body pursuant to the provisions of this Fair Hearing Plan, a joint conference committee of an equal number of members of the Executive Committee and governing body shall convene to consider the matter and shall submit its recommendation to the governing body within thirty (30) days. The joint conference committee shall be composed of a total of six (6) members selected in the following manner: three (3) members from the Executive Committee appointed by the Chief of Staff, and three (3) members from the Governing Body appointed by the Chairperson of the Governing Body.

9.2 Action of the Governing Body. The Governing Body's action on the matter following receipt of the joint conference recommendation shall be immediately effective and final.

ARTICLE X GENERAL PROVISIONS

10.1 Hearing Officer Appointment and Duties. The use of a Hearing Officer to preside at the evidentiary hearing of the Ad Hoc Committee of the medical staff is optional, and is to be determined by the Governing Body after consultation with the medical staff. A Hearing Officer may or may not be an Attorney at Law, but must be experienced in conducting hearings.

10.2 Attorneys.

(a) At Hearing (Alternative: Permitting Representation). The practitioner may be represented by an attorney at the hearing, provided the request for the hearing indicates the practitioner's intent to be represented.

(b) At Hearing (Alternative: Permitting Representation at Ad Hoc Hearing Committee's Option). If the practitioner desires to be represented by an attorney at the hearing, the request for the hearing must so state. The hearing committee determines, in its' sole discretion, whether to permit such representation.

(c) At Appellate Review. If the practitioner desires to be represented by an attorney at an Appellate Review appearance, the request for the review must declare the

practitioner's desire to be so represented. The Appellate Review Body determines, in its' sole discretion, whether to permit such representation.

(d) Equal Representation and Preparation Assistance. If, and only if, the practitioner is represented by an attorney at the hearing and/or Appellate Review, may the Executive Committee of the medical staff or the governing Body be allowed such representation. The foregoing provision shall not be deemed to deprive the practitioner, the Executive Committee of the medical staff or the governing Body of legal counsel in connection with preparation for a hearing or an Appellate Review.

10.3 Number of Hearings and Reviews. Notwithstanding any other provision of the medical staff bylaws or its' Plan, no practitioner is entitled as a right to request more than one evidentiary hearing and Appellate Review, with respect to the subject matter that is the basis of the adverse recommendation or action triggering the right.

10.4 Release. By requesting a hearing or Appellate Review, under this Plan, a practitioner agrees to be bound by the provisions of the medical staff bylaws relating to immunity from liability.

10.5 Amendment. These Corrective Action Procedures and Fair Hearing Plan may be amended or repealed in whole or in part by one of the following mechanisms provided such amendment remains consistent with the whole medical staff bylaws.

(a) a resolution of the Executive Committee of the medical staff recommended to and adopted by the Governing Body.

(b) a resolution of the Governing Body taken on its' own initiative, after notice to the Executive Committee of the medical staff of its' intent, including a reasonable time period for response.

10.6 Responsibilities and Authorities. The procedures outlined elsewhere in the medical staff and Hospital Corporate Bylaws, regarding medical staff responsibility and authority to formulate, adopt and recommend medical staff bylaws and amendments thereto and the circumstances under which the Governing Body may resort to its' own initiative in accomplishing those functions, apply as well to the formulation, adoption and amendment of these Corrective Action Procedures and Fair Hearing Plan, provided that the Executive Committee of the medical staff may act for the staff in making necessary recommendations to the Governing Body.

OUR LADY OF VICTORY HOSPITAL, INC.

Stanley, Wisconsin

I have received and read the Bylaws of the Governing Body of Our Lady of Victory Hospital, Inc., the Bylaws, Rules and Regulations and Fair Hearing Plan of the Medical, Osteopathic, Dental and Podiatric Staff and agree to be bound by the terms of these documents; additionally, I agree to provide for continuous care of my patients if I am granted membership / clinical privileges, in all matters relating to consideration of my application.

_______________________________________ _____________________________

(Signature) (Date)

____

(Printed Name)