SACRED HEART-SAINT MARY'S HOSPITALS, INCORPORATED

BYLAWS
OF THE MEDICAL STAFF OF

SAINT MARY'S HOSPITAL OF RHINELANDER, WISCONSIN

Revised September 2011

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PREAMBLE

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

DEFINITIONS

a) The term "Allied Health Professional" means an individual, other than a licensed physician, dentist or podiatrist, who is: admitted to practice in the Hospital either through the Medical Staff Bylaws process or an alternate approval process per Medical Staff policy; who is either licensed, certified or registered in the state or who is trained and qualified in a recognized health care discipline to exercise various degrees of judgment within the areas of his/her professional competence; and who is qualified to render direct or indirect medical care under the supervision of a Practitioner who has been accorded privileges to provide such care in the Hospital. Allied Health Professionals are not members of the Medical Staff, but are affiliated with the Medical Staff as a body known as the Allied Staff.

b) The term "days," unless designated otherwise, shall mean calendar days. The term "business days" shall mean those days on which the administrative offices of the Hospital are open (and therefore excludes weekends and holidays).

c) The term "Fair Hearing Plan" means those policies and procedures related to corrective action for Practitioners set forth in an appendix, and considered a part of these Bylaws.

d) The term "Medical Staff" means the Hospital's organized component of physicians, dentists, and podiatrists appointed by the Governing Body and granted specific clinical privileges for the purpose of providing quality medical, dental, and podiatric care for patients of the Hospital.

e) "Medical Staff Year" means the 12-month period commencing the 1st day of January and ending on the 31st day of December of each year.

f) The term "President" means the individual appointed by the Governing Body to act in its behalf in the overall management of the Hospital.

g) The term "Practitioner" means, unless otherwise expressly limited, any physician, dentist, or podiatrist applying for or exercising clinical privileges granted by the Hospital.

h) The term "Provider" means, unless otherwise expressly limited, any Practitioner or Allied Health Professional applying for or exercising clinical privileges granted by the Hospital.

i) The term “Governing Body” shall mean the Board of Directors of the Hospital.

j) The term “Member” means any physician (M.D. or D.O.), dentist, or podiatrist holding a current license to practice within the scope of his or her license who is a member of the Medical Staff.

k) The term “in good standing” for the purposes of these Bylaws will mean an individual who, at the time the issue of standing is raised, has not been suspended during the current term of appointment for any purpose as set forth in these Bylaws and the Rules and Regulations. Only members in good standing shall be eligible to vote for the election of officers, or for any other matters which are presented for vote at a Medical or Surgical Service meeting or at a General Medical Staff meeting.

l) The term “Medical Executive Committee” means the Executive Committee of the Hospital’s Medical Staff.

SECTION 1 PURPOSES AND RESPONSIBILITIES

1.1 <u>Purposes and Responsibilities</u>

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

(a) participate as a member of an organized health care arrangement (“OHCA”) in coordinating and supporting patient health information privacy and security practices as stated in the “Notice of Privacy Practices” and as required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”);

(b) provide leadership in the development and implementation of the organization’s patient safety program and activities;

(c) provide oversight in the process of analyzing and improving patient satisfaction;

(d) provide that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital receive quality medical care;

(e) be the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by individual Practitioners and the obligations of Medical Staff membership are fulfilled;

(f) serve as the primary means for providing assurance as to the appropriateness of the professional performance and ethical conduct of its members and to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of healing arts and the resources locally available;

(g) provide a means through which the Medical Staff may participate in the Hospital’s policy-making and planning process;

(h) provide an acceptable level of professional performance of all Practitioners and Allied Staff authorized to practice in the Hospital through appropriate delineation of the clinical privileges that each Provider may exercise in the Hospital and through an ongoing and focused review and evaluation of each Provider's performance in the Hospital;

(i) provide a continuing education program fashioned, at least in part, on the type and nature of care offered by the Hospital, on needs demonstrated through the patient care evaluation, and other quality improvement activities;

(j) provide a utilization review and management program to allocate inpatient medical and health services based upon determinations of individual medical needs;

(k) provide an organizational structure that allows continuous monitoring of patient care practices;

(l) conduct reviews and evaluation of the quality of patient care through quality improvement activities;

(m) prepare and complete, in compliance with these Bylaws, medical records for all the patients to whom care is provided in the Hospital;

(n) recommend to the Governing Body action with respect to appointments, reappointments, staff category and corrective action;

(o) assure the Governing Body that appropriate clinical privileges have been delineated;

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

(q) initiate and pursue corrective action with respect to Members when warranted;

(r) develop, administer, and seek compliance with these Bylaws and the Rules and Regulations of the Medical Staff, other patient care related Hospital and Medical Staff policies and departmental/Service Rules and Regulations;

(s) assure that members work cooperatively with Members, Allied Health Professionals, nurses, Hospital administration and others so as not to adversely affect patient care;

(t) assure that Members make appropriate arrangements for coverage for their patients as determined by the Medical Staff;

(u) assure that Members participate in such emergency service coverage or consultation panels as may be determined by the Medical Staff;

(v) provide leadership in strategic planning, identifying community health needs, and in setting appropriate institutional goals and implementing programs to meet those needs;

(w) conduct all its affairs involving the Medical Staff, patients, and employees in a manner and an atmosphere free of unlawful discrimination based on age, sex, sexual orientation, creed, disability, national origin, race, handicap or financial status or any other characteristic protected by law;

(x) comply with OSHA Standards; and

(y) discharge such other staff obligations as may be lawfully established from time to time by the Governing Body, Medical Staff or Medical Executive Committee.

1.2 On-Call Physicians

(a) It is the policy of the Hospital, that if they routinely offer a service to the public, the service will be made reasonably available through on-call Emergency Department coverage. This includes the provision of physician services through members of the Active Medical Staff.

(b) The Hospital will maintain a list of Active Medical Staff physicians, by individual name, who are designated as on-call for identified specialties, to provide requested evaluation and/or indicated stabilizing treatment to patients with an emergency medical condition, consistent with the Hospital's EMTALA policy.

(c) Each major medical specialty on the Active Medical Staff, when so designated by the Governing Body following a recommendation of the Medical Executive Committee, must have an on-call schedule, listing physicians by individual name. Coverage shall be maintained within reason, depending on the number of physicians in a specialty, Medical Staff resource limitations, and other parameters established by law and the Hospital. A physician may not refuse to be included on the call schedule if required by their specialty. Likewise, a physician may not selectively take call for only his or her own patients or those of a partner, unless such arrangement has been agreed to and approved by the Hospital. Members of the Medical Staff taking call shall, within the scope of their privileges, provide emergency care to patients without regard to source of payment or ability to pay.

(d) When a major medical specialty is comprised of Active Medical Staff physicians from a single professional group the call schedule shall be comprised of physicians from that group.

(e) If a major medical specialty is comprised of Active Medical Staff physicians from two or more professional groups, coverage for a patient requiring the services of that specialty shall be provided in the following manner in descending priority depending upon the availability of the physician:

(1) The physician with whom the patient has an existing professional relationship (i.e., his/her patients).

(2) A physician from a professional group practice with which the patient has a medical relationship (i.e., attached patients).

(3) A physician designated as on call for "unattached patients." "Unattached patients" are defined as patients who have no medical relationship with a Staff Member of the Hospital.

(4) Each professional group will be responsible for creating and maintaining a call schedule for provision of coverage for both attached and unattached patients. Emergency Department unattached patient call coverage shall be provided equitably by all members of the Medical Staff within a given specialty. Each specialty shall be responsible for creating this call schedule; cases of dispute shall be resolved by the appropriate Service Chairperson. Cases of continuing dispute shall be resolved by the Medical Executive Committee which will serve as the final arbiter.

(f) Active Medical Staff Members must comply with the call coverage requirements so established.

(g) In the event an on-call Active Medical Staff physician and Emergency Department ("ED" or "emergency") physician disagree about whether the services for the on-call physician are required, the ED physician will make a determination of whether the on-call physician will report to the Hospital. Failure to respond to a request from the attending or emergency physician is grounds for corrective action.

(h) The Active Medical Staff physician on-call for each specialty is responsible for arranging coverage in his/her absence by another physician in the same specialty with appropriate privileges, and for notifying the Hospital switchboard of the coverage arrangement.

(i) In the event that a particular specialty is unavailable due to unforeseen conditions beyond the physician's control, patient disposition will be determined by the attending Emergency Department physician, consistent with the Hospital's EMTALA policy.

SECTION 2 MEMBERSHIP

2.1 <u>Membership a Privilege</u>

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

2.2 Qualifications

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

(b) Physicians must provide evidence of graduation from a medical or osteopathic school meeting standards of the Accreditation Council of Graduate Medical Education or otherwise possess equivalent qualifications.

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

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

(c) Medical Staff Members must submit, annually, evidence of financial responsibility in at least the minimum amount required by Chapter 655 of the Wisconsin Statutes, and participation in the Wisconsin Injured Patients and Families Compensation Fund, which may be satisfied by a certificate from an acceptable insurance company evidencing professional liability coverage. Failure to maintain such required financial responsibility shall be grounds for automatic suspension of a Member's clinical privileges, and, if within 90 days after written warning of the delinquency the Member does not provide evidence of required financial responsibility, the Member's membership and privileges shall be automatically terminated.

(d) Acceptance of membership on the Medical Staff shall constitute the Member's agreement that he/she will strictly adhere to the ethics of his/her respective profession and the Ethical and Religious Directives for Catholic Health Care

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

(e) At initial appointment, reappointment, and as a condition of new privileges, Medical Staff Members must submit a statement which certifies that their current health status does not in any way impair their ability to safely exercise the clinical privileges requested or to provide high quality care for patients. A disability which can be reasonably accommodated shall not bar the granting of membership or clinical privileges. As a part of this certification, Medical Staff Members must provide evidence of a current TB skin test and be assessed, by titer, for immunity to select vaccine-preventable diseases as delineated in Hospital policy. A recent chest x-ray and a completed Employee Health TB Questionnaire are required for positive TB skin test results. The requirement for a TB skin test and titers for vaccine-preventable diseases may be waived for telemedicine providers whose services are provided offsite and, therefore, do not have direct patient contact. As a part of the initial appointment process, Applicants must provide evidence of a health assessment including a physical exam. Thereafter, the Governing Body may precondition the granting of new privileges, reappointment, or continuing exercise of clinical privileges upon the Practitioner's undergoing a health examination, as requested by the Medical Executive Committee and subject to applicable law.

(f) Medical Staff Members must submit, and at all times maintain on file in the Medical Staff Office, current evidence of continued, unrestricted licensure and DEA registration, if applicable.

(g) No person, who is otherwise qualified, shall be denied membership/privileges by reason of race, color, creed, handicap, disability, sex, sexual orientation, national origin or other legally protected characteristic.

(h) As part of their appointment and reappointment to the Medical Staff, Practitioners have a continuing obligation to comply with all Hospital and Medical Staff Bylaws, Rules and Regulations, policies and procedures, and federal and state laws and regulations, as well as The Joint Commission and other accreditation agency standards as designated by the Hospital, applicable to the practice of their profession in a hospital setting.

(i) No applicant who is currently barred from providing services in the Hospital under Chapter DHS 12 of the Wisconsin Administrative Code is eligible or qualified for Medical Staff membership or for any clinical privileges.

(j) No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified for Medical Staff membership or for any clinical privileges.

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

(l) Practitioners employed by or subject to a contract with the Hospital, whether full or part time, whose duties are medico-administrative in nature and include clinical responsibilities or functions with the Medical Staff involving their professional capacity, must be Members of the Medical Staff, achieving this status by the same procedure provided for other Medical Staff members. Their privileges should be delineated in accord with their education, training, competency and judgment.

2.3 Conditions of Appointment and Reappointment

(a) All initial appointments to the Medical Staff are provisional and shall be made by the Governing Body of the Hospital upon the recommendation of the Medical Executive Committee and shall be for a period of not less than one (1) nor more than two (2) years. Reappointments to the Medical Staff shall be for a period not to exceed two years.

(b) The Governing Body shall not take action on an application for appointment or reappointment, or cancel an appointment previously made, without prior conference and consultation with the Medical Executive Committee.

(c) Appointments to the Medical Staff shall confer on appointees only such privileges as are specified in the notice of appointment and in conformity with these Bylaws, Rules and Regulations and any other applicable Hospital or Medical Staff policies. Applicants for Active Staff membership must be able to render continuous care and supervision of their patients, or arrange for it in their absence, and agree to accept staff committee assignments and to provide emergency care and consultation within the scope of their privileges and practice for patients admitted to the Hospital.

(d) As part of appointment and reappointment to the Medical Staff and the exercise of clinical privileges, Practitioners have a duty to notify the Hospital of each of the following. Practitioners also have a continuing obligation to promptly notify the President of, and to provide such additional information as may be requested regarding, each of the following:

(1) denial, reduction, voluntary or involuntary revocation, limitation, or suspension of his or her professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal governmental agency relating to his or her professional license, or the imposition of terms of probation or limitation by any state;

(2) denial, application withdrawal, voluntary or involuntary loss, reduction, change of membership category, relinquishment or suspension of staff membership or voluntary or involuntary loss, limitation, reduction, or

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

(3) voluntary or involuntary cancellation, loss or change of professional liability insurance coverage;

(4) receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation, or the filing of charges regarding health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or of any state;

(5) any proposed or actual exclusion from any federally-funded health care program, any notice to the individual or representative of proposed or actual exclusion, or any pending investigation of the individual from any health care program funded in whole or in part by the federal government, including Medicare and Medicaid;

(6) receipt of notice of the filing of any suit against the member or submission of adversity to the Wisconsin Injured Patients and Families Compensation Fund alleging professional liability in connection with the treatment of any patient;

(7) settlement of a claim by a payment from an insurance company (or by the Practitioner or any other party) or any agreement that results in a release from liability being given by a patient to the Practitioner;

(8) any criminal conviction or pending criminal charges, including but not limited to any findings by a governmental agency that the Practitioner has been found to have abused or neglected a child or patient or has misappropriated the property of any patient;[1]

(9) removal from a managed care organization's provider panel for quality of care reasons or unprofessional conduct;

(10) any notification by any quality improvement organization or a third party payor reimbursement program concerning any utilization or quality of care review or sanction imposed; and

(11) any circumstance(s) or change in circumstance(s), including, but not limited to health status, that would materially affect his ability to perform essential functions of the Medical Staff or to exercise the clinical privileges granted, or that may put patients or Hospital staff at risk.

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

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

SECTION 3 CATEGORIES OF THE MEDICAL STAFF

3.1 The Medical Staff

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

3.2 The Provisional Medical Staff

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

3.3 The Active Medical Staff

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

3.4 The Affiliated Medical Staff

(a) The Affiliated Medical Staff shall consist of physicians who wish to fully participate in the functions of the Active Medical Staff but do not meet the criteria for Active Staff membership because they do not attend patients at the Hospital. Affiliated Medical Staff members shall complete a provisional period, as described in Section 3.8. Active medical staff membership at another hospital is not required.

(b) They may order outpatient diagnostic procedures and provide history and physical examinations.

(c) A review of office practice may be performed to provide a basis for evaluation of the member's professional competence and judgment. Members of the Affiliated Medical Staff must reasonably comply with all requests for such practice information, data, and/or reports.

(d) Affiliated Medical Staff members may serve and vote on all Medical Staff committees except the Medical Executive Committee, the Credentials Committee, and the Quality Improvement Committee, but may not hold office. They may attend and vote at General Medical Staff meetings. They will be assigned to a Service and may attend meetings and vote, but may not hold office.

(e) Members of the Affiliated Medical Staff who wish to attend patients in the Hospital will be required to either request a change in status to Provisional Staff (before being advanced to Active Staff, if appropriate), or request a change to Courtesy Medical Staff, as appropriate.

3.5 The Courtesy Medical Staff

(a) The Courtesy Medical Staff shall consist of Practitioners who attend patients in the Hospital but who are unable to actively participate in the functions of the Medical Staff. Courtesy Members shall complete a provisional period, as described in Section 3.8.

(b) Members of the Courtesy Medical Staff may serve and vote on all Medical Staff committees, with the exception of the Medical Executive Committee, the Credentials Committee and the Quality Improvement Committee, but may not hold office. They may attend General Medical Staff meetings but may not vote.

(c) Members of the Courtesy Medical Staff must be members of the Active or Provisional staff of another hospital where they actively participate in a patient care evaluation program and other quality improvement activities similar to those required of the Active Staff of the Hospital. Members of the Courtesy Staff must reasonably comply with all requests for practice information, data and/or reports. The requirement for Active Staff membership on another hospital's staff shall be waived if his/her practice is limited to the Emergency/Urgent Care Department.

(d) Members of the Courtesy Medical Staff shall be allowed to occasionally admit patients to the Hospital. "Occasional" is considered not more than twelve (12) inpatient admissions during any Medical Staff Year. If a member of the Courtesy Medical Staff admits more than twelve (12) patients in any Medical Staff Year, the member will be required to request a change in status to the Provisional Medical Staff and will be subject to Section 3.2 of these Bylaws.

(e) Physicians other than Active or Provisional Staff who contract to staff the Hospital's Emergency Department will be appointed to the Courtesy Staff upon

satisfactory completion of the credentialing process. The scope of privileges granted to Courtesy Staff Emergency Department physicians, unless otherwise specified by the Credentials Committee, is outlined in the Rules and Regulations.

(f) If a member of the Courtesy Staff has not attended a patient at the Hospital for a period of two (2) years, an application for reappointment will not be sent. The member will be considered to have voluntarily resigned unless the member requests an application for reappointment in writing prior to the end of his/her current appointment.

(g) Locum tenens/temporary physicians whose services are needed for more than one hundred twenty (120) consecutive days may be appointed to the Courtesy Staff for one 2-year period. The requirement for Active Staff membership on another hospital's Medical Staff may be waived. These physicians may have an unlimited number of admissions. In unusual circumstances, the Medical Director of the appropriate Service will be consulted to determine if a locum tenens/temporary physician may be reappointed to the Courtesy staff for an additional 2-year period. If he/she concurs, an application for reappointment will be sent.

3.6 The Consulting Medical Staff

(a) The Consulting Medical Staff shall consist of recognized specialists who are active in their specialties and have signified a willingness to accept such appointment to the Medical Staff. Members of the Consulting Staff shall be members of specialty boards, diplomats of one of the national boards of medical specialties, or other Practitioners who, in the opinion of the Credentials Committee and the Medical Executive Committee, are qualified for consultation work in their specialty.

(b) Members of the Consulting Staff shall have such non-surgical clinical privileges as may be granted by the Governing Body in accordance with these Bylaws. All surgical privileges require Active, Provisional, or Courtesy Staff membership. Consulting Members shall complete a provisional period, as described in Section 3.8.

(c) Members of the Consulting Staff may serve and vote on all Medical Staff committees, with the exception of the Medical Executive Committee and the Credentials Committee, but may not hold office. They may attend general Medical Staff meetings but may not vote.

(d) A member of the Consulting Staff must be a member of the Active or Provisional Staff of another hospital where he/she actively participates in a patient care evaluation program and other quality maintenance activities similar to those required of the members of the Active Staff of this Hospital. Members of the Consulting Staff must reasonably comply with all requests for practice information, data and/or reports.

(e) The requirement for Active Medical Staff membership at another hospital shall be waived for telemedicine providers whose practice at the Hospital is limited to providing preliminary reads/diagnoses.

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

3.7 Allied Health Professionals

The Hospital, acting through and with the assistance of its Medical Staff, has the overall responsibility for determining the scope of duties and clinical activities of those individuals who provide patient care in the Hospital. This responsibility extends not only to members of the Medical Staff, but also to such Allied Health Professionals and to employees of Medical Staff members who engage in activities in the Hospital. Accordingly, the following will be a protocol for the Hospital and its Medical Staff to fulfill this responsibility. There shall be two categories of Allied Health Professionals, and they shall hereafter be designated as Allied Health I and Allied Health II. Each initial appointment to either category of Allied Health Professional shall be provisional for a period of at least (1) one year, similar to seeking membership on the Medical Staff.

If an Allied Health I's sponsoring Practitioner's clinical privileges at the Hospital are terminated, the Allied Health I's privileges will also terminate. The president of a clinic or employing Practitioner who terminates the services of such individual shall be responsible for immediately informing the President of such termination.

Termination of the personnel relationship with a clinic or employing Practitioner shall result in automatic termination of the individual's clinical privileges and Allied Health status at the Hospital.

(a) **Allied Health I**

Eligibility: Individuals serving in this category must be either licensed or certified by the State of Wisconsin to practice their profession with a degree of independence subject to general supervision of or collaboration with a Practitioner. Allied Health I's shall include professionals as the Medical Executive Committee and the Governing Body may determine by rule.

An Allied Health I may perform specified patient care services under Medical Staff supervision or collaboration and pursuant to written guidelines. Scope of practice is determined for each individual by his/her supervising/collaborating physician with approval of the Credentials Committee, the Executive Committee the Governing Body and consistent with state law.

An Allied Health I may be employed by the Hospital, employed by another entity or individual or, except in the case of Physician Assistants, may be independent practitioners. Physician Assistants may not be self-employed.

Review Process: All individuals who are determined by the Credentials Committee as appropriate for categorization as an Allied Health I shall complete an individual application form as is approved by the Medical Executive Committee and the Governing Body. After verification of the information on the application form, the application, and any appended job description or duties, shall be reviewed by the Chairman of the Service to which the Allied Health I is assigned. The Service Chairman shall submit a recommendation as to clinical duties and privileges to the Credentials Committee. In determining the extent of duties and privileges, the following criteria shall be considered by the Service Chairman and Credentials Committee:

(1) exercising of such judgment within their areas of competence, provided always that a member of the Medical Staff shall have ultimate responsibility for the care of the patient;

(2) participating in the management of patient care under the supervision and direction of a member of the Medical Staff; and

(3) notations on patients' charts shall be permitted to the extent allowed by governing Wisconsin law and such appropriate Rules and Regulations of the Medical Staff as may apply, provided that such notations are within the scope of his or her license, certificate or other legal credential.

Upon approval of the Credentials Committee, the application shall be submitted to the Medical Executive Committee and the Governing Body of the Hospital for approval.

Responsibilities and Prerogatives: An Allied Health I is not a member of the Hospital's Medical Staff and has neither the duties nor the responsibilities required of Medical Staff members. Such individuals may, with the approval of the president of the Medical Staff or Medical Staff committee/Service Chairman, serve on Medical Staff committees to which they are appointed, or attend Service meetings. Their ability to vote on committees or at Service meetings will vary depending upon the circumstances. They are allowed to attend Medical Staff meetings at the discretion of the president of the Medical Staff when matters of interest in their profession may be discussed, and they may be required to attend meetings of the Medical Staff or its Services which entail a discussion or review of cases in which they participated in clinical care but they may not vote.

(b) **Allied Health II**

Eligibility: The category of Allied Health II shall include persons employed by Practitioners, Allied Health I's, health agencies, or the Hospital, who have certain clinical responsibilities or direct patient care duty for patients in the Hospital, as well as such employees of a clinic or agency whose duties routinely require performing tasks in the Hospital. Such individuals may or may not be certified or registered by the State of Wisconsin a professional society or association, and if

they are an employee of a clinic or foundation, may be persons who hold a counterpart position to that of a Hospital employee. Allied Health II's may include various technicians and technologists, and other categories of medical support personnel as determined by the Medical Executive Committee and Governing Body.

Review Process: Except for those requesting to perform surgical duties, the Credentials Committee of the Medical Staff may recommend that an Allied Health II be approved either individually or categorically, depending upon the intended scope of their activities, job descriptions, clinical expertise required, and such other factors as it deems appropriate. If approval is to be categorical, the personnel file of the individual shall be reviewed by the administrative head of the appropriate Hospital Service and the counterpart position at a clinic, if such exists, and approved by the Hospital's President and the clinic president. If approval is to be individualized, the Credentials Committee shall review the training, qualifications, and expected duties of the individual, letters of reference, and obtain the concurrence of the Chairman of the Service to which the Allied Health Professional or responsible staff member is assigned. A report of actions shall be included in the Credential's Committee report to the Medical Executive Committee.

An Allied Health II requesting to perform surgical duties shall complete an individual application form as is approved by the Medical Executive Committee and the Governing Body. After verification of the information on the application form, the application, and any appended job description or duties, shall be reviewed by the Chairman of Surgical Services. The Service Chairman shall submit a recommendation as to clinical duties and privileges to the Credentials Committee. Upon approval of the Credentials Committee, the application shall be submitted to the Medical Executive Committee and the Governing Body of the Hospital for approval.

Responsibilities and Prerogatives: An Allied Health II shall be an employee of a Practitioner, Allied Health I, the Hospital or a health agency and as such shall be entitled to the rights established pursuant to that employment relationship. They are not members of the Medical Staff of the Hospital and, accordingly, have no corresponding rights or duties as are granted to Members of the Medical Staff.

(c) **Provisional Period**

(1) At the end of the one-year provisional period, the Medical Executive Committee, upon written recommendation of the Credentials Committee and the Chairman of the Service to which the Allied Health Professional was assigned, may recommend to advance the Allied Health Professional to regular Allied Health Professional status, continue the provisional status for an additional period of up to one (1) year, or terminate his/her privileges. Advancement from provisional status shall be for a period of up to two years, running from the date of advancement off of provisional

status to the next date the Allied Health Professional is scheduled for reappointment.

(2) Initial Allied Health Professional appointees shall be assigned to a Service and shall have their performance observed by the Service Chairman, or his/her representative, during the provisional period. During the first six (6) months of the provisional period, it will be the responsibility of the Chairman of the appropriate Service to orient the Allied Health Professional to the Service and it shall be the responsibility of the president of the Medical Staff to establish and oversee a monitoring protocol for provisional Allied Health Professionals.

(3) The monitoring protocol shall afford the Hospital and the Allied Health Professional the following:

(i) the ability to evaluate the Allied Health Professional's working relationship with his/her supervisors and, as applicable, sponsoring Physician;

(ii) a current review of the clinical abilities of the Allied Health Professional;

(iii) a resource person or committee to whom the Allied Health Professional can or must seek consultations;

(iv) a resource, in the form of the monitor or monitoring committee, with whom other staff members or Hospital personnel may confer concerning the Allied Health Professional on interim status; and

(v) a basis for recommending privileges at the completion of the interim period.

(4) At the conclusion of the initial six (6) month monitoring period as set forth above, or upon completion of the review and satisfactory evaluation of the appropriate type and number of cases as determined by the Service Chairman/designee and the Credentials Committee Chairman, the Credentials Committee shall recommend that the interim monitoring process be terminated, that an additional interim period of monitoring be established, that the Allied Health Professional's status be terminated, or that other action be taken as deemed appropriate by the Credentials Committee. Should the Credentials Committee determine to extend the interim monitoring of an Allied Health Professional for a second period, not to exceed six months, such may be done with no further action being required by the Medical Executive Committee or the Governing Body. Further, the Allied Health Professional shall not be entitled to a hearing or review of such decision in accordance with the Fair Hearing Plan. Any decisions to extend such monitoring protocol beyond two initial six-month

periods must be recommended by the Medical Executive Committee and ratified by the Governing Body.

(5) An Allied Health Professional whose status is provisional and who does not qualify for advancement to regular status within two (2) years should be scheduled for a personal interview with the president of the Medical Staff and the Chairman of the appropriate Service to discuss the status of the Allied Health Professional's continued service at the Hospital. The president of the Medical Staff shall report to the Medical Executive Committee or Credentials Committee, as the case may be, which may recommend conditional appointment with continued monitoring, advancement to regular Allied Health Professional status, or termination of privileges.

(d) **Review Process for Adverse Privilege Determinations Involving Allied Health Professionals**

Allied Health Professionals are accorded the right to hearing and appeal set forth in the Fair Hearing Plan of these Bylaws.

(e) **Temporary Privileges**

In limited circumstances, upon receipt of an application for Allied Health Professional privileges, the President and president of the Medical Staff, or their designees, upon the recommendation of the appropriate Service Chairman, shall have the authority to grant temporary clinical privileges for a period of one hundred twenty (120) days. A minimum of information, as delineated in Medical Staff policy, will be required prior to the granting of temporary privileges. Temporary privileges will not be granted during pendency of application, except in unusual circumstances, and then only when information provided in the application materials reasonably supports favorable determination of qualifications. In exercising such privileges, the applicant shall act under supervision of the Chairman of the Service to which he/she is assigned, or under the supervision of a member of that clinical Service selected by the Chairman.

Locum tenens/temporary Allied Health Practitioners, whose services are needed for more than one hundred twenty (120) days, may be granted Allied Health privileges for one 2-year period.

Temporary privileges may be suspended or revoked at any time by the President, president of the Medical Staff, or the Service Chairman concerned without right of review by the Allied Health Professional whose temporary privileges have been terminated.

(f) **Reapplication for Allied Health Professionals**

Allied Health Professionals shall reapply for privileges on a biennial basis.

(g) **Procedure for Appointment and Reappointment**

Allied Health I and II desiring privileges shall be governed by Section 4 of these Bylaws as follows and except as stated to the contrary in this Section 3.7.

(h) **Sponsoring Practitioner Affirmations**

In requesting that an Allied Health I be authorized to practice in the Hospital, the sponsoring Medical Staff Member agrees:

(1) To accept responsibility for the Allied Health I's performance in the Hospital with respect to patients under his/her supervision/collaboration.

(2) To accept responsibility for the proper conduct of the Allied Health I within the Hospital, and for the Allied Health I's observation of all Bylaws, policies and Rules and Regulations of the Hospital and Medical Staff (including the maintenance of professional liability insurance coverage).

(3) To abide by all Bylaws, policies, Rules and Regulations and laws governing the use of Allied Health Professionals in the Hospital including refraining from requesting that the Allied Health I provide services beyond, or what might reasonably be construed as being beyond his/her authorized scope of practice in the Hospital.

(4) To immediately notify the Medical Executive Committee in the event any one of the following occurs:

(i) The physician modifies or terminates his supervisory or collaborative agreement with the Allied Health I;

(ii) Notification is given of the investigation of either the supervisory or collaborative physician or the Allied Health I by any state or federal agency or authority;

(iii) The employment status or the authorized scope of practice of the Allied Health I or the supervising or collaborating physician changes;

(iv) Professional liability insurance coverage is changed insofar as coverage of the acts of the Allied Health I is concerned.

3.8 All Initial Appointments Provisional

(a) Each initial appointment to the Medical Staff shall be provisional for a period of one year. At the end of this one-year provisional appointment, the Medical Executive Committee, upon written recommendation of the Credentials Committee and the Chairman of the Service to which the Practitioner was

assigned, may recommend: to advance the Practitioner to the Active Staff, continue the provisional status for an additional period of up to one (1) year; change the Practitioner's staff category; or terminate membership and privileges. Reappointment upon advancement from provisional status may be for a period of up to two (2) years, with the length of appointment running from the date of advancement off of provisional status to the next date the Practitioner's specialty is scheduled for reappointment.

(b) Initial appointees shall be assigned to a Service and shall have their performance observed by the Service Chairman, or his/her representative, during the provisional period. During the first six (6) months of the provisional appointment, it will be the responsibility of the Chairman of the appropriate Service to orient the Practitioner to the Service and it shall be the responsibility of the President of the Medical Staff to establish and oversee a monitoring protocol as set forth in Credentials Policy, Proctoring-QI Process.

(c) The monitoring protocol shall afford the Hospital and the Practitioner the following:

(1) the ability to establish pretreatment consultation requirements;

(2) a current review of the clinical abilities of the Practitioner;

(3) a resource person or committee to whom the Practitioner can or must seek voluntary or required consultations;

(4) a resource, in the form of the monitor or monitoring committee, with whom other staff members or Hospital personnel may confer concerning the Practitioner on interim status; and

(5) a basis for recommending privileges at the completion of the interim status.

(d) At the conclusion of the initial six-month monitoring period as set forth above, or upon completion of the review and satisfactory evaluation of the appropriate type and number of cases as determined by the Service Chairman/designee and the Credentials Committee Chairman, the Credentials Committee shall recommend that the interim monitoring process be terminated, that an additional interim period of monitoring be established, that the Practitioner's Medical Staff membership be terminated and privileges withdrawn, or that other action be taken as deemed appropriate by the Credentials Committee. Should the Credentials Committee determine to extend the interim monitoring of a Practitioner for a second period, not to exceed six months, such may be done with no further action being required by the Medical Executive Committee or the Governing Body. Further, the Practitioner shall not be entitled to a hearing or review of such decision in accord with the Fair Hearing Plan. Any decisions to extend such monitoring protocol beyond two (2) initial six-month periods must be recommended by the Medical Executive Committee and ratified by the Governing

Body. If the Practitioner has not attended a patient at the Hospital during his/her provisional year, the Practitioner may have his/her membership terminated and privileges withdrawn or may request to have his/her staff category changed.

(e) During the provisional period, the provisional Member of the Medical Staff shall have the prerogatives and be subject to the restrictions as set forth in these Bylaws for the category of the Medical Staff in which regular appointment is being sought.

(f) A Member of the Medical Staff whose appointment is provisional and who does not qualify for advancement to regular staff status within two (2) years should be scheduled for a personal interview with the president of the Medical Staff and the Chairman of the appropriate Service to discuss the status of the Practitioner's continued interest in membership on and privileges with the Medical Staff of the Hospital. The president of the Medical Staff shall report to the Medical Executive Committee, which may recommend to the Governing Body conditional appointment with continued monitoring, appointment to the regular staff, or termination of the staff appointment and privileges. A provisional appointee whose membership is so terminated shall have the hearing and appeal rights afforded by these Bylaws to a Member of the Medical Staff who has failed to be reappointed.

SECTION 4 PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

4.1 <u>Application for Appointment</u>

(a) Applicants desiring appointment to the Medical Staff or for designation as Allied Staff status (hereafter "Applicant") shall obtain an application and privilege request form from the President who will, in addition to the forms, supply or make available to the Applicant a copy of the appointment process and a copy of the Bylaws, Rules and Regulations, pertinent policies of the Medical Staff, the Ethical and Religious Directives for Catholic Health Care Services and the Hospital's mission statement. Physician applicants shall also receive the Medicare Notice to Physicians acknowledgement form.

(b) All Applicants shall have the burden of producing adequate information or a proper evaluation of his/her current clinical competence, character, judgment, ethics, and other qualifications, and for resolving any doubts about such qualifications. Failure to adequately complete the application form, withholding requested information, omitting significant information, or providing false or misleading information (whether intentional or not) or omitting material necessary for a full picture of the Applicant's professional history shall be a basis for denial of the application/privileges or removal from the Medical/Allied Staff and termination of privileges.

(c) Contracted Providers who desire membership/clinical privileges are subject to the same procedures as all other Applicants.

(d) All applications for the Medical/Allied Staff shall be in writing and shall be signed by the Applicant on a form prescribed by the Medical Executive Committee. The application shall require, at a minimum but as applicable, detailed information concerning the Applicant's professional education, graduate professional training, licensure, registrations, board certifications and/or other certifications, financial responsibility, previous practice and institutional affiliations (including a list of all prior hospital Medical/Allied Staff associations), CME, current health status, and at least two (2) professional references (other than program directors) pertaining to the Applicant's professional competence and ethical character. Professional references should have had direct contact with the Applicant within the preceding twenty four (24) months; have personal knowledge of the Applicant's general competencies, including patient care, medical/clinical/technical knowledge and skills, practice-based learning and improvement, interpersonal and communication skills, clinical judgment, professionalism, and systems-based practice; and be willing to provide specific written comments on these matters upon request from Hospital or Medical Staff authorities. Professional references from residents and fellows in training programs and relatives of the Applicant are not acceptable as references. Relevant practitioner-specific data, as compared to aggregate data and morbidity and mortality data, when available, shall also be considered.

(e) The application shall include information as to whether the Applicant's membership and/or clinical privileges have ever been or are in the process of being voluntarily or involuntarily revoked, suspended, reduced, denied or not renewed, or subject to probationary conditions, disciplinary action or sanctions at any other hospital or institution and whether the Applicant voluntarily or involuntarily resigned membership or privileges, withdrew an application for membership or privileges, or voluntarily or involuntarily reduced privileges as a result of peer evaluation or investigation. The application shall also include information as to whether his/her membership in local, state or national professional societies or his/her license/certification/registration to practice any profession in any jurisdiction or other professional registration (State, District or DEA) had ever been voluntarily or involuntarily revoked, suspended or reduced, or conditions of probation imposed, and as to any currently pending challenges or investigations relating to any licensure or registration, and whether he/she has ever been reprimanded or otherwise disciplined by any state or federal agency relating to the practice of his/her profession. Further, the application shall provide for the furnishing of information about professional liability claims pending or finalized and as to whether or not the Applicant has ever been refused professional insurance or had coverage canceled, had limitations placed on scope of coverage or had coverage rated up because of unusual conditions. The application shall also include information as to any past or pending involvement in any quality inquiry, sanction action or formal investigation by Medicaid, Medicare, a peer review or quality improvement organization, the Department of

Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or of any state.

(f) The application must contain a request for the specific clinical privileges desired by the Applicant.

(g) The application form shall include a signed statement that a Practitioner Applicant agrees to provide continuous care for his/her patients. All Applicants shall attest that he/she has read and understands the Bylaws and Rules, Regulations, the Ethical and Religious Directives and pertinent policies of the Medical Staff and agrees in writing to be bound by the terms thereof during the consideration of his/her application for membership on the staff and/or for clinical privileges, whether or not granted membership or clinical privileges.

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

(i) The Applicant shall sign and submit, along with the completed application, such other consents, authorizations, and releases as may be required under these Bylaws or as requested by the Hospital for the proper evaluation of the Applicant's qualifications for membership and/or privileges. The Applicant must present a current picture hospital ID card or a valid picture ID issued by a state or federal agency.

(j) Each Applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application, authorizes the Hospital to consult with members of Medical Staffs and administration of other hospitals with which he/she has been associated, and with others who may have information bearing on his/her current competence, judgment, character, relevant training, physical and emotional stability, and ethical qualifications; consents to the Hospital's inspection of all records and documents that may be material to any evaluation of his/her professional qualifications and competence to carry out the clinical privileges requested, as well as of his/her moral and ethical qualifications and physical and emotional health for staff membership and/or privileges; releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in connection with evaluating the Applicant and his/her credentials; and releases from any liability all individuals and organizations who provide information to the Hospital concerning the Applicant's current competence,

ethics, judgment, character, relevant training, and other qualifications for staff appointment and/or clinical privileges, including otherwise privileged or confidential information.

4.2 Initial Appointment Process

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

(b) Reasonable effort (two (2) written requests) will be made to secure replies from individuals/institutions listed on the application. It is the Applicant's responsibility to secure the necessary references within sixty (60) days after notification of deficiencies in the application. If an Applicant fails to obtain necessary references within sixty (60) days after notification, the application will be considered withdrawn and will cease to be processed without recourse to the Fair Hearing Plan. Exceptions may be made when information is not obtainable for good cause.

(c) After collecting references and other materials deemed pertinent, the President shall transmit the application and all supporting materials to the Chairman of the Clinical Service in which the Applicant seeks privileges for his/her documented opinion as to staff appointment, staff category assignment and/or clinical privileges and then to the Credentials Committee.

(d) Within sixty (60) days after receipt of the completed application for membership and/or clinical privileges, including references, reports and other supporting data requested of the Applicant, the Credentials Committee shall make a written report of its recommendations to the Medical Executive Committee, or, in the case of a non-surgical Allied Health II, as set forth in Section 3.7. In preparing this report, the Credentials Committee shall examine the character, professional competence, judgment, qualifications, training and ethical standing of the Applicant and shall verify, through information contained in the references given by the applicant and from other sources available to the Credentials Committee, including an appraisal from each Clinical Service in which privileges are sought, that the applicant meets all the necessary qualifications for the category of staff membership and/or the clinical privileges requested as set forth in these Bylaws.

(e) The Credentials Committee may require the Applicant to arrange for a personal interview with such individuals as the Credentials Committee may designate,

including the Chairman of the Service in which the applicant has requested clinical privileges. The Service Chairman shall provide the Credentials Committee specific written recommendations for delineating the Applicant's clinical privileges, and these recommendations shall be made a part of the Credentials Committee's report to the Medical Executive Committee or, in the case of a non-surgical Allied Health II, as set forth in Section 3.7. Refusal to participate in the interview may be grounds for Administrative denial.

(f) As part of this process, the Credentials Committee shall specifically assess competence in six core areas:

(1) Patient Care: Providers are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

(2) Medical/Clinical Knowledge: Providers are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

(3) Patient-Based Learning and Improvement: Providers are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

(4) Interpersonal and Communication Skills: Providers are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

(5) Professionalism: Providers are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and responsible attitude toward their patients, their profession, and society.

(6) System-Based Practice: Providers are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

(g) The Medical Executive Committee, at its next scheduled meeting following receipt of the Credentials Committee report (generally within thirty (30) days), shall make a recommendation to the Governing Body to approve, defer, or reject the application of those Providers whose applications are presented consistent with these Bylaws.

(h) The Governing Body or Medical Executive or Credentials Committee or Service may, at any time, request additional information in connection with a completed application, and the processing of the application shall be suspended for sixty (60)

days or until the Applicant has provided the information requested or satisfactorily explains his or her failure to do so, whichever occurs first.

(i) If the Credentials Committee and Medical Executive Committee recommendations are favorable, a Practitioner or Allied Health I and designated Allied Health II applicants shall be requested to submit information regarding his/her health status, which shall be verified and appended to the reports of the Credentials Committee and the Medical Executive Committee, for consideration by the Governing Body. Allied Health II applicants who are not applying to perform surgical duties shall be requested to submit information regarding his/her health status following a Credentials Committee recommendation.

(j) When the recommendation of the Medical Executive Committee is to defer an application for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation for provisional appointment with specified clinical privileges or for rejection for Medical Staff membership and/or clinical privileges.

(k) When the recommendation of the Medical Executive Committee is favorable to the Applicant, the President shall promptly forward it, together with all supporting documentation, to the Governing Body.

(l) Upon receipt of the reports of the Credentials Committee and the Medical Executive Committee and the Provider's health status information, the Governing Body, at its next regular meeting (generally within thirty (30) days), shall consider the reports and provisionally accept, defer, or reject the application. Any recommendations for initial appointment/privileges may include probationary conditions relating to clinical privileges and practice.

(m) The Governing Body's determination on appointment, reappointment, and/or granting of clinical privileges is based on its review and evaluation of the services of the Applicant in connection with the Hospital's program to help improve the quality of health care and to avoid improper utilization of services or facilities.

(n) When the recommendation of the Medical Executive Committee will constitute a professional review action for a Practitioner as defined in the Fair Hearing Plan, prior to any referral of the recommendation to the Governing Body for action, the Practitioner should be notified of the recommendation and given an opportunity either to waive, by accepting the recommendation, or to exercise any procedural rights to review as set forth in the Fair Hearing Plan.

(o) The Governing Body's determination includes independent criticism and evaluation of the applicant's practice based on documentation submitted by the Medical Staff. The Governing Body's consideration is independent from the conclusions of the Credentials Committee and Medical Executive Committee and may involve further investigation, but such recommendations will be taken into account in the Governing Body's review of the applicant's practice.

(p) The quality of patient care in the Hospital is considered by the Governing Body, the Medical Executive Committee, and all other committees as a primary goal in the staff appointments, reappointments, and the granting or limiting of clinical privileges.

(q) While the recommendations regarding appointment to the Medical Staff and/or clinical privileges shall be based primarily on the professional competence of the applicant, the present and future composition of the Medical and Allied Staffs shall be a consideration and criterion, as well as the ability of the Hospital to provide adequate facilities and supportive services for the Applicant and his/her patients, and patient care needs for additional staff members with the Applicant's skill and training, and the geographic location of the Applicant and his/her practice to the extent it affects the Applicant's ability to provide effective continuity of care for Hospital patients.

(r) Solely the Governing Body shall determine whether to select or reject any Applicant based on the limitations of facilities, services, staff, support capabilities, or any combination thereof. Decisions to deny membership or privileges to any otherwise qualified Provider in accord with criteria of a Medical Staff development plan or due to the existence of any contracts for exclusive provision of clinical services, shall be made by the Governing Body.

(s) The Governing Body shall, at its next regular meeting after receipt of the application and supporting material and the recommendation of the Medical Executive Committee, either:

(1) refer the application back to the Medical Executive Committee, indicating reasons for non-acceptance and setting a time limit in which a subsequent recommendation is to be made; or

(2) take final action on the application, after which the President will submit the decision to the Applicant, except that if the Governing Body's proposed final action will be contrary to the Medical Executive Committee's recommendation, the Governing Body shall submit the matter to a Joint Conference Committee with equal representation of the Medical Staff and the Governing Body for review before the Governing Body makes its final decision.

(t) When the regular Governing Board meeting schedule would delay the timely approval of a routine application that meets the criteria set forth in the Medical Staff policy on expedited credentialing, an expedited review/approval process, as set forth in the "Expedited Credentialing" policy, may be implemented following an in depth review and positive recommendation of the application by the appropriate Service Chairman, the Credentials Committee, and the Medical Executive Committee.

(u) The President will notify the president of the Medical Staff, the Service Chairman concerned, and the Applicant of the Governing Body's final decision. If the Applicant is granted membership and/or clinical privileges, the notice will state the specific Medical Staff category/type and privileges granted.

4.3 Reappointment Process

(a) The President will provide each Medical Staff Member or Allied Health Professional whose clinical privileges and/or membership are about to expire with an appropriate application for reappointment and/or renewal of clinical privileges which must be completed and submitted by a specified date. Failure without good cause to return the form and/or supporting documentation may be deemed a voluntary resignation from the Medical/Allied Staff and of all Hospital clinical privileges at the expiration of the Member's/Allied Health Professional's current appointment. A Practitioner whose membership and/or privileges are so terminated shall be entitled to the procedural rights provided in the Fair Hearing Plan for the sole purpose of determining the issue of good cause.

(b) The reappointment year will occur biennially by medical specialty.

(c) Contracted physicians, Medical Staff Officers, and Service Chairmen who desire membership and clinical privileges are subject to the same procedures as all other applicants.

(d) The reappointment application form shall include all information necessary to update the information contained in the Member or Allied Health Professional's initial application for appointment and/or clinical privileges since the last time such information was updated, including, as applicable and without limitation:

(1) voluntary or involuntary changes in Medical Staff membership and/or clinical privileges at any other hospital or institution, including, without limitation, any revocation, suspension, reduction, denial, relinquishment, or non-renewal thereof, and any withdrawal of any application for membership or privileges and the imposition of probationary conditions or disciplinary action;

(2) voluntary or involuntary suspension or revocation of licensure or registration (State, District or DEA) or any reprimand or imposition of sanctions related thereto or suspension or revocation of membership or imposition of other sanctions by any local, state or national professional society;

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

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

(5) certification of current freedom from physical or mental disability that would affect the Provider's ability to safely exercise the privileges sought, and documentation of the health assessment required by law and Hospital policy for persons providing direct patient services in the Hospital;

(6) any criminal conviction(s) or pending criminal charges;

(7) such other information about the Provider's ethics, qualifications, and ability as may be relevant to his/her current ability to provide quality patient care at the Hospital;

(8) current evidence of licensure and DEA registration and of professional liability insurance coverage;

(9) any proposed or actual exclusion from any health care program funded in whole or in part by the federal government; or any notice to the individual or his representative of proposed or actual exclusion or any pending investigation of the individual from any health care program funded in whole or in part by the federal government, including Medicare and Medicaid;

(10) receipt of any quality inquiry letter, an initial sanction notice or notice of proposed sanction or of the initiation of a formal investigation or the filing of charges related to health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or any state;

(11) updated information regarding any findings by a governmental agency that the Provider has been found to have abused or neglected a child or patient or has misappropriated the property of any patient including a fully completed Background Information Disclosure form;

(12) minimum CME requirements to maintain the license to practice his/her profession; and

(13) such other information about the Provider's ethics, qualifications and ability as may be relevant to his/her ability to provide quality patient care at the Hospital including, without limitation, a current NPDB report.

(e) In a timely manner before the monthly meeting of the Governing Body prior to the expiration of the individual's current appointment and/or clinical privileges, the Credentials Committee shall review all pertinent information available on each appointee scheduled for periodic appraisal for the purpose of determining its recommendations for reappointments to the Medical Staff and/or for the granting of clinical privileges for the ensuing two (2) years and shall transmit its recommendations, in writing, to the Medical Executive Committee, or as provided in Section 3.7.

(f) In arriving at recommendations for the reappointment of each Medical Staff member and/or the assignment of privileges to a Provider, specific consideration will be given, as appropriate, to the individual's licensure, DEA registration, professional liability coverage, current professional competency and clinical judgment in the treatment of patients, ethics and conduct, physical and mental capabilities, as they relate to the individual's ability to perform the privileges requested, participation in continuing education, the individual's pattern of care and performance within the Hospital, based on such reliable information as may be available, attendance at Medical Staff and Service meetings and participation in staff affairs, compliance with the Hospital Bylaws and the Medical Staff Bylaws, Rules & Regulations, and pertinent policies (including the timeliness of medical record completion), cooperation with Hospital personnel, efficient and effective use of the Hospital's facilities for patients, relations with other staff members, and general attitude toward patients, the Hospital and the public and other information as deemed necessary and appropriate for a proper evaluation. The applicant for reappointment and/or renewal of clinical privileges is required to submit any reasonable evidence of current health status relevant to the performance of duties that may be requested by the Hospital.

(g) Reappointment consideration will include review of the periodic appraisal of the professional activities of each member of the Medical Staff and all other individuals granted clinical privileges through the Medical Staff credentialing process, as well as periodic appraisal of health status.

(h) The results of quality assessment and improvement activities, and any monitoring performed during the prior term of appointment, if any, shall be considered in the appraisal of the applicant's professional performance, judgment, and technical or clinical skills.

(i) In a timely manner before the bimonthly meeting of the Governing Body prior to the expiration of the Practitioner, Allied Health I or designated Allied Health II's current appointment, the Medical Executive Committee shall make its recommendations concerning the reappointment or non-reappointment, as applicable, and the continuation or alteration of privileges for the next appointment period of each Provider scheduled for reappraisal. In all cases when non-reappointment or a change in staff status or clinical privileges is recommended, the reasons for the recommendation shall be stated and documented.

(j) When the recommendation of the Medical Executive Committee is a professional review action against a Practitioner giving rise to hearing rights as specified in the Fair Hearing Plan, prior to any referral of the recommendation to the Governing Body for action, the appointee involved shall be notified of the negative recommendation, and given an opportunity either to use the procedural rights contained in the Fair Hearing Plan or to accept the recommendation.

(k) Thereafter, the procedure provided herein relating to recommendation on applications for initial appointments shall be followed.

(l) When the regular Governing Board meeting schedule would delay the timely approval of a routine application that meets the criteria set forth in the Medical Staff policy on expedited credentialing, an expedited review/approval process, as set forth in the expedited credentialing policy, may be implemented following an in depth review and positive recommendation of the application by the appropriate Service Chairman, the Credentials Committee, and the Medical Executive Committee.

4.4 Modification of Membership Status or Privileges

(a) A member of the Medical Staff or any Allied Health Professional may, either in connection with the reappointment or re-privileging process or at any other time, as applicable, request modification of his/her staff category, Service assignment, or clinical privileges by submitting a written application to the President on the prescribed form, subject to the limitations of Section 4.5. Such application shall be processed in the same manner as provided in Section 4.3 above for reappointment.

(b) Requests for privileges that involve either technology or procedures new to the Hospital shall not be processed until the process for approving new technology and/or new procedures, as established by Medical Staff policy, has been completed.

(c) Requests for additional clinical privileges shall include:

- Documentation of training and experience for the privilege(s) being requested;
- Outline of course curriculum, if applicable;
- Applicable guidelines and standards from recognized specialty boards, societies, etc.;
- Patient outcome information if available; and
- Letter from proctor/Chair/etc. attesting to competency to perform the procedure/privilege being requested.

(1) Such requests shall be processed in a similar manner as provided for reappointment. Any grant of new, extended or increased clinical privileges shall also be subject to evaluation and to monitoring.

(2) Requests for privileges that involve either technology or procedures new to the Hospital shall not be processed until the process for approving new technology and/or new procedures, as established by Medical Staff policy, has been completed.

(d) Because it is inevitable that from time to time, some Providers will develop physical or mental conditions that may limit their ability to safely exercise the clinical privileges granted them, it shall be the responsibility of all Providers to

bring to the attention of the president of the Medical Staff, the appropriate Service Chairman, or the President, such conditions. Refer to Medical Staff policy entitled "Providers' Health."

(e) If, as a result of a Provider's self-reporting of a condition, the Medical Executive Committee recommends modification of membership status or privileges, the affected Provider shall be notified, in writing, of the recommendation. The recommendation shall not be considered a professional review action unless and until the Provider chooses to exercise the right to hearing available under the Fair Hearing Plan and the notice to the Provider shall so state. If the Medical Executive Committee recommends modification of membership status or privileges due to a Provider's condition initially discovered by means other than self-reporting, such recommendation shall constitute a professional review action without regard to whether or not the Provider exercises the hearing rights available under the Fair Hearing Plan.

4.5 Reapplication After Adverse Action

(a) A Provider who has received a final adverse professional review action regarding appointment or clinical privileges or both, and who did not exercise any of the hearing rights provided in the Fair Hearing Plan, shall not be eligible to reapply for the membership status or privileges that were the subject of the adverse action for a period of six (6) months from the date of final adverse action.

(b) A Provider who has received a final adverse professional review action regarding appointment or clinical privileges or both, and who exercised some or all of the hearing rights provided in the Fair Hearing Plan, shall not be eligible to reapply for the membership status or privileges that were the subject of the adverse action for a period of two (2) years from the date of final adverse action.

(c) Any reapplication under this Section 4.5 shall be processed as an initial application, but the Applicant shall submit such additional information as the Medical Executive Committee, Service or Governing Body may require in demonstration that the basis for the earlier adverse action no longer exists.

(d) If the recommendation of the Medical Executive Committee, or the action proposed by the Governing Body, upon a reapplication under subsection 4.5(b) continues to be adverse to a Provider, the scope of the hearing and review to which the Provider is entitled shall be limited to consideration of the sufficiency of the additional information submitted in demonstration that the basis for the earlier adverse action no longer exists.

4.6 Leave of Absence and Reappointment

(a) Any member of the Active, Consulting, Courtesy Staff and any Allied Health Professional who will be absent for a period of time exceeding eight (8) weeks must provide written notification to the Medical Staff president or the President. Written notification of a leave will also be accepted from Clinic Administration.

Such notification shall state the start and, if known, anticipated end dates of the leave and the reasons for the leave (i.e., military duty, additional training, family matters or personal health). If the Provider fails to return before the last day of approved leave (including any extension granted up to the end of the current term of appointment), and does not reapply as describe below, the Provider shall be considered to have resigned his or her membership and/or clinical privileges, as applicable, and shall not be entitled to any hearing or appellate review. A request for Medical Staff membership and/or clinical privileges subsequently received from a Provider so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for reappointments.

(b) Upon return from leave of absence prior to the expiration of the Provider's then current term of appointment, the Provider shall be required to submit a written request for reinstatement to the appropriate Service Chairman and the Credentials Committee. The Provider may be required to submit such additional information as may be relevant to his/her request for reinstatement, including interval status information. The Credentials Committee and the Service Chairman will review the request and submit their recommendations to the Medical Executive Committee or otherwise consistent with Section 3.7. Thereafter, the process for reappointment contained in Sections 4.3(e) through 4.3(i) shall be followed.

(c) The Practitioner or Clinic Administration, or, in the case of an Allied Health I, the Allied Health Professional and/or his/her sponsoring Practitioner, when applicable, shall be responsible for obtaining coverage for his/her patients during the leave.

(d) A leave of absence may not extend beyond the term of the Provider's current term of appointment. If the Provider is not able to return from leave before his/her current appointment term and/or clinical privileges are set to expire but has submitted an application for reappointment and/or renewal of clinical privileges, action on the application will be deferred for up to two (2) years until the Provider identifies with reasonable certainty the date of anticipated return from leave. Deferring the application due to continued leave of absence shall not give Providers any rights to hearing or appeal. The Provider will then be required to supply interval data through the date of the notice of anticipated return from leave to begin the reappointment process. The Provider's Medical Staff membership and/or clinical privileges shall be considered expired between the time of the expiration of the term in which the leave began and the date of reappointment.

4.7 Time Periods for Processing

Applications for appointment or reappointment and clinical privileges shall be considered in a timely and good faith manner by all individuals and groups who are required by these Bylaws to act on such applications and, except for good cause, shall be processed within the time periods specified in this Section 4. However, the time periods specified are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the Provider to have his/her application processed within those periods nor to

create a right for a Provider to be automatically appointed, reappointed for the coming term or granted requested privileges.

4.8 Administrative Denial

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

SECTION 5 PRIVILEGES

5.1 Delineation of Clinical Privileges

(a) A Provider providing clinical services in the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Governing Body pursuant to the procedures set forth in these Bylaws, except as provided in Sections 5.2 and 5.3 of this Section, or as otherwise described in Section 3.7.

(b) Every initial application for staff appointment and/or designation as an Allied Health Professional must contain a request for the specific clinical privileges desired by the Provider. The evaluation of such request shall be based upon the Provider’s current licensure, education, training, specific and relevant experience, judgment, demonstrated current competence, peer references, evidence of physical ability to perform the privileges requested, professional practice review data, and other relevant information. The Provider shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests. A separate file is provided for each individual.

(c) Periodic redetermination of clinical privileges, and the increase or curtailment of same, shall be based upon the criteria set forth in subsection 5.1(b) above and factors such as: direct observation of care provided; the health of the Provider as it relates to the Provider’s ability to safely perform the privileges requested; review of records of patients treated in the Hospital, other hospitals or the Provider's clinic/office, as applicable; and review of the records of the Medical Staff which document the evaluation of the Provider’s participation in the delivery of patient care. Whether the individual has actually exercised all the requested privileges

with sufficient frequency since the time of last appointment to indicate current proficiency shall also be a factor in the redetermination process.

(d) Requests to modify clinical privileges or to obtain additional clinical privileges shall be made in writing to the President on a prescribed form on which the type of clinical privileges desired and the Provider's relevant recent training and/or experience must be stated. The President shall then forward such request to the Credentials Committee. The request shall then be reviewed and it shall be processed in the same manner and pursuant to the same criteria as an application for initial appointment and clinical privileges.

(e) If the Provider voluntarily relinquishes staff appointment and/or clinical privileges, the Provider may not reapply for appointment and/or for the same clinical privileges for a period of one year. lf privileges and/or appointment are restricted by the Governing Body, Section 4.5 shall determine when the Provider may reapply.

(f) Privileges granted to dentists and podiatrists should be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist and podiatrist may perform must be specifically defined and recommended in the same manner as all other surgical privileges. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chairman of Surgical Services. All dental and podiatric patients must receive the same basic medical appraisal as patients admitted to other services. A physician Member of the Medical Staff must be responsible for the general care of the patient during hospitalization. The dentist or podiatrist is responsible for the dental or podiatric care of the patient including the dental or podiatric history and physical examination, discharge summary, and all appropriate elements of the patient's record.

(g) Practitioners and Allied Health Professionals may write orders within the scope of their license, as limited by law and as consistent with Medical Staff regulations.

(h) Privileges granted to Allied Health Professionals shall be based upon the criteria set forth in Section 5.1(b) above, as well as direct observation by the Medical Staff.

(i) Each individual with clinical privileges agrees to provide for continuous quality care for patients.

(j) Providers granted privileges to perform history and physical examinations must complete and document the results of the history and physical examination no more than thirty (30) days before or twenty-four (24) hours after admission or registration of each patient, but prior to surgery or a procedure requiring anesthesia services. When the history and physical examination is completed within the thirty (30) days prior to admission or registration, an examination of the patient must be documented in the medical record within twenty four (24)

hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. Additional rules and policies may be present for examinations for specific conditions, which, if present, also apply.

(k) Clinical privileges shall be reviewed for renewal or revision biennially and shall coincide with the reappointment process or re-privileging process for Allied Health Professionals, as applicable.

5.2 Temporary Privileges

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

(a) Upon receipt of a complete application for privileges, and when the Practitioner is otherwise qualified, the President and the president of the Medical Staff, or their designees, upon the recommendation of the Chairman of the Service concerned or his/her Service designee, shall have the authority to grant temporary clinical privileges for a period of one hundred twenty (120) days. Certain minimum information, as delineated in Medical Staff policy, including verification of current licensure and a comprehensive background check, will be required prior to the granting of temporary privileges. Temporary privileges will not be granted during pendency of application, except in unusual circumstances, and then only when information provided in the application materials reasonably supports favorable determination of qualifications and the Practitioner has provided evidence of financial responsibility in accordance with the requirements of these Bylaws. In exercising such privileges, the Practitioner shall act under the supervision of the Chairman of the Service to which he/she is assigned, or under the supervision of a member of that clinical Service selected by the Chairman.

(b) The President and/or his/her designee, upon the recommendation of the Medical Staff president, may grant temporary privileges to a Practitioner who is neither a member of the Medical Staff nor an applicant for membership in the same manner and upon the same conditions as in granting temporary privileges for an applicant for Medical Staff membership. Under these circumstances, however, temporary privileges are granted to attend not more than six (6) patients in any one year, after which the Practitioner to whom such temporary privileges have been granted shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients. Before being granted such privileges, the applicant must sign an acknowledgment that he/she has received a copy and read the Medical Staff Bylaws, Rules and Regulations and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges.

(c) A Practitioner serving as a locum tenens for a member of the Medical Staff may be permitted to attend patients for a period not to exceed one hundred twenty (120) days without applying for membership on the Medical Staff, provided the Practitioner's credentials have been approved by the Chairman of the Service

concerned and the President. Except in unusual circumstances, locum tenens Practitioners whose services are required for more than the one hundred twenty (120) days allowed for locum tenens privileges, may be appointed to the Courtesy Staff pursuant to these Bylaws.

(d) In connection with the granting of temporary privileges, special requirements of supervision and reporting may be imposed on the individual to whom such privileges are granted. Failure to comply with such special conditions shall immediately terminate such Practitioner's temporary privileges. Temporary privileges may be suspended or revoked at any time by the President, the president of the Medical Staff, or the Service Chairman without right of hearing or appeal by the individual whose temporary privileges have been terminated. In the event of such termination, the Practitioner's patients then in the Hospital shall be assigned to a Medical Staff member by the president of the Staff, The wishes of the patient shall be considered, where feasible, in choosing a substitute.

(e) No Practitioner is entitled to temporary privileges, as a matter of right nor to the procedural rights afforded by the Fair Hearing Plan because of his/her inability to obtain temporary privileges or the termination, modification or suspension of temporary privileges.

5.3 Emergency Privileges

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

5.4 Disaster Privileges

(a) A modified credentialing and privileging process for eligible volunteer physicians may be implemented when the disaster plan has been implemented, and the Hospital is unable to handle immediate patient care needs. The President (or designee) or the Medical Staff president (or designee) are authorized to grant disaster privileges. Decisions to grant privileges will be made on a case-by-case basis, in accordance with the needs of the organization and its patients and the qualifications of volunteer physicians, upon presentation of a valid government-issued photo ID and at least one of the following: (1) a current picture hospital ID card that clearly identifies professional designation; (2) a current license to practice or primary source verification of the license; (3) identification indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), MRC, ESAR-VHP or another recognized state or federal organization or group; (4) identification indicating the individual has been granted authority to render

patient care treatment, and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity); or (5) identification by current Hospital or Medical Staff member(s) who possess knowledge regarding the individual's ability to act as a Practitioner during a disaster.

(b) In the case of a disaster, any physician, to the degree permitted by his/her license, regardless of Medical Staff status or clinical privileges, shall be authorized to do everything reasonably necessary to preserve the life or health of a patient. Members of the Active Medical Staff will be expected to respond if called.

(c) The Medical Staff will oversee the professional practice of volunteer physicians.

(d) Primary source verification of licensure will begin as soon as the immediate disaster situation is under control and must be completed within seventy-two (72) hours from the time the volunteer physician presents to the organization, or as soon as possible in the extraordinary circumstance that primary source verification cannot be completed within seventy-two (72) hours. If extraordinary circumstances exist, there must be documentation of why primary source verification could not be performed in the required time frame, evidence of the physician's demonstrated ability to continue to provide adequate care, treatment, and services, and an attempt to rectify the situation as soon as possible. Based on information obtained regarding the professional practice of the volunteer, the Hospital will make a decision regarding the continuation of the initially granted disaster privileges within seventy-two (72) hours.

(e) Medical Staff Services will issue a Hospital badge to volunteer physicians who have been granted disaster privileges identifying them as a credentialed disaster volunteer physician.

(f) Disaster privileges will be granted for the period needed during the disaster, and will automatically terminate at the end of that time. Privileges will be terminated, immediately, upon receipt of adverse information or upon receipt of evidence that the volunteer physician is not competent to render services. Termination of disaster privileges does not entitle the volunteer to a fair hearing or appeal under the Fair Hearing Plan. All documentation will be retained in the Medical Staff Office.

5.5 Limited Clinical Privileges

(a) Limited clinical privileges may be granted to Practitioners in residency or fellowship training at another institution when additional coverage is needed to ensure quality care.

(b) Limited clinical privileges may be granted for up to one 2-year period, will expire upon completion of residency or fellowship training, and may not be requested after submission of an application for Medical Staff membership.

(c) Application for limited clinical privileges does not preclude subsequent formal application for Medical Staff membership upon completion of the Practitioner's formal training.

(d) Practitioners in residency or fellowship training may apply for core privileges only. Special requirements of supervision and reporting may be imposed on Practitioners who have been granted such privileges. Failure to comply with such special conditions shall immediately terminate the Practitioner's privileges.

(e) See Credentials Policy, Clinical Privileges for Residents and Fellows.

5.6 Telemedicine Privileges

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

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

5.7 Focused Professional Practice Evaluation

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

(1) for all initially requested privileges; and

(2) in response to concerns regarding the provision of safe, high quality patient care. Triggering events for such evaluation may consist of single incidents or evidence of a clinical practice trend.

(b) The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of the Provider's current clinical competence, practice behavior and ability to perform the requested privilege.

(c) Information for focused professional practice evaluation includes, as appropriate, chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient.

5.8 Ongoing Professional Practice Evaluation

(a) A process of ongoing professional practice evaluation exists to continuously review Providers' care and to identify professional practice trends that impact on quality of care and patient safety.

(b) The criteria used in the ongoing professional practice evaluation may include such factors as:

(1) The review of operative and other clinical procedures performed and their outcomes;

(2) Patterns of blood and pharmaceutical usage;

(3) Requests for tests and procedures;

(4) Length of stay patterns;

(5) Morbidity and mortality data;

(6) Provider's use of consultants; and

(7) Other relevant factors as determined by the Medical Staff.

(c) The information used to review the ongoing professional practice evaluation factors shall include, as appropriate, periodic chart reviews, direct observations, monitoring of diagnostic and treatment techniques and discussions with other individuals involved in the care of each patient, such as consulting Practitioners, assistants at surgery, nursing, and administrative personnel.

(d) Relevant information obtained from the ongoing professional practice evaluation shall be integrated into Medical Staff performance improvement activities. Such information shall help determine whether existing privileges should be maintained, revised or revoked.

SECTION 6 IMMUNITY FROM LIABILITY

6.1 Conditions

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

(a) any act, communication, report, recommendation or disclosure, with respect to any individual performed or made at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law;

(b) such privileges shall extend to members of the Medical Staff and Governing Body, the President and designated representatives and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purposes of this Section, the term "third parties" means both individuals and organizations that have supplied information to or received information from an authorized representative of the Governing Body or of the Medical Staff.

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

(d) such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related but not limited to:

(1) applications for appointment or clinical privileges;

(2) periodic reappraisals for reappointment or clinical privileges;

(3) investigations and corrective action, including summary suspension;

(4) hearings and appellate reviews;

(5) medical care evaluations;

(6) monitoring of members of the provisional staff or of any other individual under the monitoring protocol established by the Medical Staff;

(7) utilization reviews;

(8) profiles and profile analyses;

(9) malpractice loss prevention; and

(10) other Hospital, Service, or committee activities related to quality patient care and inter-professional conduct,

(e) the acts, communications, reports, recommendations and disclosures referred to in this Section may relate to an individual's professional qualifications, clinical competency, character, ethics, conduct, judgment, or any other matter that might directly or indirectly have an effect on patient care;

(f) in furtherance of the foregoing, each individual shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Section in favor of the individuals and organizations specified in Section 6.1(b), subject to such requirement, including the exercise of a reasonable effort to ascertain

truthfulness, as may be applicable under the laws of this state. Execution of such releases is not a prerequisite to the effectiveness of this Section;

(g) the consents, authorizations, releases, rights, privileges and immunities provided by Section 4.1 of Section 4 of these Bylaws for the protection of this Hospital's Practitioners, Allied Health Professionals, appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointments, shall also be fully applicable to the activities and procedures covered by this Section. All provisions in these Bylaws and in other forms used in the credentials process relating to authorizations, confidentiality of information and immunity from liability are in addition to and not in limitation of other immunities provided by law; and

(h) each individual who exercises clinical privileges or performs any service that is monitored under the monitoring protocols established under these Bylaws, as a condition of exercising the clinical privileges or performing the service, shall indemnify and hold harmless all members of the Medical Staff and Governing Body, the President, and their designated representatives from any liability arising from or out of the services performed by the individual being monitored, including but not limited to claims of malpractice, negligent supervision, and any other basis. The exercise of clinical privileges or performance of any service that is monitored constitutes the individual's acceptance of the terms of this indemnification agreement.

SECTION 7 CORRECTIVE ACTION AND HEARING RIGHTS

7.1 <u>Hearing Rights</u>

Whenever privileges are denied, suspended, reduced, limited or terminated; staff membership denied, suspended, or revoked; admitting prerogatives limited; consultation required which limits clinical privileges; or terms of probation/preceptorship imposed which limit clinical privileges, the Provider affected may have a right to have a hearing in the manner and according to the limits set forth in the Fair Hearing Plan.

7.2 <u>Corrective Action</u>

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

7.3 <u>Exceptions</u>

Neither the issuance of a warning, a letter of admonition, or a letter of reprimand, nor the denial, termination or reduction of temporary privileges, nor any other action except

those specified in the Fair Hearing Plan shall give rise to any right to a hearing or appellate review.

7.4 Agreements with Providers

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

SECTION 8 OFFICERS

8.1 Officers of the Medical Staff

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

(1) President

(2) Vice President

8.2 Qualifications of Officers

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

8.3 Election of Officers

(a) Nominations for officer positions may be identified by the Hospital's Nominating Committee, or may occur from the floor if the nominee is present and consents to the nomination.

(b) The Nominating Committee shall consist of a minimum of three Provisional/Active/Affiliated Staff Members, including the immediate Past President, appointed by the president of the Medical Staff.

(c) The Nominating Committee will nominate one or more candidates for the positions of:

(1) President

(2) Vice President

(d) Officers shall be elected by a majority vote of the Active Medical Staff Members present, every other year, as further described herein.

(e) Election years for Medical Staff officers will be staggered with the election years of Service Chairman and Service Representatives to the Medical Executive Committee.

8.4 Term of Office

All officers shall serve a two-year term unless they are removed pursuant to Section 8.7. No officer may serve more than three (3) consecutive terms. Officers shall take office on the first day of the Medical Staff Year.

8.5 Vacancies in Office

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

8.6 Duties

(a) **President**: The president shall serve as the chief administrative officer of the Medical Staff and report to the Medical Executive Committee and the Governing Body. The Medical Staff president's duties are to:

(1) act in coordination and cooperation with the President of the Hospital in all matters of mutual concern within the Hospital;

(2) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

(3) be responsible for accurate and complete minutes of all meetings, attend to all correspondence, and, if there are funds, act as treasurer;

(4) be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations and policies; for implementation of sanctions where these are stipulated for noncompliance; and for presentation to the Medical Executive Committee in those instances where corrective action may be recommended to the Governing Body;

(5) appoint committee members to all standing and special Medical Staff committees, including multidisciplinary committees, except the Medical Executive Committee and appoint all committee Chairmen who may serve an unlimited number of two-year terms;

(6) serve as ex officio member of all Medical Staff committees and Chairman of the Medical Executive Committee;

(7) represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and President of the Hospital;

(8) serve as the responsible representative of the Medical Staff to receive, understand and interpret the policies of the Governing Body to the Medical Staff and to report and interpret to the Governing Body, in return, on the performance and maintenance of quality of its delegated responsibility to provide medical care;

(9) ensure, with the President, that the Hospital's quality assurance program is implemented and effective for all patient care related services; that the findings of the program are incorporated into a well-defined method of accessing staff performance; and that the findings, actions and results of the program are reported to the Governing Body as necessary;

(10) be responsible for the orientation and educational activities of the Medical Staff, subject to the policies of the Governing Body;

(11) be spokesman for the Medical Staff in its external professional and public relations;

(12) in conjunction with the Chairmen of Medical and Surgical Services:

- oversee the clinical and administrative activities of the Medical Staff;
- oversee the professional performance of all Medical Staff members and recommend clinical privileges for each member;
- recommend criteria for clinical privileges relevant to care provided in each Service;
- recommend off-site sources needed for patient care;
- ensure the Medical Staff is involved in the integration of the primary functions of the organization;
- oversee the integration of interdepartmental and intradepartmental services;
- recommend a sufficient number of qualified competent persons to provide care/services;
- determine the qualifications and competence of staff who are Practitioners or Allied Health Professionals;

- ensure that the Medical Staff continually assesses and improves its performance through participation in quality improvement activities;
- recommend space and other resources needed by the Medical Staff; and

(13) perform such other functions as may from time to time be delegated by the Medical Staff or the Governing Body.

(b) **Vice President**: In the absence of the president, he/she shall assume all the duties and have the authority of the president. He/she shall be a member of all committees as assigned and in particular shall function as liaison between the Credentials Committee and the Medical Executive Committee.

8.7 Removal from Office

(a) Bases for removal from office may include, without limitation:

(1) failure to continuously meet the qualifications for office

(2) failure to satisfactorily perform the duties of office

(b) An officer of the Medical Staff may be permanently removed from office by a 2/3 majority vote of the Governing Body following its receipt of a recommendation of a 2/3 majority vote of the Provisional/Active/Affiliated Medical Staff and a recommendation from the Medical Executive Committee.

(c) An officer may be temporarily removed from office by a majority vote of the Medical Executive Committee. The temporary removal will be effective until the next meeting of the Provisional/Active/Affiliated Medical Staff at which time removal may become permanent if approved by the Governing Body as provided in Section 8.7(b).

SECTION 9 CLINICAL SERVICES

9.1 Organization of Services

(a) Each Service in the Hospital shall be organized as a separate division of the Medical Staff, and shall elect a Chairman who shall be a member of the Medical Executive Committee and responsible to the Medical Executive Committee and the president of the Medical Staff.

(b) The Hospital's clinical Services are comprised as follows: Medical Services (Internal Medicine, Family Practice, Hospitalist, Emergency Medicine, Psychiatry, Oncology, Pediatrics, Radiation Oncology, Rheumatology, Neurology, Dermatology, Occupational Medicine, Physiatry, Cardiology) and Surgical Services (General Surgery, Orthopedic Surgery, Anesthesiology,

Obstetrics/Gynecology, Radiology, Pathology, Ophthalmology, Otolaryngology, Urology, Podiatry, Dentistry, Pain Management) and others as designated by recommendation of the Medical Executive Committee and approved by the Governing Body, from time to time.

(c) The creation of additional Services or sections, or the termination of Services or sections shall be accomplished as the need arises by the Hospital Medical Executive Committee with the approval of the Governing Body.

(d) Medical and Surgical Service meetings will be scheduled quarterly in January, April, July, and October.

9.2 Qualifications, Selection and Tenure of Service Chairmen

(a) The Service Chairman shall be a member of the Hospital's Active Medical Staff, qualified by training and experience and demonstrated ability for the position and in the Service's clinical area, and who is willing and able to discharge the functions of a Service Chairman.

(b) The Chairman shall be certified by an appropriate specialty board or shall have affirmatively established comparable competence through the credentialing process.

(c) The Chairman shall be elected by a simple majority vote at a fall Service meeting on the odd-numbered years, by those Provisional, Active and Affiliated Medical Staff Members assigned to the Service. In the event of a tie vote among the top vote-getters, the names of the tied Practitioners will be sent on a second ballot.

(d) The Chairman shall serve a two-year term beginning the first day of the Medical Staff year but no more than three consecutive terms.

(e) Election years for Service Chairmen will be staggered with the election years of Medical Staff Officers.

9.3 Functions of Service Chairmen

(a) The Chairman shall be responsible for the clinically-related and administratively-related activities of the Service, including the functioning of the Service. He/she shall have general supervision over the clinical work within the Service, and shall report to the Medical Staff president and the Medical Executive Committee.

(b) The Chairman shall be responsible for continually assessing and improving the quality of care, treatment, and services and performance through participation in quality improvement activities, for coordinating the integration of interdepartmental and intradepartmental services, for integrating the Service into the overall functioning of the organization, and for the maintenance of quality control programs.

(c) The Chairman will be responsible for the orientation and continuing medical education of all Service members.

(d) The Chairman is an essential element in the line of authority within the Medical Staff organization and shall be accountable to the Medical Executive Committee and president of the Medical Staff for all professional and Medical Staff administrative activities in the department.

(e) The Chairman is responsible for the implementation of actions taken by the Medical Executive Committee.

(f) The Chairman must maintain continuing surveillance of the professional performance of all Members of the Medical Staff and other Providers with privileges in the Service and must report regularly thereon to the Medical Executive Committee.

(g) The Chairman shall assure adherence to the Hospital Bylaws and the Medical Staff Bylaws and Rules and Regulations by all Medical Staff members practicing in his/her Service.

(h) The Chairman is responsible for recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Service and shall transmit to the Medical Executive Committee the Service's recommendations concerning the classification, reappointment, and delineation of clinical privileges for all members of the Service.

(i) The Chairman, together with the Medical Staff and administration, shall establish the type and scope of services required to meet the needs of the patients and the Hospital, including recommendations for space and other resources needed within the Service and off-site sources for needed patient care, treatment, and services not provided by the Service or the organization.

(j) The Chairman shall develop and implement policies and procedures that guide and support the provision of care, treatment, and services in the Service.

(k) The Chairman shall be responsible for recommending a sufficient number of qualified and competent persons to provide care, treatment, and services within the Service,

(l) The Chairman is responsible for determining the qualifications and competence of Hospital Staff, including those who are not Practitioners or Allied Health Professionals, in the Service who provide patient care, treatment, and services.

9.4 <u>Removal from Service Chairmanship</u>

(a) Bases for removal from Service Chairmanship include, without limitation:

(1) failure to continuously meet the qualifications for the position

(2) failure to satisfactorily perform the duties of the position

(b) A Service Chairman may be permanently removed from the position by a 2/3 majority vote of the Governing Body following its receipt of a recommendation of a 2/3 majority vote of the Provisional, Active, and Affiliated Medical Staff and a recommendation from the Medical Executive Committee.

(c) A Service Chairman may be temporarily removed from the position by a majority vote of the Medical Executive Committee. The temporary removal will be effective until the next meeting of the Provisional, Active, and Affiliated Medical Staff at which time removal may become permanent if approved by the Governing Body as provided in Section 9.4(b).

9.5 Vacancies in Service Chairmanship

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

9.6 Function of the Service

(a) Each clinical Service must recommend to the Medical Executive Committee its own criteria for the granting of clinical privileges in that Service based on the medical specialties involved.

(b) The Medical Staff Services, whether acting through their Service Chairpersons, subcommittees, or as a whole, are a major component in the Hospital's program organized and operated to help improve the quality of health care in the Hospital and its activities will be conducted in a manner consistent with the provisions of Sections 146.37 and 146.38 of the Wisconsin Statutes. The peer review protections of these statutes, including the protection of the confidentiality of Service records and proceedings, are intended to apply to all activities of the Service and include activities of the individual members of the Service as well as other individuals designated by the Service to assist in carrying out the duties and responsibilities of the Service (including but not limited to participating in monitoring plans) including Hospital administration and the Governing Body. Service and/or Service committees may also be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act and a "review body" as referenced in the Wisconsin Statutes.

(c) Each medical specialty, through its designated Service, shall develop objective criteria that reflect current knowledge and clinical experience to be used in assessing and improving patient care. Pursuant to these criteria, each Service will have representatives serve on the Quality Improvement Committee to review and consider selected deaths, unimproved patients, patients with infections, complications, problems in diagnosis and treatment, and such other instances believed to be important. In addition, high risk, high volume, or problem prone populations will be selected for in depth evaluation.

(d) Each Service is responsible for acting on reports from Medical Staff committees.

(e) The medical specialties within each Service shall be encouraged, but not required, to meet separately monthly to review and analyze, on a peer-group basis, the clinical work of the specialty.

9.7 Assignment to Services

(a) Assignments of members of all categories of the Medical Staff and all other Providers with clinical privileges to clinical Services shall be made by the Governing Body on the recommendation of the Medical Executive Committee pursuant to Section 4 of these Bylaws or provided in Section 3.7. Members of the Services shall be well qualified, meeting the criteria established by the individual Service.

(b) Providers may have clinical privileges in one or more Service in accord with their experience and training, and shall be subject to all the rules of each Service and to the jurisdiction of the Chairman of the clinical Service involved. A Provider should identify himself/herself with one clinical Service for the purposes of participating in required functions of the Medical Staff, holding office, or fulfilling any of the other obligations which go with Medical Staff membership.

SECTION 10 COMMITTEES

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

10.1 Standing Committees

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

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

(1) The Medical Executive Committee will be composed of the president, the vice president, the Medical and Surgical Service Chairmen, two internal medicine representatives, two individuals representing specialties with fewer than three physicians, and one individual from each specialty with three or more physicians. The Service Chairmen and Medical Staff Officers shall be the representatives of their respective specialties. When the Service Chairman or Medical Staff Officer is from a specialty having

two representatives, only one additional representative from that specialty will be elected. Medical Executive Committee membership may include Providers other than physicians so long as the majority of the voting members are fully licensed physician members of the Medical Staff actively practicing in the Hospital. No Medical Staff member actively practicing in the Hospital is ineligible for membership on the Executive Committee solely because of his/her professional discipline or specialty. The President and/or his designees, and the Nurse Executive of the Hospital, should attend all meetings of this committee ex officio and without vote.

(2) The Medical Executive Committee is empowered to act on behalf of the organized Medical Staff, between meetings of the Medical Staff, and to coordinate the activities and general policies of the various administrative departments and the Services, as indicated by the Medical Staff Bylaws and Rules and Regulations. The Medical Executive Committee shall meet monthly and maintain a permanent record of its proceedings and actions.

(3) The duties of the Medical Executive Committee shall be:

(i) to represent the Medical Staff and to act on its behalf as needed under such limitations as may be imposed by these Bylaws;

(ii) to be regularly involved in Medical Staff management including the enforcement of Medical Staff Rules and Regulations and committee and Service affairs;

(iii) to coordinate the activities and general policies of the Medical Staff as required;

(iv) to receive and act upon reports from the Medical Staff Services, functions, committees, and other assigned activity groups;

(v) to formulate and implement policies of the Medical Staff not otherwise the responsibility of clinical Service personnel;

(vi) to take all reasonable steps to ensure professionally ethical conduct on the part of all members of the Medical Staff, and to initiate and/or participate in Medical Staff disciplinary or appeals measures as indicated;

(vii) to provide liaison between Medical Staff and the President and the Governing Body;

(viii) to recommend action to the President on matters of a medico-administrative nature;

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

(x) to fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to the patients in the Hospital. The Medical Executive Committee shall monitor all medical care quality assessment and improvement activities and be responsible for taking any necessary and appropriate action or delegating the responsibility for such action to the appropriate Medical Staff or multi-disciplinary committee or group;

(xi) to ensure that the Medical Staff is kept abreast of the accreditation status of the Hospital;

(xii) to report to each of the Services through the Service Chairmen who are Medical Executive Committee members;

(xiii) to review the credentials of all Applicants and to make recommendations for Medical Staff membership, assignment to Services, and delineation of clinical privileges;

(xiv) to consider periodically all information available regarding performance and clinical competence of Medical Staff members and others with clinical privileges;

(xv) to request evaluations of Providers privileges through the Medical Staff process in instances where there is doubt about an applicant's ability to perform the privileges requested;

(xvi) to consider amendments to the Bylaws, Rules and Regulations and policies of the Medical Staff as necessary for the proper conduct of its work;

(xvii) to have the option to review and approve Service rules and regulations subject to the approval of the Governing Body;

(xviii) to be responsible for making recommendations to the Governing Body relating to the structure of the Medical Staff; the mechanisms used to review credentials and delineate individual clinical privileges; the mechanisms by which memberships on the Medical Staff may be terminated; the mechanism for fair hearing procedures; and the participation of the Medical Staff in Hospital performance improvement activities;

(xix) to be responsible for annual review of the adequacy and appropriateness of all services; and

(xx) to perform such other functions as may from time to time be delegated by the Medical Staff or Governing Body.

(4) Election to the Medical Executive Committee. The Medical Staff president and vice president are elected as set forth in Section 8.3. Service Chairmen are elected as set forth in Section 9.2. Individuals on the Medical Executive Committee representing particular specialties or groups of specialties are elected biennially by the members of the specialty groups they represent at the last specialty meeting of the Medical Staff Year.

(5) Removal from the Medical Executive Committee.

(i) Upon written request of 20% of the Active Medical Staff directed to the chair of the Medical Executive Committee, or the Medical Staff president or the President, or by certification by two physicians with special qualification in the appropriate medical field(s) that the member cannot be expected to perform his duties because of illness for minimum of three months, a member will be considered for removal. Such request shall include a list of the allegations or concerns precipitating the request for removal.

(ii) Reasons for Removal may include: removal from current office or Service Chair position; or loss or suspension of medical staff appointment.

(iii) A member removed from service pursuant to this Section shall be so notified in writing by the Medical Staff president and advised of his rights to a review by the remaining Medical Executive Committee, if any. If the Medical Staff president is the member in question, the immediate past-president of the Medical Staff shall carry out the duties of the president during the removal process until the issue is resolved, at which time the president (if not removed) will resume his duties or the vice president will take over the remaining term of the removed president. The member in question will be relieved of his Medical Executive Committee duties until the question is resolved.

(iv) A meeting of the Medical Executive Committee shall be called within seven (7) business days to consider the matter. A quorum of the Medical Executive Committee must be present to act on the matter. The member in question shall have no vote in the matter and may be excluded from the meeting. The member in question shall be permitted to make an appearance before the Medical Executive Committee prior to its taking final action on the request. A member may be removed by an affirmative vote of two-thirds of the Medical Executive Committee members present at a meeting at which there is a quorum. The final decision of the Medical

Executive Committee shall be given promptly to the member in question in writing by the Medical Staff president.

(b) **The Credentials Committee**: The Credentials Committee shall be a joint committee of both the Hospital and Ministry Sacred Heart Hospital, an affiliated facility operated as a critical access hospital in Tomahawk, Wisconsin. Membership on the Credentials Committee shall consist of Members of the Active Staff of each Hospital, to include each Hospital's Vice President, so selected as to insure representation of the major clinical specialties and consideration of each hospital's specific needs and opportunities. Its duties shall be:

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

(2) to send a specific report to the Hospital's Medical Executive Committee on each Applicant for Medical Staff appointment and/or clinical privileges, as applicable. Such reports relative to staff appointment and delineation of clinical privileges shall include a consideration of the recommendations from the Service Chairman in which the Applicant requests privileges;

(3) to review reports that are referred by the Medical Executive and Quality Improvement Committees and by the president of the Medical Staff;

(4) to arrive at a decision regarding the performance of a Practitioners and Allied Health Professionals and formulate a recommendation to the Medical Executive Committee or other referring committee;

(5) to review all information available regarding the competence of staff members and as a result of such reviews, to make recommendations for the granting of privileges, reappointments, and the assignment of

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

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

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

10.2 Multi-disciplinary Committees Involving Medical Staff

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

(a) Infection Control Committee

(b) Quality Improvement Committee

(c) Emergency Department Committee

(d) Bylaws Committee

(e) Utilization Review Committee.

10.3 Special Committees

The Medical Executive Committee may establish such other special committees as may be required for the effective and efficient operation of the Hospital and for the proper discharge of the Medical Staff's responsibility for assuring optimum patient care in the Hospital, and may provide for Medical Staff and, as applicable, Allied Health Professional representation thereon. The Medical Executive Committee may also assign new functions to existing committees or make certain committee functions the responsibility of the Medical Staff as a whole. The president of the Medical Staff may appoint members of the Medical Staff and, as applicable, Allied Health Professionals to special committees.

10.4 Medical Staff Functions

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

10.5 Peer Review Protection

Medical Staff committees are a major component in the Hospital’s program organized and operated to help improve the quality of health care in the Hospital, and their activities will be conducted in a manner consistent with the provisions of Sections 146.37 and 146.38 of the Wisconsin Statutes. The peer review protections of these statutes, including the protection of the confidentiality of committee records and proceedings, are intended to apply to all activities of the committee and include activities of the individual members of Medical Staff committees as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committees (including, but not limited to, participating in monitoring plans) including, but not limited to, Hospital administration and the Governing Body. Medical Staff committees may also be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act and a “review body” as that term is used in the Wisconsin Statutes.

10.6 Removal from Committees

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

SECTION 11 MEETINGS

11.1 Staff Meetings

There shall be regular meetings of the general Medical Staff as determined by the Medical Staff, but at least twice a year. The officers of the Medical Staff shall be elected at the last meeting of the Medical Staff Year on the even-numbered years and take office at the following January meeting. The annual meeting of the Staff shall be the January meeting.

11.2 Special Meeting

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

11.3 Attendance at Meetings

Each member of the Active/Affiliated and Provisional Medical Staff categories shall be encouraged to attend meetings of the Medical Staff, their assigned Service, and assigned committees, but attendance at any specified frequency is not required unless specified as criteria for membership in their assigned Service. Nonetheless, attendance records will be maintained.

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

11.4 Quorum and Voting

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

11.5 Minutes

Minutes of each regular and special meeting of the Hospital's Medical Staff, and its Committees or Services, shall be prepared and shall include a record of attendance of members and the action taken on each matter. The minutes shall be signed by the presiding officer and copies shall be submitted to those in attendance for approval, and

the minutes shall, thereafter, be forwarded to the Medical Executive Committee. The Medical Staff Services Office and each committee and Service shall maintain a permanent file of the minutes of each meeting. All Medical Staff members may have access to meeting minutes that are not otherwise privileged and confidential, upon sufficient notice to the Medical Staff president, committee or Service Chairman, as applicable.

SECTION 12 RULES, REGULATIONS AND POLICIES

12.1 Medical Staff Responsibility

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

12.2 Methodology

(a) The Medical Staff Rules and Regulations shall be reviewed periodically and revised as necessary. The review shall be undertaken by a committee appointed by the president of the Medical Staff and any proposed amendments and revisions shall be recommended to the Medical Executive Committee. The Medical Executive Committee will consider the recommendations and bring proposals to the Medical Staff.

(b) Rules and Regulations may be adopted, amended or repealed at any regular or special meeting of the Medical Staff by a two-thirds majority vote of the Provisional/Active/Affiliated Staff members present, provided at least 10% of all Provisional/Active/Affiliated Staff members entitled to vote are present in person or by written proxy. Such changes shall become effective when approved by the Governing Body.

(c) In addition to the amendment process for the Rules and Regulations set forth above, the Medical Staff may, upon a vote of the Medical Staff using the methodology described in subsection (b) above, recommend amendments to the Rules and Regulations directly to the Governing Body, provided that the recommendation is first communicated to the Medical Executive Committee. The timing and method of presentation to the Governing Body will be consistent with the Hospital's corporate bylaws.

(d) In the event that urgent amendment of the Rules and Regulations is required in order to comply with law, regulation or accreditation requirements, the Medical Staff hereby delegates authority to the Medical Executive Committee to recommend, for the Governing Body's provisional approval, a provisional amendment to the Rules and Regulations without prior notification to or approval of the Medical Staff. In such cases, the Medical Executive Committee shall immediately notify the Medical Staff of the provisional amendment and provide an opportunity for retrospective review of the provisional amendment. If there is

no conflict over the provisional amendment, the amendment stands. If conflict exists, the Conflict Resolution process set forth in Section 14.2 will be initiated.

12.3 Policies

(a) Policies are apart from the Rules and Regulations and, if specific to a Service of the Hospital, may be adopted, amended or repealed at any regular or special Service meeting by a two-thirds majority vote of the Provisional/Active/Affiliated Staff members present at the Service meeting provided at least 10% of all Provisional/Active/Affiliated Staff members entitled to vote in the Service are present in person or by written proxy.

(b) For policies that affect the Medical Staff as a whole, the Medical Staff hereby delegates authority to the Medical Executive Committee to adopt and amend policies as may be necessary to carry out its functions. Approval for adoption, amendment or repeal must be obtained from the Medical Executive Committee at a regular or special meeting of the Medical Executive Committee by a vote of two-thirds majority of members present, provided at least 40% of the Medical Executive Committee members are present. All policies are subject to the approval of the Governing Body, but shall become and remain effective upon Medical Executive Committee approval unless and until such time as the Governing Body votes to reject a particular policy.

(c) In addition to the procedure set forth above, if membership support is evidenced by a vote of the Medical Staff using the methodology described in Section 12.2(b), requests for adoption, amendment or repeal of policies may be made directly to the Governing Body.

SECTION 13 ADOPTION AND AMENDMENT OF BYLAWS

13.1 Medical Staff Responsibility

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the Governing Body, Medical Staff Bylaws, and amendments thereto, which shall be effective when approved by the Governing Body. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, so as to have Bylaws of generally recognized quality, to provide a basis for acceptance by accreditation agencies, to comply with supervising licensing authorities, and to provide a system of ongoing effective professional review.

13.2 Methodology

(a) The Medical Staff Bylaws and policies shall be reviewed periodically and revised as necessary. The review shall be undertaken by a committee appointed by the president of the Medical Staff and any proposed amendments and revisions shall be recommended to the Medical Executive Committee. The Medical Executive Committee will consider the recommendation and bring proposals to the Medical Staff.

(b) Medical Staff Bylaws may be adopted, amended or repealed by: the affirmative vote of two-thirds of the Provisional, Active, and Affiliated Staff eligible to vote on this matter who are present at a meeting at which a quorum is present, provided at least ten (10) days' written notice, accompanied by the proposed Bylaws and/or alterations, has been given of the intention to take such action, and provided at least 10% of all Provisional, Active, and Affiliated Staff Members entitled to vote are present in person or by written proxy; and the affirmative vote of a majority of the Governing Body.

(c) In addition to the amendment process for the Bylaws set forth herein, the Medical Staff may, upon a vote of the Medical Staff using the methodology described in this subsection (b) above, recommend amendments to the Bylaws directly to the Governing Body, provided that the recommendation is first communicated to the Medical Executive Committee. The timing and method of presentation to the Governing Body will be consistent with the Hospital's corporate bylaws.

13.3 Effective Date

These Bylaws, together with the appended Rules and Regulations and Fair Hearing Plan, shall be adopted at any regular meeting of the Hospital's Provisional, Active, and Affiliated Staff, shall replace any previous Bylaws, Rules and Regulations, and Fair Hearing Plan and shall become effective when approved by the Governing Body of the Hospital. They shall, when adopted and approved, be equally binding on the Governing Body and the Medical Staff.

SECTION 14 OTHER GOVERNANCE CONSIDERATIONS

14.1 Periodic Review

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

Policies of the Medical Staff will be reviewed at regular committee or Service meetings as the need arises or at least on a biennial basis.

14.2 Conflict Resolution

In the event the Medical Staff has a concern regarding the Medical Staff Bylaws, Rules and Regulations, associated policies, Service Rules and Regulations, or any other conflict that cannot be resolved or otherwise appropriately managed through existing processes, representative members of the Active Medical Staff may request an opportunity to meet with the Executive Committee. If the members remain unsatisfied, they may prepare and present the issue at a regularly scheduled Medical Staff meeting. If the issue is supported by the Medical Staff, as evidenced by a vote of the Medical Staff using the methodology

described in Section 13.213.2(b), such issue may proceed directly to the Governing Body according to the Hospital's policies and administrative process.

14.3 Automatic Amendment to Conform to Law

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

14.4 General Provisions

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

14.5 Governing Law

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

ADOPTED by the Provisional/Active/Affiliate Medical Staff of Saint Mary's Hospital.

____________________ ____

Date Medical Staff President

APPROVED by the Governing Body of Saint Mary's Hospital.

____________________ ____

Date Secretary of Board of Directors