BLACK RIVER MEMORIAL HOSPITAL

MEDICAL STAFF BYLAWS

Revised by the Medical Staff
January 6, 2010
April 7, 2010
October 13, 2010
January 5, 2011
April 4, 2012
July 11, 2012
May 1, 2013
May 6, 2015
August 2, 2017
August 7, 2019
March 3, 2020
June 3, 2020
November 3, 2021

Approved by the Board of Directors
January 26, 2010
April 27, 2010
October 26, 2010
January 25, 2011
April 24, 2012
July 31, 2012
May 28, 2013
May 26, 2015
September 26, 2017
August 27, 2019
April 28, 2020
June 23, 2020
November 23, 2021

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

Page

BLACK RIVER MEMORIAL HOSPITAL
MEDICAL STAFF BYLAWS

ARTICLE I
DEFINITIONS

1.1 **ACT** means the federal Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 et seq., as may be amended from time to time.

1.2 **ADVANCED PRACTICE PROFESSIONAL**, or **APP**, is defined as individual who is licensed or certified by their respective licensing or certifying agency to practice as an an Advanced Practice Nurse Prescriber (or APNP), Certified Respiratory Nurse Anesthetist (CRNA), or Physician Assistant (PA) or any other category added to Appendix A, and who is eligible for or holds medical staff membership and clinical privileges at the Hospital. APPs are included in the definition of "Practitioners" below.

1.3 **ALLIED HEALTH PROFESSIONAL**, or **AHP**, means an individual qualified by the appropriate licensing or certifying agency to practice in one of the categories specified in Appendix B, who is eligible for or holds clinical privileges at the Hospital. AHPs are not "Practitioners" as that term is defined below and used in these Bylaws. AHPs are included in the definition of "Providers" below.

1.4 **BOARD OF DIRECTORS**, or **BOARD** refers to the Board of Directors of Black River Memorial Hospital, Inc., which is the governing body responsible for conducting the ordinary business affairs of the Hospital, and which, for purposes of these Bylaws, and, except as the context otherwise requires, shall be deemed to act through the authorized actions of the officers of the corporation and through the Chief Executive Officer of the Hospital.

1.5 **CHIEF EXECUTIVE OFFICER**, or **CEO**, is defined as the individual appointed by the Board of Directors to act on its behalf in the overall management of the Hospital. The term “Chief Executive Officer” includes a duly appointed acting administrator serving when the Chief Executive Officer is away from the Hospital.

1.6 **CLINICAL PRIVILEGES**, or **PRIVILEGES**, refers to the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental, or surgical services.

1.7 **DENTIST** means a Practitioner with a D.D.S. or D.M.D. degree who is currently licensed to practice by the Wisconsin Dentistry Examining Board.

1.8 **EX OFFICIO** means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

1.9 **HOSPITAL** means Black River Memorial Hospital, Inc. and shall be construed to include all provider-based clinics unless the context clearly indicates otherwise.

1.10 **MEDICAL EXECUTIVE COMMITTEE**, or **MEC**, means a committee of the Medical Staff consisting of the Chief of Staff, Vice-Chief of Staff, Secretary, and Treasurer of the Medical Staff and one member at large, with the Hospital CEO serving as an ex officio member without voting rights.

1.11 **MEDICAL STAFF** or **STAFF** is defined as that group of health care professionals who have been granted appointment by the Board of Directors in accordance with Article IX of these Bylaws.

1.12 **MEDICAL STAFF YEAR** shall begin on January 1 and end on December 31 each year.

1.13 **PARTIES** mean the Practitioner who requested the hearing or appellate review and the body or bodies upon whose adverse action a hearing or appellate review request is predicated.

1.14 **PHYSICIAN** means an individual with an M.D. or D.O. degree who is currently licensed by the Wisconsin Medical Examining Board to practice surgery or medicine in the state of Wisconsin.

1.15 **PODIATRIST** means an individual with a degree from an accredited college of podiatric medicine who is currently licensed to practice by the Wisconsin Podiatry Affiliated Credentialing Board.

1.16 **PRACTITIONER** is defined as any Physician, Dentist, Podiatrist or Advanced Practice Professional who is applying for or has been granted Medical Staff appointment and/or Clinical Privileges in this Hospital.

1.17 **PROVIDER** is defined to include Practitioners and Allied Health Professionals who are appropriately licensed and/or certified who are applying for, or have been granted Clinical Privileges to care for patients of the Hospital.

1.18 **QUORUM** with respect to Medical Staff meetings means at least eight (8) members of the Active Medical Staff, present and voting.

1.19 **SPECIAL NOTICE** means written notification sent by certified or registered mail, return receipt requested.

ARTICLE II
NAME OF ORGANIZATION

The name of this organization shall be the "Medical Staff of Black River Memorial Hospital."

ARTICLE III
PURPOSE AND RESPONSIBILITIES OF MEDICAL STAFF

3.1 **Purpose.** The purpose of this Medical Staff is to bring qualified Practitioners who practice at the Hospital together into a cohesive body to promote high quality care. To this end, among other activities, the Medical Staff will assist in screening applicants for Medical Staff membership, review Privileges of members, evaluate and assist in improving the work done by the Practitioners, provide education, and offer advice and recommendations to the Chief Executive Officer and the Hospital Board of Directors.

3.2 **Responsibilities.** The responsibilities of the Medical Staff are as follows. These responsibilities may be carried out through the actions of Medical Staff officers, medical directors, and/or committees.

A. To facilitate a high level of professional performance of all members of the Medical Staff and AHPs authorized to practice in the Hospital through appropriate delineation of Clinical Privileges and through an ongoing review and evaluation of each individual's performance in the Hospital.

B. To provide and/or recommend continuing education fashioned, at least in part, on needs demonstrated through patient care audits and other quality assessment and improvement programs.

C. To participate in utilization review to facilitate allocation of patient medical services based upon evaluation of individual medical needs.

D. To recommend to the Board action with respect to appointments, reappointments, Clinical Privileges, Staff category, and corrective action.

E. To account to the Board for the quality and efficiency of patient care rendered to patients at the Hospital through reports and recommendations.

F. To advise the Board and senior leaders on clinical services provided through contractual arrangement to promote safe and effective delivery of such services.

G. To initiate and pursue corrective action with respect to Practitioners when warranted.

H. To assure that Medical Staff matters are pursued in accordance with applicable law and accreditation standards.

I. To develop, administer, and seek compliance with these Bylaws, the Rules and Regulations of the Medical Staff, and other Hospital and Medical Staff policies related to patient care.

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

K. To conduct all affairs involving Medical Staff, patients, and Hospital employees in a manner and an atmosphere free of discrimination because of sex, race, religion, color, creed, ancestry, disability, sexual orientation, marital status, gender identity or expression, national origin, age, source of payment, military service, or any other prohibited basis defined by federal or state law.

ARTICLE IV
MEDICAL STAFF ORGANIZATION

4.1 Categories of the Medical Staff. The Staff shall consist of Active Staff, Courtesy Staff and APP Staff categories. The prerogatives set forth under each Staff category are general in nature and may be subject to limitation by special condition attached to a Practitioner's Staff appointment, by other sections of these Bylaws, by the Rules and Regulations of the Medical Staff, and/or by policies of the Hospital.

4.2 Active Staff.

A. *Qualifications*. The Active Staff shall consist of Physicians, Dentists or Podiatrists who:

1. Continuously meet the basic qualifications set forth in Sections 9.1 and 9.2(B)(1) of these Bylaws.

2. Are involved in a minimum of twenty-five (25) patient contacts (a patient contact is defined as an inpatient admission, consultation, or outpatient service) at the Hospital biennially; and have their residence or primary practice within thirty (30) miles of the Hospital.

B. *Prerogatives.* An appointee to this category may:

1. Exercise such Clinical Privileges as are granted by the Board including but not limited to the prerogative to admit patients to the Hospital, pursuant to Article IX, except to the extent precluded by Medical Staff Rules and

Regulations or other Medical Staff or Hospital policy, or by Medical Staff action restricting exercise of certain Privileges.

2. Vote on all matters presented at general and special meetings of the Medical Staff, and of committees of which the appointee is a member.

3. Hold office, sit on or be chairperson of any committee, and serve as a medical director of a clinical service area, unless otherwise specified elsewhere in these Bylaws.

C. *Responsibilities.* Appointees to this category must:

1. Provide each patient with continuous care and supervision at the generally recognized professional level of quality and efficiency and in a manner consistent with scope of practice;

2. Actively participate in recognized functions of the Medical Staff including, but not limited to:

a. Quality/performance improvement;

b. Risk management;

c. Monitoring activities including but not limited to Focused and Ongoing Professional Practice Evaluations;

d. Any other Medical Staff, committee, and Hospital functions as may be reasonably required or requested from time to time.

3. If a Physician, participate in the emergency call coverage in accordance with the Rules and Regulations and Hospital policies to help ensure that patient care needs are provided for and that applicable laws (including, but not limited to, the Emergency Medical Treatment and Active Labor Act) and Hospital policies, as approved by the Board, are satisfied.

4. Contribute to the organizational and administrative affairs of the Medical Staff including, but not limited to, the fulfillment of any meeting attendance requirements as established by the Medical Staff.

5. Abide by the ethical principles of the Medical Staff member's profession, as applicable.

6. Pay dues and special assessments, if any, as determined by action of the MEC.

7. Abide by the Medical Staff Bylaws, Rules and Regulations, and all other Medical Staff and Hospital policies and rules.

4.3 Courtesy Staff.

A. *Qualifications*: The Courtesy Staff shall consist of Physicians, Dentists or Podiatrists who:

1. Consistently meet the basic qualifications set forth in Sections 9.1 and 9.2(B)(1) of these Bylaws.

2. Only occasionally admit and/or treat patients at the Hospital, provide consultations for Hospital patients, or have their residence or primary practice more than thirty miles (30) away from the Hospital.

3. Are members of the medical staff of another hospital where they are subject to the peer review process and other quality assessment and improvement activities similar to those required of the Medical Staff at this Hospital.

B. *Prerogatives/ Limitations*. Appointees to this category:

1. May exercise such Clinical Privileges as are granted pursuant to Article IX unless otherwise provided in the Medical Staff Rules and Regulations, or by specific privilege restriction.

2. May not vote at Medical Staff meetings.

3. May be appointed to Medical Staff committees and vote on matters presented at such committee meetings.

4. May not be an officer of the Medical Staff or a medical director of a clinical service area, nor serve as chairperson of a committee, unless an exception is granted by the Medical Staff.

C. *Responsibilities*. Appointees to the Courtesy Staff must:

1. Assist the Hospital in the fulfillment of its mission and assist the Medical Staff in fulfillment of its obligations under these Bylaws.

2. Provide each patient with continuous care and supervision at the generally recognized professional level of quality and efficiency.

3. Abide by the ethical principles of the Medical Staff member's profession, as applicable.

4. Pay dues and special assessments, if any, as determined by action of the MEC.

5. Abide by the Medical Staff Bylaws, Rules and Regulations, and all other Medical Staff and Hospital policies and rules.

4.4 APP Staff.

A. *Qualifications*: The APP Staff shall consist of APPs appointed to the Medical Staff who:

1. Consistently meet the basic qualifications for Medical Staff membership set forth in Sections 9.1 and 9.2(B)(1) of these Bylaws to the extent applicable to APPs.

2. Admit patients to the Hospital if privileged to do so, or otherwise treat patients in accordance with their scope of practice and Clinical Privileges.

3. Practice within the scope of their license / certification, with appropriate supervision by or collaboration with a Physician as required by law and Hospital policy. Each patient's general medical condition and care shall be provided in conjunction with a qualified Physician member of the Medical Staff.

B. *Prerogatives / Limitations*. Appointees to this category:

1. May exercise such Clinical Privileges as are granted pursuant to Article IX unless otherwise provided in the Medical Staff Rules and Regulations, or by specific privilege restriction.

2. May not vote at Medical Staff meetings.

3. May be appointed to chair Medical Staff committees or as members of Medical Staff committees and may vote on matters presented at such committee meetings.

4. May not be an officer of the Medical Staff.

C. *Responsibilities*. Appointees to the APP Staff must:

1. Ensure appropriate documentation of supervision by or collaboration with a Physician in accordance with applicable law. Immediate identification of and documentation of an appropriate replacement in the event that the APP Staff's collaborating or supervising Physician is no longer able to serve that function.

2. Assist the Hospital in the fulfillment of its mission and assist the Medical Staff in fulfillment of its obligations under these Bylaws.

3. Provide each patient with continuous care and supervision at the generally recognized professional level of quality and efficiency.

4. Abide by the ethical principles of the Medical Staff member's profession, as applicable.

5. Pay dues and special assessments, if any, as determined by action of the MEC.

6. Abide by the Medical Staff Bylaws, Rules and Regulations, and all other Medical Staff and Hospital policies and rules.

ARTICLE V
CLINICAL SERVICES

5.1 Organization of Clinical Service Areas. Each clinical service area described below, or appropriately described hereafter, shall be an advisory group to the Medical Staff as a whole and shall have a medical director who is selected and has the authority, duties, and responsibilities as

specified elsewhere in these Bylaws. Each clinical service area may adopt rules and regulations to fulfill its responsibilities under these Bylaws.

5.2 Designation of Clinical Service Areas.

A. *Current Clinical Services*. The clinical services of the Medical Staff include but are not limited to:

1. Medicine and Surgery (both Adult and Pediatric);

2. Obstetrics/Newborn;

3. Emergency Medicine;

4. Home Based Services;

5. Outpatient/ Specialty Care.

Each of these clinical service areas shall have a medical director and a peer review committee. The provider-based clinics shall also have a separate peer review committee.

B. *Future Designation*. When deemed appropriate, the MEC, with the approval of the Board, may create new, eliminate, subdivide or combine clinical service areas or may reorganize the Medical Staff into a departmentalized structure.

5.3 Obligations of Clinical Service Areas.

A. Each clinical service area shall recommend to the MEC written criteria for the assignment of Privileges within the clinical service area, which shall be effective when approved by the Board.

B. Each clinical service area shall monitor and evaluate medical care on retrospective, concurrent, and prospective bases in all major clinical activities of the clinical service area. This monitoring and evaluation will include:

1. The routine collection of information about important aspects of patient care and about the clinical performance of members of the clinical service area; and

2. The periodic assessment of this information to identify opportunities to improve care and to identify problems in patient care. When important problems in patient care or opportunities to improve care are identified, the clinical service area will document actions taken and evaluate the effectiveness of such actions.

The clinical service area functions shall also include the committee responsibilities outlined in Article VII below. These functions may be accomplished by a multi-clinical service area quality assurance committee established by the MEC and appointed by the Chief of Staff, as provided in Article VII below.

C. Each clinical service area, or a committee thereof, shall hold meetings with a frequency to be determined by the medical director of that service area. Such meetings shall not release members of the clinical service area from their

obligation to attend the general meetings of the Medical Staff or other committee meetings as provided in Article VIII of these Bylaws.

5.4 Assignment to Clinical Service Areas.

A. The Chief of Staff shall make initial assignments to a clinical service area for all members of the Medical Staff and for all other Providers with Clinical Privileges.

B. Providers may hold Clinical Privileges in one or more clinical service areas in accordance with their education, training, experience, and demonstrated competence. Providers shall exercise only those Clinical Privileges approved in accordance with these Bylaws. The exercise of Privileges within any clinical service area shall be subject to the rules and regulations of that clinical service area and the authority of the medical director of the clinical service area.

C. Providers with Clinical Privileges in more than one clinical service area may attend meetings of all of the clinical service areas in which they have Clinical Privileges.

5.5 Medical Directors.

A. *Qualifications*. Each clinical service area of the Medical Staff shall have a medical director who shall be a qualified Practitioner on the Active Staff in good standing, shall be willing and able to faithfully discharge the functions of the office, and shall satisfy the following criteria:

1. Have no pending adverse recommendation concerning Medical Staff appointment or Clinical Privileges; and

2. Be qualified by training, experience, and demonstrated ability for the position.

B. *Selection*. Medical directors shall be Practitioners appointed by the Chief of Staff with no limit to the number of years or terms they may serve.

C. *Removal*. A medical director may be removed either (i) by a two-thirds (2/3) majority vote of all Active Staff members, with ratification by the Board, or (ii) by the Board on its own motion. If removal is initiated by Medical Staff vote, the vote results shall be forwarded to the Board by the Chief of Staff, along with the reasons for requested removal. A medical director will also be automatically removed upon loss of Active Staff status. Removal will be effective upon ratification by the Board.

D. *Duties.* Each medical director shall:

1. Be responsible for all clinical activities within the clinical service area;

2. Provide guidance on the overall medical policies of the Hospital and make specific recommendations and suggestions regarding their own clinical service area in order to assure quality patient care;

3. In cooperation with the quality program, maintain continuing review of the professional performance of all Providers with Clinical Privileges in their clinical service area and report as necessary thereon to the MEC. In addition, the medical director shall recommend any other types of peer review activities that he deems appropriate for the clinical service area;

4. Be responsible for enforcement within the clinical service area of the Hospital Bylaws, Medical Staff Bylaws and Rules and Regulations, and actions taken by the Board and MEC;

5. Coordinate collaboration between clinical service areas when necessary;

6. Make recommendations to the MEC, at its request, for Staff classification, reappointment, and Clinical Privileges for each member of the clinical service area;

7. Participate in every phase of administration of their clinical service area through cooperation with the nursing service and Hospital administration in matters affecting patient care, including personnel, supplies, rules and regulations, standing orders, techniques, and medical records;

8. Recommend to the MEC, with input from clinical service area members, the criteria for Clinical Privileges that are relevant to care provided in the clinical service area;

9. Recommend to the MEC, with input from clinical service area members, the resources needed for care, treatment and services including staffing needs;

10. Ensure that all persons in the clinical service area receive orientation and continuing education, as may be required by the Hospital;

11. Assist in the preparation of such annual reports, including budgetary planning, pertaining to the clinical service area as may be required by the CEO or the Board of Directors;

12. Cooperate with the Hospital's administrative staff on purchase of supplies and equipment;

13. Make recommendations to the Hospital's administrative staff regarding the planning of Hospital facilities, equipment, routine procedures and any other matters concerning patient care;

14. Arrange and implement inpatient and outpatient programs, which include organizing, engaging in educational activities and supervising and evaluating the clinical work;

15. Represent the service in a medical advisory capacity to the Hospital's administrative staff and governing body; and

16. Perform such other duties and responsibilities commensurate with the office as may be assigned by the Medical Staff, MEC, or Board from time to time.

ARTICLE VI
OFFICERS OF THE MEDICAL STAFF

6.1 **Officers of the Medical Staff.** The officers of the Staff shall be:

A. Chief of Staff;

B. Vice-Chief of Staff;

C. Secretary; and

D. Treasurer.

6.2 Qualifications. The Chief of Staff must be a Physician appointee to the Active Medical Staff and must remain an appointee in good standing during the Chief's term of office. The other Officers listed above must be appointees to the Active Medical Staff, unless an exception is granted, and must remain appointees in good standing during their terms of office.

6.3 Selection. Officers shall be selected annually at the last Medical Staff meeting of the Medical Staff Year (January 1) by a majority vote of the Active Medical Staff present.

6.4 Tenure of Office. Each officer shall serve a one-year term, commencing on January 1 of each Medical Staff year.

6.5 Duties of Officers.

A. *Chief of Staff*. The Chief of Staff has the following duties:

1. Aid in the coordination and alignment of activities and concerns of the Hospital administration, nursing, and other patient care services with those of the Medical Staff;

2. Continuously evaluate and communicate to the Board, the CEO, and other officers of the Staff the effectiveness of policies and processes, performance and maintenance of quality, and the opinions, concerns, needs, and grievances of the Medical Staff;

3. Serve as chair of the MEC. The Chief of Staff shall also serve as an Ex Officio member of all other Medical Staff committees. The Chief of Staff shall also participate, if and as provided in the Hospital's bylaws, as an Ex Officio member of the Board and serve on Hospital or Board committees receiving and interpreting the policies of the Board that apply to the Medical Staff;

4. Be responsible for the enforcement of Medical Staff Bylaws and Rules and Regulations and other Medical Staff policies, for collegial intervention or initiation of corrective action where indicated, and to ensure that all procedural rights of Medical Staff members are observed;

5. Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff and MEC;

6. Be responsible for developing and supporting the educational activities of the Medical Staff and encourage Medical Staff leadership and participation in the interdisciplinary clinical performance activities. The Chief of Staff may delegate any or all of the educational activities to qualified personnel;

7. Be the spokesperson for the Medical Staff in its external professional and public relations; and

8. Perform such other duties, and exercise such authority, corresponding with the office as are set forth in these Medical Staff Bylaws.

B. *Vice-Chief of Staff.* The Vice-Chief of Staff shall fulfill the following duties:

1. Be a member of the MEC;

2. Assume all the duties and possess the authority of the Chief of Staff in the Chief's absence until the vacancy is filled in accordance with Section 6.7 of these Bylaws; and

3. Perform such additional duties as may be assigned by the Chief of Staff, the MEC, or the Board.

C. *Secretary*. The Secretary shall fulfill the following duties:

1. Be a member of the MEC;

2. Give proper notice of all Staff meetings on order of the appropriate authority, prepare accurate and complete minutes for all meetings, and attend to all correspondence of the Medical Staff and serve as secretary of the ad hoc Bylaws committee whenever it convenes;

3. Act as presiding officer in the absence of the Chief of Staff and Vice-Chief of Staff; and

4. Perform such other duties as ordinarily pertain to this office, as well as those additional duties that may be assigned by the Chief of Staff, the MEC, or the Board.

The Secretary may delegate any or all of the clerical duties to qualified personnel.

D. *Treasurer.* The Treasurer shall fulfill the following duties:

1. Be a member of the MEC;

2. Supervise the collection and accounting for any funds that may be collected in the form of Staff dues, assessments, or application fees;

3. Act as presiding officer in the absence of the Chief of Staff, Vice-Chief of Staff, and Secretary; and

4. Perform such other duties as ordinarily pertain to this office, as well as those additional duties that may be assigned by the Chief of Staff, the MEC or the Board.

The Treasurer may delegate any or all of the clerical duties to qualified personnel.

E. *Immediate Past Chief of Staff*. The immediate past Chief of Staff shall serve as a consultant to the Chief of Staff, Vice-Chief of Staff, Secretary, and Treasurer providing feedback regarding their performance of assigned duties on an annual or as needed basis.

6.6 <u>Removal and Resignation of Officers.</u>

A. *Removal of Officers.* The Board may initiate the removal of a Medical Staff officer only after a joint conference with the MEC and confirmation by a two-thirds (2/3)

vote of the Medical Staff members eligible to vote. The affected individual will not be present at such a joint conference. The Medical Staff may remove any officer by a two-thirds (2/3) affirmative vote of the appointees to the Medical Staff eligible to vote. Removal may be based upon failure to abide by the Bylaws and Rules and Regulations or to perform the duties of the position held as described in these Bylaws or other policies and procedures of the Medical Staff. Removal may also be based on conduct or statements damaging to the Hospital, the Hospital's goals or programs, or a failure to remain a member of the Medical Staff in good standing. A Medical Staff officer will also be automatically removed upon loss of Active Staff status.

B. *Resignation of Officers.* Any elected officer of the Medical Staff may resign at any time, without recrimination, by giving written notice to the MEC. Such resignation, which may or may not be made contingent upon acceptance by the MEC, takes effect on the date of receipt, when a successor is elected or given notice, or any later time specified therein.

6.7 Vacancies in Office. Vacancies shall be filled at the next Medical Staff meeting at which there is a quorum, by a majority vote of the Active Medical Staff. The individual who is selected to fill the vacancy shall serve in this role for the remainder of the current term.

ARTICLE VII
MEDICAL STAFF COMMITTEES AND FUNCTIONS

7.1 Establishment.

A. There shall be a Medical Executive Committee (MEC) as described herein that performs functions as further described in these Bylaws. In addition to the duties ascribed specifically to the MEC, the MEC is empowered to act on behalf of the full Medical Staff during a declared public health emergency, a localized emergent situation requiring Medical Staff action, or during other circumstances as necessary unless prohibited under these Bylaws.

B. The MEC may establish Medical Staff committee(s) to perform one or more of the Medical Staff functions in the normal course. In the same manner, the MEC may dissolve or rearrange committees and their structures, duties or composition as needed.

C. Unless otherwise provided in these Bylaws, members of all Medical Staff committees shall be appointed by the Chief of Staff, who shall also designate a chair for each committee. Unless otherwise specifically provided or the member resigns or is removed from the committee by the Chief of Staff, a member (other than one serving Ex Officio) of a Medical Staff committee shall continue as such until the end of the individual's normal period of Staff appointment or until a successor is elected or appointed. Administrative staff committee members shall be appointed by and may be removed by action of the CEO or designee.

D. Unless otherwise specifically provided, vacancies on any Medical Staff committee shall be filled in the same manner in which original appointment to such committee is made.

E. Medical Staff committees shall meet as needed to fulfill their assigned duties, unless a specific number of meetings is required by these Bylaws, Hospital or Medical Staff policy, regulation, resolution, or the mandate given to any special committee.

7.2 Medical Staff Functions.

A. Whenever these Bylaws or a Medical Staff policy require that a function be performed by, or that a report or recommendation be submitted to, a named Medical Staff committee but no such committee exists, the MEC shall perform such function or receive such report or recommendation or shall assign the functions of such committee to a new or existing committee of the Medical Staff or to the Medical Staff as a whole.

B. Whenever these Bylaws or a Medical Staff policy require that a function be performed by, or that a report or recommendation be submitted to, the MEC but a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

7.3 Medical Executive Committee (MEC).

A. *Composition.* The MEC shall consist of the Chief of Staff (who shall serve as the MEC chair), the Vice-Chief of Staff, the Secretary, the Treasurer, and the Chief Medical Officer, all with the right to vote. The MEC shall always consist of five (5) members. If circumstances evolve such that there are only four (4) of the designated members serving on the committee for any reason, the MEC will appoint a member at large to serve as the fifth member of the MEC. However, it is not necessary that all voting members of the MEC be present at each and every meeting, provided that a quorum is present as necessary in order to vote. The CEO shall also serve as an Ex Officio member, without vote.

B. *Primary Duties.* The primary duties of the MEC shall be to:

1. Receive and act upon reports and recommendations from the clinical service areas, committees and officers of the Medical Staff concerning patient care and quality, evaluation and monitoring functions and the discharge of their delegated administrative responsibilities, and recommend to the Board specific programs and systems to implement these functions;

2. Serve as the Medical Staff credentialing committee and submit recommendations to the Board concerning all matters relating to appointment, reappointment, Staff category, Clinical Privileges, clinical service area assignments, corrective action, as well as the structure of the Medical Staff and the process used to review credentials and delineate Privileges;

3. Account to the Board and to the Medical Staff for the overall quality and efficiency of professional patient care provided in the Hospital by individuals with Clinical Privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

4. Formulate and recommend to the Board Medical Staff rules, policies, and procedures including the structure of the Medical Staff, the mechanism by which Medical Staff membership or Privileges may be terminated, and the mechanisms for fair hearing procedures;

5. Represent and act on behalf of the Medical Staff between Medical Staff meetings and as otherwise deemed necessary, subject to such limitations as may be imposed by these Bylaws;

6. Represent and act on behalf of the Medical Staff during declared public health emergencies, during localized emergent situations requiring Medical Staff action, or during other circumstances as necessary unless prohibited under these Bylaws.

7. Work together with the Board and senior leaders to: define leadership responsibilities; identify the skills required of individual leaders; create and maintain a Hospital culture of safety and quality, including regular discussion and evaluation of issues of safety and quality; develop an ongoing process to manage conflicts among leadership groups; and develop a policy addressing conflicts of interest that have the potential to affect the safety or quality of care, treatment, or services;

8. Work together with the Board and senior leaders to create the Hospital's mission, vision and values, and evaluate the Hospital's performance with respect to such mission, vision and values.

9. Coordinate the implementation of policies adopted by the Board, as well as the activities and policies adopted by the Staff and its committees;

10. Make recommendations to the Board on medico-administrative matters;

11. Consistent with its mission and philosophy, participate in identifying community health needs;

12. Inform the Medical Staff of the accreditation program and the accreditation status of the Hospital; and

13. Take reasonable steps to assure professionally ethical conduct and competent clinical performance on the part of Staff appointees, including collegial and educational efforts, as well as initiating investigations and pursuing corrective action when warranted.

The peer review activities and reports of the MEC shall be protected and kept confidential unless disclosure is mandated by State or Federal law, unless the MEC in its discretion opts to disclose where applicable law would permit but not require the disclosure.

C. *Meetings*. The MEC shall meet approximately monthly or as often as necessary to transact pending business and shall maintain a permanent record of its proceedings and actions.

7.4 Protection of Committee Work. All standing and special Medical Staff committees and Hospital committees, including but not limited to committees that perform Medical Staff functions, are a major component in the Hospital's overall quality improvement program, organized and operated to help maintain and improve the quality of health care in the Hospital. Committee activities will be conducted in a manner consistent with applicable law including but not limited to the peer review protections specified in Wis. Stat. ss. 146.37 and 146.38. The health care services review protections of these statutes, including protection of confidentiality of committee records and proceedings, are intended to apply to all activities of these committees relating to privileging and maintaining and improving the quality of health care and include activities of individual members of the committee, as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee, including but not limited to, participation in monitoring plans.

ARTICLE VIII
MEETINGS

8.1 General Staff Meetings.

A. *Regular Meetings.* Regular Medical Staff meetings shall be held at least twice per year and more often as necessary. The MEC shall establish the schedule for the annual full Medical Staff meeting(s) at the beginning of each calendar year, and shall notify the Medical Staff Members accordingly. The notice shall designate the time and place for all regular Staff meetings. Any change in the schedule of regular Staff meetings shall be provided to each appointee to the Medical Staff in the same manner as notice for special meetings.

B. *Special Meetings.*

1. Request for Meeting. Special meetings of the Medical Staff may be called at any time by the Board, the Chief of Staff, the MEC, or upon written request to the Chief of Staff by not fewer than one-fourth (1/4) of the appointees of the Active Staff. The Chief of Staff shall designate the time and place of any special meeting.

2. Notice of Meeting. At the direction of the Chief of Staff, notice stating the place, date, time and purpose of any special meeting of the Medical Staff shall be sent to each appointee of the Medical Staff not fewer than four (4) days prior to the date of such meeting. Notification shall be made by email. If the Hospital does not have an email address for a Practitioner, notice may be provided via phone or mailed by U.S. mail.

C. *Agenda.*

1. Regular Meetings. The Chief of Staff shall determine the order of business at a general Staff meeting.

2. Special Meetings. The agenda of any special Staff meeting shall include only a reading of the notice calling the meeting, transaction of business for which the meeting was called, and adjournment. No business shall be transacted at any special meeting other than that stated in the notice calling the meeting.

8.2 Committee Meetings.

A. *Regular Meetings*. Committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these Bylaws or, if not stated in the Bylaws, by resolution of the committee or clinical service area.

B. *Special Meetings.* A special meeting of any committee may be called by, or at the request of, the chairman thereof, the Board, the medical director, the Chief of Staff, or by no fewer than one-third (1/3) of the committee's current members (but in any event no fewer than two (2) members). No business shall be transacted at any special committee meeting except that stated in the meeting notice.

C. *Notice of Meetings.* Notice stating the place, date, and time of any committee meeting shall be sent via email or other means of communication to each person entitled to be present at such meeting.

8.3 Quorum.

A. *Medical Staff Meetings* A minimum of eight (8) members of the Active Medical Staff (present and voting) shall constitute a quorum.

B. *Committee Meetings*.

1. MEC Meetings: A majority of the members of the MEC, present and voting, shall constitute a quorum.

2. All other committee meetings: A minimum of two (2) committee members present and voting shall constitute a quorum.

C. *Definition of "Present."* For purposes of determining a quorum at Medical Staff meetings, MEC meetings, and all other committee meetings, a person is "present" if that person: (1) is present in person at the meeting, or (2) is participating in the meeting by electronic means in a manner that permits all participants in the meeting to participate real-time with all other participants.

8.4 Manner of Action. Any person who is eligible to vote and is present under Section 8.3(C), may cast one (1) vote at a meeting at which a quorum is present. Except as otherwise specified in these Bylaws, the action of a majority of those present, shall be the action of the group. Except for actions by the Medical Staff as a whole, such recommendations will then be forwarded to the MEC for final action. A committee may take action without a meeting as long as the recommendation is documented in writing and each committee member entitled to vote signs the document, thereby setting forth the action. When needed, the latest edition of *Robert's Rules of Order* shall prevail at all meetings of the Medical Staff, MEC, committees, and clinical service area, except that the chairperson of any meeting may vote.

8.5 Minutes. Minutes of all meetings shall be prepared by the secretary (or designee) of the Medical Staff or the applicable committee and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be approved by the attendees, signed by the presiding officer or chairperson, and forwarded to the MEC. A permanent file of the minutes of each meeting shall be maintained.

8.6 Attendance Requirements.

A. *Attendance by Active Staff Members*. Each appointee to the Active Staff shall be required to attend:

1. All Active Staff members are required to attend at least one general Medical Staff meeting annually, absent prior approved absence excused by the Chief of Staff or by a majority of the MEC

2. At least fifty percent (50%) of all meetings of each committee of which the person is a member.

B. *Attendance by Courtesy Staff Members*. Each appointee to the Courtesy Staff shall be required to attend at least fifty percent (50%) of all meetings of each committee of which the person is a member. Each appointee to the Courtesy Staff is encouraged to attend general Medical Staff meetings.

C. *Attendance by APP Staff Members.* Each appointee to the APP Staff shall be required to attend at least fifty percent (50%) of all meetings of each committee of

which the person is a member. Each appointee to the APP Staff is encouraged to attend general Medical Staff meetings.

D. *Absence from Meetings.* An excuse for absence shall be provided to the presiding officer or chair. Unless excused for good cause by the Chief of Staff or designee, a Medical Staff appointee who fails to attend the required number of meetings may be referred for corrective action, at the discretion of the Chief of Staff or desginee.

8.7 Participation by the Chief Executive Officer. The CEO or designee and any representative invited by the MEC may attend any committee meetings of the Medical Staff, provided that such attendance complies with the requirements of these Bylaws.

8.8 Rights of Ex Officio Members. Any person appointed to a committee as an Ex Officio member shall be presumed to have all rights of other members except for voting rights, and will be presumed not to have voting rights unless specified otherwise.

ARTICLE IX
ELIGIBILITY, APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES

9.1 Eligibility.

A. *Threshold Eligibility Criteria*. In order to be eligible to apply for Medical Staff appointment and Clinical Privileges, the individual must be able to satisfy the following threshold eligibility criteria to the extent applicable to the individual's area of practice. A waiver of a threshold eligibility criterion may be granted in exceptional cases in accordance with the process outlined in Section 9.1(B) of this Article.

1. A current, unrestricted license to practice in Wisconsin or evidence that the individual is in the process of obtaining licensure in Wisconsin.

2. A current, unrestricted federal DEA registration, if applicable.

3. For Physicians, completion of an approved postgraduate residency training program, as applicable and defined in the privileging form, in the specialty in which the applicant is seeking Clinical Privileges, except that residents in their final year of residency are eligible to apply for Medical Staff appointment and/or Privileges prior to completion of the program.

4. As applicable, current, valid, and unrestricted professional liability insurance coverage in an amount sufficient to comply with the requirements of the Hospital and Wisconsin law, or initiation of a process or application for obtaining such coverage, in an amount sufficient to comply with the requirements of the Hospital and Wisconsin law.

5. No record of conviction of Medicare, Medicaid, or insurance fraud and abuse, payment of civil money penalties for same, or exclusion or prohibition from participation in such programs.

6. No record of conviction of, or plea of guilty, no contest, or nolo contendere to, any felony or misdemeanor related to the applicant's practice or profession, other health care-related matters, third-party reimbursement, violence, or controlled substance violations.

7. No record of denial, revocation, relinquishment or involuntary termination of appointment or Clinical Privileges at any health care organization for reasons related to professional competence or conduct.

8. Board certified or eligible to become certified within eighteen (18) months in the applicant's primary area of practice by the appropriate specialty or subspecialty board as identified within the privilege form for each specialty as specified in the Emergency and Hospitalist Provider Certification Requirements Policy No. 953-0009 and in the timeframe specified in such policy.

9. The requested Privileges are those for which the Hospital has a need and for which the Hospital can provide appropriate facilities and support.

10. The requested Privileges are not subject to an exclusive contract that prohibit the granting of such Privileges.

11. No mental or physical health condition that impairs the applicant's ability to carry out the obligations associated with the appointment, reappointment or Privileges requested and which cannot be reasonably accommodated, in the discretion of the MEC.

An individual who submits an application but is not able to meet the applicable threshold eligibility criteria shall be notified and informed in writing that the individual not eligible to apply for appointment and/or Clinical Privileges. A determination that an applicant is not eligible to apply for appointment and/or Clinical Privileges does not constitute an adverse action and shall not entitle the individual the right to a hearing or appellate review.

B. *Waiver of Threshold Eligibility Criteria*. A waiver of one or more of the threshold eligibility criteria outlined in Section 9.1(A) of this Article may be granted in exceptional cases in accordance with the following process:

1. Any individual applicant may request that one or more of the criteria outlined above in Section 9.1(A) be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances warranting a waiver.

2. A request for a waiver will be submitted to the MEC for consideration. In reviewing the request for a waiver, the MEC may consider the specific qualifications of the individual in question, input from the relevant medical director and the Chief of Staff, and the best interests of the Hospital and the community it serves. Additionally, the MEC may, in its discretion, consider other information supplied by the applicant.

3. After the MEC reviews the request for a waiver, the MEC shall make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any such recommendation must include the basis for such recommendation.

4. The Board may grant waivers in exceptional cases after considering the findings and recommendations of the MEC, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual applicant or group.

5. No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or Clinical Privileges.

6. An application for appointment and/or Privileges that does not satisfy an eligibility criterion that applies to the applicant will not be processed unless and until the Board has determined that a waiver should be granted in accordance with this Section.

9.2 Appointment.

A. *Nature of Medical Staff Appointment*. Appointment to the Medical Staff shall be extended only to professionally competent individuals who meet the threshold eligibility criteria and who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to the Medical Staff shall confer on the appointee only prerogatives specified in these Bylaws or granted by the Board in the form of Clinical Privileges. No Practitioner shall admit or provide services to patients in the Hospital unless that Practitioner has been granted Clinical Privileges in accordance with this Article IX.

B. *Qualifications for Appointment.*

1. Basic Qualifications. Only Practitioners who meet the applicable threshold eligibility criteria and who demonstrate and maintain at least the following basic qualifications shall be qualified for initial and continued appointment to the Medical Staff:

a. Graduated from an accredited medical, osteopathic, podiatric or dental school or other appropriate training program;

b. Currently holds an unrestricted license to practice medicine, dentistry, podiatry, or as an APP (as defined in Appendix A) in Wisconsin;

c. Possesses current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Hospital (as applicable to the individual Practitioner);

d. Will be providing services for which the Hospital has a need and for which it can provide appropriate facilities and support;

e. Possesses and can document the individual's:

i. Experience, background, training and demonstrated competence;

ii. Adherence to the ethics of the individual's profession;

iii. Good reputation and character;

iv. Physical and mental health status required to safely perform the requested Privileges; and

v. Ability to work harmoniously with others sufficiently such that all patients treated by them in the Hospital will receive

quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner.

f. Where appropriate and applicable, demonstrates fulfillment of the six (6) areas of "General Competencies" developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative, which consist of the following: patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

g. Is eligible to participate in the Medicare and Medicaid programs and treat beneficiaries without restrictions; and

h. Any other qualifications required by MEC or the Hospital for the specific Privileges requested, including satisfactory answers to any questions posed related to qualifications.

2. Health Evaluation. When the MEC or Board has reason to question the physical and/or mental health of an appointee, the appointee may be required to submit to an evaluation of physical and/or mental health status by a Physician or Physicians acceptable to the MEC and/or Board and to authorize disclosure of the examination results, as a prerequisite to further consideration of the application for appointment or reappointment, to the exercise of previously granted Privileges, or to maintain Medical Staff appointment.

3. Effect of Other Affiliations. No Practitioner shall automatically be entitled to appointment to the Medical Staff or to the exercise of particular Clinical Privileges merely because (1) that person is licensed to practice in this or in any other state, (2) that person is a member of any professional organization, (3) that person resides in the geographic service area of the Hospital, or (4) because that person had, or presently has, Staff appointment or Privileges at the Hospital or at another health care facility or in another practice setting.

4. Nondiscrimination. No aspect of Medical Staff appointment or particular Clinical Privileges shall be denied on the basis of the individual's sex, race, religion, color, creed, ancestry, disability, sexual orientation, marital status, gender identity or expression, national origin, age, source of payment, military service, or any other prohibited basis defined by federal or state law.

5. Continuing Medical Education. Each member of the Medical Staff or applicant for the Medical Staff must be able to furnish evidence of compliance with current Continuing Medical Education (CME) credit requirements for licensure in the State of Wisconsin in the applicant's field.

C. *Leave of Absence.*

1. Leave Status.

a. A leave of absence may be granted to any member of the Medical Staff who intends to be absent from practice continuously for a

period in excess of three (3) months and who submits a written request for such a leave to the MEC, who shall notify the CEO. A leave of absence will not be granted for more than twelve (12) months. The decision to grant or deny a request for a leave of absence shall be at the discretion of the MEC.

b. Leaves of absence are a matter of courtesy, not of right. In the event that an individual has not demonstrated good cause for a leave and the request is denied, or where an extension of a leave of absence is not granted, that determination shall be final, and the individual shall not be entitled to a hearing and appeal.

D. *Termination of Leave.*

a. A Medical Staff member returning from a leave of absence may be reinstated upon the MEC's approval of a written request for reinstatement, which includes a written statement summarizing professional activities during the leave of absence, describing current mental and physical health status, a confirmation that the member continues to meet the requirements of Medical Staff appointment and Privileges and any other information requested by the MEC. The Medical Staff member shall also confirm current professional liability coverage and status.

b. If the leave of absence was for health reasons, the CEO, Chief of Staff, MEC, or Board may require that the individual undergo a physical or mental examination by a qualified Physician or psychologist as agreed upon by the Medical Staff member and the CEO, Chief of Staff, MEC or Board, and that the individual authorize disclosure of the results, for the purpose of assessing whether the Medical Staff member's health status will compromise the delivery of safe and effective patient care.

c. Failure to request reinstatement or failure to provide information necessary for reinstatement within twelve (12) months of commencing the leave will constitute an automatic termination of Medical Staff appointment and Clinical Privileges. without giving rise to any procedural rights under these Bylaws. A request for Staff appointment subsequently received from a Staff appointee so terminated shall be submitted and processed in the same manner specified for applications for initial appointments.

9.3 <u>Procedures for Appointment and Reappointment.</u>

A. *General Procedure*. The MEC shall investigate and consider applications for appointment to the Medical Staff from eligible Practitioners, as well as applications for reappointment to the Medical Staff, and requests for modifications of Staff status or Privileges. The MEC shall transmit such recommendations to the Board in accordance with the procedures outlined in these Medical Staff Bylaws.

B. *Application for Initial Appointment.*

1. <u>Application Form</u>. Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form, and signed by the

applicant. The applicant shall be given access to (or a copy of) the Bylaws and Rules and Regulations of the Medical Staff.

2. Content. The application form shall include the following:

a. Documentation: A request for copies of all of the following to the extent applicable:

i. State license(s);

ii. Controlled substances registration certificate from the Drug Enforcement Agency;

iii. Face sheet of malpractice insurance policy;

iv. Evidence of participation in the State of Wisconsin Injured Patients and Families Compensation Fund;

v. Diploma from appropriate medical, osteopathic, dental, podiatry, or other appropriate educational program;

vi. Specialty board certificate(s);

vii. Recertification documentation; and

viii. A valid picture ID issued by a state or federal agency (e.g., driver's license or passport).

b. Acknowledgments and Agreements: An acknowledgement that the applicant has received and read the Bylaws and Rules and Regulations of the Medical Staff and that the applicant agrees to be bound by the terms thereof in all matters relating to consideration of the application (whether or not the applicant is granted appointment and/or Clinical Privileges), and statements that the applicant:

i. Shall not engage in prohibited fee-splitting, kickback, or referral arrangements;

ii. Shall not delegate responsibility for the diagnosis or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not supervised in accordance with Hospital policy and applicable law; and

iii. Shall appear for personal interviews in regard to the individual's application; understands that any misrepresentation or misstatement in, or omission from the application, whether intentional or not, will render the application incomplete and will not be processed; and, in the event that appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in automatic termination from the Medical Staff and automatic termination of Clinical Privileges.

c. Qualifications: Detailed information concerning the applicant's eligibility and qualifications, including (as applicable) information in satisfaction of the basic qualifications specified in Sections 9.1, 9.2(B)(1), and 9.4, and of any additional qualifications specified in these Bylaws or the policies for the particular Staff category to which the applicant requests appointment, or any other information requested by the MEC or the Board.

d. Medical Staff Category; Privileges: A statement regarding the Medical Staff category and specific Clinical Privileges for which the applicant wishes to be considered.

e. References: The names of at least three (3) professional individuals, one of whom must be in the same professional discipline as the applicant, who have recently worked extensively with the applicant and directly observed the applicant's professional performance over a reasonable period of time and who can and will provide reliable written information regarding the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. The references may not be personally related to the applicant.

f. Other Health Care Facilities: The names and complete addresses of the hospitals or other health care facilities at which the applicant has worked, trained, and/or has been a member of the medical staff in the last ten (10) years. The applicant shall also provide the names and addresses for chairpersons of each clinical service area or service of each hospital or other institution identified.

g. Professional Sanctions: Information as to whether any of the following have ever been or are in the process of being denied, revoked or not renewed, restricted, suspended, reduced, subject to probationary or other conditions, challenged or investigated, or whether any of the following have been voluntarily relinquished (or an application for any of the following withdrawn) during any investigation or before any final decision by a hospital or health care facility's or organization's governing board:

i. Appointment, Clinical Privileges or employment at any health care institution;

ii. Membership/fellowship in local, state, or national professional organizations;

iii. Specialty board certification/eligibility;

iv. License, registration, or certification to practice any profession in any jurisdiction;

v. Participation in any managed care or other payor networks;

vi. Drug Enforcement Agency registration; and

vii. Enrollment in Medicare, Medicaid, or other State or Federally funded health care programs.

h. Legal Actions: Detailed information as to whether any legal actions (including but not limited to suits, claims, mediations or panel proceedings) involving the applicant's professional capabilities, or any alleged criminal conduct, have ever been initiated against the applicant or are currently pending, and whether any judgments have ever been entered against the applicant or are currently pending, and the underlying reasons .

i. Professional Liability Insurance: A statement that the applicant carries any required professional liability insurance coverage at the minimum level required by the Hospital, including (as applicable) participation in the State of Wisconsin Injured Patients and Families Compensation Fund, and information on the applicant's malpractice claims history and experience, including a consent to the release of information by the applicant's present and past malpractice insurance carrier(s).

j. Physical and Mental Health Status: A statement regarding the applicant's physical and mental health status, including any information that may affect the applicant's ability to safely perform the requested Privileges.

k. Health Screening Results: Results of health screenings, including a health history, evidence of immunity to rubella (either titer results or immunization confirmation) and TB (and any other required immunization) for Active or Courtesy Staff who physically provide care within the Hospital.

l. Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions of Section 9.3(E) of these Bylaws.

m. Background Checks: Any documentation necessary to permit the Hospital to conduct a criminal background check, including but not limited to, a Caregiver Background Check in accordance with Wisconsin law, and any other state, federal, military, or international background checks.

n. Administrative Remedies: A statement whereby the applicant agrees that if an adverse recommendation or action (as defined in Article XII) is made with respect to the applicant's Staff appointment, Staff status, and/or Clinical Privileges, he shall proceed under the administrative remedies afforded by these Bylaws, if applicable.

o. Citizenship Status: Information on the applicant's citizenship and/or visa status.

p. Applicant's Signature.

q. Additional Information. Such additional information as the MEC and/or Board deems appropriate to request during the application process.

C. *Effect of Application.* The following undertakings shall be applicable to every Medical Staff appointee and every applicant for Staff appointment, Privileges, or reappointment as a condition of consideration of such application, and as a condition of continued Medical Staff appointment and Privileges if granted:

1. An obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the Hospital for whom the individual has responsibility;

2. An agreement to abide by these Bylaws, the Rules and Regulations, and policies of the Hospital and Medical Staff;

3. An agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to the applicant after appointment;

4. An agreement to provide the Hospital, upon request or without request, current information that is pertinent to any question on the application form;

5. An agreement not to misrepresent the identity of of an operating surgeon or any other individual providing treatment or services;

6. An obligation to seek consultation whenever necessary;

7. An obligation to abide by generally recognized ethical principles applicable to the applicant's profession;

8. An agreement to notify the CEO or designee within twenty-four (24) hours of, and provide such additional information as may be requested regarding, any of the following:

a. Voluntary or involuntary revocation, relinquishment, limitation or suspension of the individual's professional license/certification or DEA registration, any reprimand or other disciplinary action taken by any state or federal government agency relating to the individual's professional license, or the imposition of terms of probation or limitation by any state or federal government agency;

b. Voluntary or involuntary loss, relinquishment, suspension, or restriction of Staff membership or Privileges at any hospital or other health care institution, whether temporary or permanent;

c. Voluntary or involuntary cancellation or change of professional liability insurance coverage;

d. Receipt of a quality inquiry letter or initial sanction notice, notice of proposed sanction, or of the commencement of a formal investigation relating to health care matters by a Medicare peer review organization, the Department of Health and Human

Services, or health regulatory agency of the United States or the State of Wisconsin;

e. Indictment, conviction, or plea of guilty, no contest, or nolo contendere pertaining to any felony;

f. Any misdemeanor substantially related to health care, and any misdemeanors involving: (a) controlled substances; (b) illegal drugs; (c) Medicare, Medicaid, or insurance or other health care fraud or abuse; or (d) violence against another;

g. Receipt of notice of the filing of any suit against the individual alleging professional liability in connection with the treatment of any patient in or at the Hospital or any other hospital or health care facility; or

h. Any challenge to or suspension, restriction, termination, revocation, or change to the individual's participation in Medicare, Medicaid, or any other state or federally funded program.

9. An authorization for the MEC or designees to consult with any and all members of the medical staffs at other hospitals or health care facilities with which the applicant has been associated as well as with any other persons or entities who may have information bearing on the applicant's competence, character, and moral and ethical qualifications;

10. A consent to the inspection of any and all records made at such hospitals or other entities which would be helpful in the evaluation of professional qualifications and competence to carry out the Privileges requested;

11. An agreement to release the Hospital, its representatives, and all third parties from liability as set forth in Section 9.3(E);

12. An agreement to participate in quality improvement activities; and

13. An agreement to undergo a health examination, at the request of the MEC or Board, by a Physician acceptable to the MEC or Board, or to submit other reasonable evidence of current health status that may be requested by the MEC or the Board, and to authorize disclosure of health information as necessary. (The presence of a physical or mental condition that would impair the Practitioner's ability to exercise the Clinical Privileges requested, or to care for patients, will not constitute a ban to the granting of Medical Staff membership or Clinical Privileges if, with reasonable accommodation, the Practitioner can safely perform the Clinical Privileges requested and safely care for patients.)

Each applicant for Medical Staff appointment and reappointment and Clinical Privileges shall specifically agree to these undertakings as part of the application and reappointment process.

D. *Incomplete Application.* The withholding of requested information, the omission of information, the submission of an incomplete information, the providing of false or misleading information in the application at any stage in the review process will render the application incomplete and it will not be processed further unless and until the applicant provides the necessary additional or clarifying information. The

inability to process an incomplete application shall not confer upon the applicant any hearing or procedural rights under Article XII.

E. *Immunity and Release.* The following statements are express conditions applicable to any Medical Staff applicant, any appointee to the Medical Staff, and all others having or seeking Clinical Privileges in the Hospital. By applying for appointment, reappointment, or Clinical Privileges, the applicant expressly agrees:

1. That these Bylaws are express conditions to the application for, or acceptance of, Medical Staff membership and the continuation of such membership, and/or to application for, or the exercise of, Clinical Privileges, whether or not the person is granted appointment or Clinical Privileges.

2. That the hearing and appeal procedures set forth in these Bylaws shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital and its authorized representatives.

3. If, notwithstanding these requirements, an individual institutes legal action and does not prevail, that individual shall reimburse the Hospital and its authorized representatives named in the action, for all costs incurred in defending such legal action, including reasonable attorney fees. This applies during the time of any appointment or reappointment and thereafter.

4. Immunity. To the fullest extent permitted by law, the individual releases from any and all liability, and extends absolute immunity to and agrees not to sue, the Hospital, its authorized representatives and any third parties as defined in subsection (F)(4) below, with respect to any and all civil liability that might arise from any acts, communications, documents, recommendations or disclosures involving the individual, including but not limited to the following:

a. Applications for appointment, reappointment, or Privileges, including but not limited to Clinical Privileges, temporary Privileges, emergency Privileges, and disaster Privileges;

b. Evaluations concerning reappointment or changes in Clinical Privileges or Staff category;

c. Proceedings for revocation, suspension, restriction or reduction of Clinical Privileges or Medical Staff appointment, or any other disciplinary sanction;

d. Summary suspension;

e. Hearings and appellate reviews;

f. Collegial intervention or corrective action;

g. Medical care evaluations;

h. Utilization and quality assurance reviews;

i. Peer review;

j. Other activities relating to the quality of patient care or professional conduct;

k. Soliciting, providing, or acting upon information bearing on the individual's professional ability, qualifications, character, mental or emotional stability, physical condition, ethics, behavior; or

l. Any other matter that might directly or indirectly have an effect on the individual's competence, on patient care or on the orderly operation of this or any other hospital or health care facility.

F. *Obtaining and Releasing Information*. By applying for appointment or Privileges, or by exercising Clinical Privileges or providing patient care services within this Hospital, each individual applicant understands and agrees with all of the following:

1. Authorization to Obtain Information. The individual applicant authorizes the Hospital, Medical Staff or representatives to confer with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, physical or mental health status, ethics, behavior or any other matter reasonably having a bearing on the individual's satisfaction of the criteria for initial and continued appointment to the Medical Staff or for Clinical Privileges. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such issues. The individual also specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request. The individual applicant agrees to execute consent form(s) to facilitate the release of privileged or confidential records and to cooperate with criminal background checks (including a Wisconsin criminal background check, such as the care Caregiver Background Check, and any out-of-state, military, federal, or international criminal background checks).

2. Authorization to Release Information. The individual applicant authorizes the Hospital, Medical Staff or representatives to release information to other hospitals, health care facilities, managed care organizations, government authorities, licensure bodies, and their agents, who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to the applicant's request for appointment or Clinical Privileges, or for any licensure or regulatory matter.

3. Confidentiality. The Hospital, the Medical Staff and the indivual applicant shall maintain the confidentiality (and to the extent applicable, privilege) of any and all Information with respect to any individual applicant submitted, collected, prepared, or disclosed by the Hospital and its authorized representatives or any other health care facility, Medical Staff, or other third party for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research. In addition, the information contained in investigations, evaluations, and assessments of the individual's care or behavior undertaken pursuant to these Bylaws or otherwise shall, to the fullest extent permitted or required by law, be maintained as confidential and privileged.

4. Definitions.

a. As used in this Section, the term “Hospital and its authorized representatives” includes but is not limited to the Hospital corporation; the Board of Directors; employees, volunteers, or other workforce members; senior leaders; the MEC; the CEO; Medical Staff officers; Chief of Staff; medical directors; Medical Staff members and other Providers with Clinical Privileges; consultants to the Hospital; the Hospital's attorneys; and any other person or entity that, on behalf of or for the benefit of the Hospital, obtains, evaluates, or acts upon the individual's credentials, application, or conduct, or who provides or is asked to provide information, statements, reports, or testimony for any of the activities to which this Section applies.

b. As used in this Section, the term “third parties” means all individuals or government agencies, organizations, associations, partnerships and corporations, regardless of whether they are health care facilities, from whom information has been requested by the Hospital and its authorized representatives or that has requested such information from the Hospital and its authorized representatives.

5. Cumulative Effect. Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof, and in the event of conflict, the applicable law shall be controlling.

G. *Processing the Application.*

1. Applicant’s Burden.

a. The applicant shall have the burden of producing adequate information for a proper evaluation of the applicant's experience, background, training, current competence, ability, and of resolving any doubts about these or any other qualifications set forth in these Bylaws.

b. If the CEO or designee determines that an application is not complete, the applicant shall be so notified, and shall have sixty (60) days in which to forward the missing documentation. If the information is not received within sixty (60) days, and the applicant has not contacted administration during this time with a reasonable explanation of the delay, the application will be deemed incomplete and the file will be closed. In such event, the applicant shall not be entitled to a hearing and none of the procedural rules provided in Article XII shall apply.

2. Verification of Information.

a. The applicant shall deliver a completed application to the CEO or designee, who, in timely fashion, shall:

i. Verify that the applicant meets the threshold eligibility requirements outlined in Section 9.1. Only complete applications from applicants who meet the threshold

eligibility requirements will be processed. Those individuals who do not satisfy the threshold eligibility criteria shall be notified in writing that they are not eligible to apply for appointment or Privileges and the applicants will not be entitled to hearing and appeal rights.

ii. Verify that the applicant is the same applicant identified in the credentialing documents by viewing either a valid picture identification issued by a state or federal agency (e.g., driver's license or passport).

iii. Collect all information and documentation related to the application and verify the applicant's Wisconsin license to practice, education, training and current competence; perform National Practitioner Data Bank (NPDB), Office of Inspector General of the Department of Health and Human Services (OIG), and System for Award Management (SAM) queries; obtain verifying information from the appropriate state licensing boards and related sources; and undertake a criminal background check, including but not limited to, a Caregiver Criminal Background check as is required by Wisconsin law. The Hospital shall verify the applicant's licensure, relevant training, basic qualifications, and current competence in writing and from the primary source whenever feasible, or from a credentials verification organization. If required, the applicant will authorize any special releases that the agencies may require.

b. The CEO or designee shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. When data collection and verification is accomplished and all information requested from the applicant has been provided, the application is deemed complete, and the CEO or designee shall transmit the application and all supporting materials to the MEC. An application that was initially deemed complete may subsequently be deemed incomplete at any time if there is a need for additional information. Misrepresentations, misstatements, and omissions are also addressed in Section 9.3(D).

c. At any time during the application and review process, the MEC or the Board may request the applicant to meet with the MEC or Board to discuss the application or to obtain additional or clarifying information. This interview shall not constitute a hearing and none of the procedural rules provided in Article XII shall apply.

3. MEC Action.

a. The MEC shall review and evaluate the application, the supporting documentation and such other information available to it (including, if available, data from professional practice review by an organization(s) that currently privileges the applicant, relevant Practitioner-specific data as compared to aggregate data, and morbidity and mortality data, as well as factors identified in

Sections 9.1 through 9.4) that may be relevant to consideration of the applicant's qualifications for the Staff category and Clinical Privileges requested.

b. The MEC shall then vote that the application be accepted, deferred, or rejected. If appointment is recommended by the MEC, the recommendation shall include a recommendation for Medical Staff category, the Clinical Privileges to be granted, and any conditions, restrictions, or terms of probation to be attached to the appointment and/or Privileges.

4. Effect of MEC Action.

a. Deferral: Action by the MEC to defer the application for further consideration must be followed-up within sixty (60) days with a subsequent recommendation for appointment with specified Clinical Privileges, or for rejection for Staff appointment.

b. Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the CEO or designee shall promptly forward it, together with all supporting documentation, to the Board. For purposes of this Section, "all supporting documents" means information required by and accompanying the application form, and the report and recommendations of the MEC.

c. Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant (as defined in Article XII), the CEO shall promptly inform the Practitioner by Special Notice, that the applicant entitled to the procedural rights as provided in Article XII of these Bylaws. Such notice shall comply with the notice requirements outlined in Article XII.

5. Board Action.

a. On Favorable MEC Recommendation: The Board shall, in whole or in part, adopt or reject a favorable recommendation of the MEC or refer the recommendation back to the MEC for further consideration stating the reason for such referral and setting a time limit within which a subsequent recommendation shall be made.

i. If the Board refers the matter back to the MEC and the MEC's subsequent recommendation is adverse to the applicant (as defined in Article XII), the CEO or designee shall promptly so inform the Board. The CEO shall promptly inform the Practitioner by Special Notice, that the applicant entitled to the procedural rights as provided in Article XII of these Bylaws. Such notice shall comply with the notice requirements outlined in Article XII. The Board shall not take any action in the matter until it has received the hearing report and final recommendation of the MEC or it has been notified that the applicant has waived the applicant's right to a hearing.

ii. If the Board's action is favorable to the applicant, the applicant shall be notified in accordance with Section 9.3(G)(8), and such action shall be the final decision of the Board and the matter shall be considered closed.

iii. If the Board's action will be adverse to the applicant (as defined in Article XII), the MEC and Board shall meet in compliance with Section 9.3(G)(7). If after such meeting, the Board's action continues to be adverse to the applicant, the CEO shall promptly inform the Practitioner by Special Notice, that the applicant is entitled to the procedural rights as provided in Article XII of these Bylaws. Such notice shall comply with the notice requirements outlined in Article XII.

b. After Procedural Rights: In the case of an adverse MEC recommendation pursuant to Section 9.3(G)(4)(c) or an adverse Board decision pursuant to Section 9.3(G)(5)(a)(iii), the Board shall take final action in the matter only after the applicant has exhausted or has waived the applicant's procedural rights as provided in Article XII of the Medical Staff Bylaws. Final action shall be taken in accordance with requirements outlined in Section 12.7 and shall be the conclusive decision of the Board.

6. Hospital's Inability to Accommodate. A recommendation by the MEC, or a decision by the Board, to deny Staff appointment or Staff category assignment or particular Clinical Privileges, either:

a. On the basis of the Hospital's present inability, as supported by documented evidence, to provide adequate facilities or supportive services for the applicant and/or the applicant's patients; or

b. On the basis of inconsistency with a plan of development, if such plan is documented, and includes the mix of patient care services to be provided;

shall not be considered adverse in nature and shall not entitle the applicant to the procedural rights as provided in Article XII of the Bylaws.

An individual denied appointment, Privileges, or Medical Staff category based on this Section may submit a new application no earlier than two (2) years from the date of denial for inability to accommodate. If, however, the Board later determines there is a need in that particular area and that the Hospital has gained the ability to accommodate, the Board may waive the two (2) year waiting period.

7. Conflict Resolution. Whenever the Board's proposed decision will be contrary to the MEC's favorable recommendation, the Board shall submit the matter to a joint conference of equal numbers of Medical Staff appointees and Board members for review and recommendation before making its final decision and giving notice of final decision required by Section 9.3(G)(8).

8. Notice of Final Decision.

a. Notice of the Board's final decision shall be given, through the CEO or designee, to the applicant by means of Special Notice and to the Chief of Staff.

b. A decision and notice to appoint shall include:

i. The Medical Staff category to which the applicant is appointed;

ii. The Clinical Privileges he may exercise, as determined in accordance with Section 9.4 of these Bylaws;

iii. Any special conditions, restrictions, or terms of probation attached to the appointment; and

iv. The period for which appointment and Privileges are granted, which shall not exceed two (2) years.

9. Reapplication After Adverse Appointment Decision. Unless otherwise provided herein, an applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of two (2) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the MEC or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.

10. Time Periods for Processing. The CEO or designee shall transmit a completed application to the MEC after he has collected and verified the required information as expeditiously as is feasible. The MEC shall then act on the application at the next scheduled meeting after receiving it from the CEO. The Board or the appropriate committee thereof shall then take final action on the application at its next regular meeting or, if applicable, after the applicant has exhausted the applicant's appeal rights.

11. Length of Appointments. Appointment to any category of the Medical Staff and any Privileges granted shall be for a period of not more than two (2) years. Appointment for a period of time less than two (2) years does not, in and of itself, entitle the individual to the procedural rights set forth in Article XII.

12. Appointments that are Set to Expire during a Declared National Emergency. Provider's Medical Staff appointments and/or Clinical Privileges that are set to expire during the time of a declared national emergency may be automatically extended beyond the 2-year period if the Hospital has activated its Emergency Operations Plan. Within sixty (60) days of the expiration of the state of emergency (national, federal, or local level depending upon which allows the most time to address), the Practitioner shall be required to apply for reappointment and the application shall be processed in accordance with 9.3(H) below.

H. *Reappointment Process and Renewal of Privileges.*

1. General Requirements.

a. The CEO or designee shall, at least ninety (90) days prior to the expiration date of the current Staff appointment of each Medical Staff appointee, provide such appointee with an interval information form for use in requesting reappointment and the renewal of Privileges. Each Medical Staff appointee who desires reappointment and the renewal of Privileges shall, at least sixty (60) days prior to such expiration date, send the completed interval information form to the CEO or designee. Failure, without good cause, to return the form in this time frame shall be deemed a voluntary resignation from the Medical Staff and shall result in termination of appointment and Privileges at the expiration of the appointee's current term unless the MEC decides otherwise. Such termination shall not result in procedural rights under Article XII.

b. All terms, conditions, requirements, and procedures relating to initial appointment and Clinical Privileges shall apply to continued appointment and Clinical Privileges and to reappointment and renewal of Clinical Privileges.

c. When appropriate, the MEC or Board may require that an individual currently seeking reappointment procure an independent physical or mental examination either as part of the reapplication process or during the appointment year to aid it in determining whether Clinical Privileges and/ or Medical Staff appointment should be granted or continued and make the results available for consideration. When informing the individual that such an examination is required, the MEC or Board shall establish the time period within which the examination must be completed and the results provided. Failure of the individual seeking reappointment to procure such an examination or facilitate the provision of the examination results within the specified time period shall constitute an automatic termination of Medical Staff membership and Clinical Privileges, without giving rise to any procedural rights under these Bylaws. Any subsequent application shall be treated as an initial application for Medical Staff membership and Privileges.

d. At any time during the reappointment process, the MEC or Board may request to meet with the applicant to discuss the application or to obtain additional or clarifying information. This interview shall not constitute a hearing and none of the procedural rules provided in Article XII shall apply.

2. Content of Reappointment Form. The reappointment form shall request data necessary to update the Medical Staff file on the Staff appointee's qualifications and health care related activities. This form shall include, without limitation, information about the following:

a. Evidence of current unrestricted licensure/certification, current and unrestricted DEA certificate, and, if applicable, evidence of medical specialty board certification;

b. Current physical and mental health status as required by the Medical Staff or the Board (or appropriate committee thereof), including completion of the TB attestation form and any

necessary follow-up as determined by the responses on such form.;

c. The name and address of any other health care organization or practice setting where the Staff appointee provided clinical services during the preceding period;

d. CME credits earned since the appointee's most recent application or reapplication to the Medical Staff;

e. Sanctions of any kind imposed or pending by any other health care institution, professional health care organization, or licensing authority, including but not limited to any professional sanctions identified in Section 9.3(B)(2)(g);

f. Malpractice insurance coverage (including cancellations, non-renewals and limits), participation in the State of Wisconsin Injured Patients and Families Compensation Fund, as applicable, and if relevant, claims, suits, mediations, and settlements during the previous two (2) years;

g. Such other specifics about the Staff appointee's professional ethics, qualifications, and ability that may bear on the ability to provide good patient care in the Hospital;

h. Provide a copy of a valid government issued picture ID;

i. Information regarding any other changes to previously submitted information; and

j. Any requested changes to Privileges.

3. Verification of Information.

a. The CEO or designee shall, in timely fashion, seek to collect or verify the additional information made available on each interval information form and, if necessary, to collect any other material or information deemed pertinent, including information regarding the Medical Staff appointee's professional activities, performance and conduct in the Hospital and the appointee's fulfillment of Staff appointment obligations. The CEO or designee shall promptly notify the Staff appointee of any problems in obtaining the information required.

b. The Staff appointee shall then have the same burden of producing adequate information and resolving doubts as provided in Section 9.3(G)(1). When collection and verification are accomplished, the CEO shall transmit the information form and supporting materials to the MEC through the Chief of Staff or designee.

c. At each reappointment, the Hospital shall verify current licensure and DEA registration and perform NPDB, OIG, and SAM queries.

4. Basis for Recommendations. Each recommendation concerning the reappointment of a Staff appointee and the Clinical Privileges to be

granted upon reappointment shall be based upon factors such as the appointee's:

a. Ethical behavior, clinical competence, and clinical judgment in the treatment of patients;

b. Participation in Medical Staff responsibilities;

c. Compliance with the Hospital bylaws and policies and with the Medical Staff Bylaws, Rules and Regulations, and policies;

d. Behavior in the Hospital, cooperation with Hospital personnel and other Providers as it relates to patient care or the orderly operation of the Hospital, and the appointee's general attitude toward patients, the Hospital and its personnel;

e. Use of the Hospital's facilities for the appointee's patients, taking into consideration the individual's comparative utilization patterns;

f. Physical and mental health as it pertains to the ability to safely provide patient care services;

g. Capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality assessment activities or other reasonable indicators of continuing qualifications;

h. Satisfactory completion of such continuing education requirements as may be imposed by law, the Hospital, or applicable accreditation agencies;

i. Current professional liability insurance status and any pending malpractice challenges, including claims, lawsuits, judgments and settlements;

j. Current licensure and registration, including any currently pending challenges to any license or registration or voluntary relinquishment of such licensure or registration;

k. Voluntary or involuntary termination, limitation, reduction, suspension or loss of Medical Staff membership or clinical privileges at any other hospital or health care facility;

l. Information obtained from the NPDB, OIG and SAM;

m. Professional practice evaluation data that are collected and assessed on an ongoing basis;

n. Peer recommendation, including written information regarding the appointee's current: medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism;

o. Relevant Practitioner-specific data as compared to aggregate data, when available;

p. Morbidity and mortality data, when available;

q. The factors identified in Sections 9.2(B) and 9.4(B)(2); and

r. Other relevant findings from the Hospital's quality assessment activities.

5. MEC Action. The MEC shall review each interval information form and all other pertinent information available on each appointee being considered for reappointment, and shall forward to the CEO for transmittal to the Board its report and recommendation that appointment and Privileges be either renewed, renewed with modified Staff category and/or Clinical Privileges, renewed with conditions, or terminated. The MEC may also defer action.

6. Final Processing and Board Action. Thereafter, the procedure provided in Section 9.3(G)(4) through 9.3(G)(8) shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those Sections shall be read respectively as "Staff appointee" and "reappointment."

7. Time Periods for Processing. Transmittal of the interval information form to a Staff appointee and the return of it shall be carried out in accordance with Section 9.3(G)(10). Thereafter and except for good cause, each person and committee required by these Bylaws to act thereon shall complete such action in a timely fashion so that all reports and recommendations concerning the reappointment of a Staff appointee shall have been transmitted to the Board for its action prior to the expiration date of the Staff appointment of the appointee being considered for reappointment.

8. Length of Reappointments. Reappointments to any category of the Medical Staff and any Privileges granted shall be for a period of not more than two (2) years. Reappointment for a period of time less than two (2) years does not, in and of itself, entitle the individual to the procedural rights set forth in Article XII.

9. Reappointments that are Set to Expire during a Declared National Emergency. Provider's Medical Staff reappointments and/or Clinical Privileges that are set to expire during the time of a declared national emergency may be automatically extended beyond the 2-year period if the Hospital has activated its Emergency Operations Plan. Within sixty (60) days of the expiration of the state of emergency (national, federal, or local level depending upon which allows the most time to address), the Practitioner shall be required to apply for reappointment and the application shall be processed in accordance with 9.3(H) below

I. *Requests for Modification of Appointment Status.* A Medical Staff appointee may, either in connection with reappointment or at any other time, request modification of Staff category by submitting a written application to the CEO or designee on the prescribed form. Such application shall be processed in substantially the same manner as provided in Section 9.3(H) for reappointment.

9.4 Determination of Clinical Privileges.

A. *Exercise of Privileges.* Except as otherwise provided in Sections 9.6 and 9.7, Providers are entitled to exercise only those Clinical Privileges specifically granted to the Provider by the Board. Each Provider may practice only within the scope of the license, certificate, or other legal credentials authorizing the Provider to practice in this state. Continued exercise of such Privileges shall be contingent on ongoing professional practice evaluation, as set forth in Section 9.12.

B. *Delineation of Privileges in General.*

1. Requests. Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the applicant. A request by a Provider for additional Privileges must be supported by documentation of relevant additional training and/or experience. Requests for modification of Privileges at any other time must be made by written application to the CEO or designee with supporting documentation. Requests for Clinical Privileges will be considered only when all information specified in the Hospital's description of threshold requirements has been submitted.

2. Basis for Privileges Determination. Requests for Clinical Privileges (initial and renewal) shall be evaluated on the basis of the following factors:

a. The Provider's education, training, experience, competence, demonstrated ability and judgment, peer references (addressing the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and character), and health status;

b. If such information is available, observed clinical performance and the documented results of the quality assessment and improvement, evaluation and monitoring activities conducted at the Hospital as required by the Medical Staff Bylaws and the Hospital corporate bylaws, including but not limited to results of focused and ongoing professional practice evaluations and peer review activities (if applicable);

c. If such information is available, pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a Provider exercises or has exercised the requested Clinical Privileges;

d. Adequate levels of professional liability insurance coverage with respect to Clinical Privileges requested;

e. The Hospital's available resources and personnel;

f. Any previous or pending challenges to licensure or registration, or voluntary or involuntary relinquishment, restriction, suspension, or modification of licensure or registration;

g. Any previous or pending voluntary or involuntary review actions, including but not limited to any voluntary or involuntary termination, denial, limitation, suspension, reduction, probation, or loss of Medical Staff membership or Clinical Privileges at the Hospital or any other hospital or health care facility;

h. Professional liability actions, including but not limited to such actions that reflect an unusual pattern or excessive number of actions against the applicant;

i. Evidence of ability to perform the Privileges requested competently and safely;

j. Relevant data specific to the Provider as compared to aggregate data, when available;

k. Morbidity and mortality data, when available; and

l. Other relevant information.

3. Burden. The applicant shall have the burden of establishing the applicant's qualifications for and competency in the Clinical Privileges he requests, including sufficient clinical performance information, as determined by the MEC, to make a decision to grant, limit, or deny the requested privilege(s).

4. Procedure. All requests for Clinical Privileges shall be processed pursuant to the procedures outlined in Article IX relating to appointment and reappointment.

C. *Conditions for New or Special Privileges.* The MEC shall establish specific guidelines on the minimum training requirements a Provider must have before Clinical Privileges in a new or special procedure may be approved. Providers requesting Privileges for newly developed or special courses of treatment or procedures must submit adequate documentation of training and competency in accordance with such guidelines. The MEC may impose proctoring, monitoring or other similar requirements, as the MEC deems appropriate, prior to granting any new or special Privileges. Proctoring is expected where feasible and appropriate. However, if there is no appointee on the Medical Staff with sufficient training, capacity and experience to proctor a Provider who requests Privileges to perform such treatment or procedures, the MEC may choose to increase the minimum level of training and/or establish other criteria that the Provider must meet before approving Privileges.

D. *Special Conditions for Dental and Podiatric Privileges.* Requests for Clinical Privileges from Dentists and Podiatrists shall be processed in the manner specified in Section 9.4(B). Surgical procedures performed by Dentists and Podiatrists shall be under the overall supervision of the Physician advisor for surgery or an appropriately qualified designee. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A Physician appointee of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk, effect, and appropriateness of the proposed surgical procedure on the total health status of the patient. This shall include the performance by a Physician member of the Medical Staff of an admission history and physical examination. The Dentists or Podiatrist, as applicable, shall be responsible for the dental and podiatric portion of the history and physical.

E. *Privileges that are Set to Expire during a Declared National Emergency.* A Provider's Clinical Privileges that are set to expire during the time of declared national emergency may be automatically extended.

F. *Special Conditions for Allied Health Professionals*. Requests to perform specified patient care services from Allied Health Professionals shall be processed in the manner specified in Article X.

G. *Outpatient Orders from Non-Privileged Practitioners.* Non-privileged providers, including Physicians, Dentists and Podiatrists, and other licensed health care professionals may issue orders for outpatient services in accordance with their scope of practice, subject to the Medical Staff policy addressing orders from non-privileged providers.

H. *Therapy Orders from APNPs and PAs*. Advanced Practice Nurse Prescribers and Physician Assistants with appropriate Clinical Privileges may order outpatient Physical Therapy, Occupational Therapy, and Speech Therapy services without a Physician co-signature.

9.5 Temporary Privileges.

A. *Circumstances.* Temporary Clinical Privileges may be granted by the CEO or designee, upon recommendation of the Chief of Staff or designee in the following circumstances:

1. Pending Application: For a pending application, temporary Privileges shall be granted only after the applicant completes the initial application forms and provides the documentation required by Section 9.3(b)(2)(a). An applicant who has received a favorable recommendation from the MEC for Medical Staff membership may be granted temporary Privileges for a period not to exceed one hundred and twenty (120) days pending final approval by the Board, provided that the MEC has verified the following:

a. Current licensure and DEA registration (where applicable);

b. Relevant education, training and experience;

c. Current competence;

d. Ability to safely perform Privileges requested;

e. Satisfaction of other criteria required by these Bylaws;

f. A query and evaluation of NPDB, as well as the OIG and SAM exclusion databases;

g. A complete application;

h. No current or previously successful challenge to licensure or registration;

i. No subjection to involuntary termination of medical staff membership at another organization or facility; and

j. No subjection to involuntary limitation, reduction, denial, or loss of Clinical Privileges at another organization or facility.

k. Current malpractice insurance coverage (in the amount sufficient to satisfy the requirements imposed by Wisconsin law and the Board of Directors);

l. The applicant's identity by viewing a valid picture ID issued by a state or federal agency (e.g., driver's license or passport); and

m. The applicant's immunizations for Tuberculosis and Rubella.

If the Board's recommendation following a favorable recommendation of the MEC is to reject the MEC's recommendation in whole or in part, or to refer the application back to the MEC for further consideration, such temporary Privileges shall be immediately revoked.

2. To Meet an Important Patient Care Need: Temporary Clinical Privileges to meet an important patient care need may be granted upon written request only where the CEO (or designee) or Chief of Staff (or designee) verifies current licensure, registration and/ or certification as well as current competence for the Privileges requested. The Hospital must perform queries of the NPDB and OIG and SAM Exclusion Databases, submit requests for criminal background checks, and verify malpractice insurance prior to granting such Privileges. Prior to exercising temporary Privileges, the Provider must agree in writing to be bound by the Bylaws, Rules and Regulations, policies and procedures of the Medical Staff and the Hospital. Categories of temporary Privileges that may be granted to meet an important patient care need include without limitation:

a. Care of Specific Patients: Temporary Privileges may be granted for the care of one or more specific patients. Such Privileges shall be for a period not to exceed one hundred and twenty (120) days, after which such Provider shall be required to apply for appointment to the Medical Staff or Clinical Privileges before being allowed to attend additional patients.

b. Locum Tenens: Temporary Privileges may be granted to a Provider who is serving in a locum tenens capacity for an appointee to the Medical Staff. Such temporary Privileges shall be for a period not to exceed one hundred and twenty (120) days after which Provider shall be required to apply for appointment to the Medical Staff or Clinical Privileges.

B. *Conditions.* Special requirements of consultation and reporting may be imposed on a Provider granted temporary Privileges by the Chief of Staff or designee.

C. *Termination.* Temporary Clinical Privileges shall automatically terminate, without the opportunity for renewal, at the end of the designated period, unless earlier terminated in accordance with these Bylaws. The Provider's patients shall be assigned to another Provider by the Chief of Staff or designee. The wishes of the patient shall be considered, where feasible, in choosing a substitute Provider.

D. *Rights of A Practitioner with Temporary Privileges.* In the event that a Practitionerr's temporary Privileges are terminated or are restricted for a period of

more than thirty (30) days as the result of a professional review action or are voluntarily surrendered while under investigation, to avoid one, or in exchange for not conducting one, the Practitioner shall be entitled to the procedural rights specified in these Bylaws except where the temporary Privileges are awarded to the Practitioner for a specific period of time with no opportunity for renewal and the temporary Privileges expire while the Practitioner is under investigation.

9.6 Emergency Privileges.

A. For the purposes of this Section, an "emergency" is defined as a condition in which serious or 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.

B. In the case of an emergency, any individual, to the degree permitted by their license and regardless of Staff status or Clinical Privileges, shall be permitted to provide any type of patient care, treatment and services necessary to save the life of a patient or to save a patient from serious harm, and shall be assisted by Hospital personnel in doing so.

C. When an emergency situation no longer exists, such individual must request, in accordance with this Article IX, any Privileges necessary to continue to treat the patient. In the event such Privileges are denied or the individual does not desire to request such Privileges, the patient shall be assigned to an appropriate appointee to the Medical Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute Provider.

9.7 Disaster Privileges. When the Hospital's Emergency Operations Plan has been activated, the CEO, Chief of Staff, or their designee(s) may grant disaster Privileges on a case-by-case basis in accordance with the Disaster Privileges Policy. The Hospital shall determine within seventy-two (72) hours of the Provider's arrival if the Provider's disaster Privileges should continue.

9.8 Telemedicine Privileges.

A. Any individual who provides services through a telehealth link must have been granted Medical Staff appointment and/or Clinical Privileges prior to the exercise of any telemedicine Privileges. However, Providers who hold Clinical Privileges to practice in the Hospital, who desire to provide the same services via a telehealth link to patient, do not require any additional credentialing or privileges.

B. Eligible individuals applying for Medical Staff appointment and/or Privileges for telemedicine services shall either be credentialed and privileged in the same manner as any other applicant for appointment and/or Clinical Privileges or shall be credentialed by proxy in accordance with applicable law and accreditation standards, and with Hospital or Medical Staff policy.

C. Practitioners seeking only telemedicine Privileges are eligible only for Courtesy Staff membership, unless a waiver of this provision is approved by the MEC.

D. Medical Staff members and Allied Health Professionals providing telemedicine services are subject to these Medical Staff Bylaws, the Medical Staff policies and Rules and Regulations, and all Hospital rules and policies in the same manner as any other Medical Staff member or Allied Health Professional.

E. The MEC, after review by the Medical Staff, shall recommend the services that will be provided by telemedicine to the Board. The Medical Staff shall, on an ongoing basis, evaluate the Hospital's ability to safely provide telemedicine services to its patients in accordance with commonly accepted quality standards.

F. Medical Staff membership and Privileges granted in conjunction with a contract for telemedicine services shall automatically terminate when the contract terminates, without any right to a hearing or appeal under Article XII, unless the Board agrees to continue the Provider's membership and/ or Privileges.

G. In the event of any conflict between this Section and a contract for telemedicine services, the contract shall control.

9.9 Health Care Services Review. All minutes, reports, communications, recommendations and actions made or taken by the Medical Staff, MEC, and related committees pursuant to Article IX of these Bylaws are deemed to be covered by the provisions of Wisconsin Statutes, Sections 146.37 and 146.38 and the Act, as may be amended, and any other federal or state statute providing protection to peer review or related activities.

9.10 Continuing Education. All Medical Staff appointees and other personnel with delineated Clinical Privileges shall participate in appropriate continuing medical education programs, as required by to maintain licensure, designed to keep them informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care, in the areas related to their Clinical Privileges, and to refresh them in various aspects of their basic medical education.

9.11 History and Physical Examinations.

A. As required by 42 C.F.R. §§ 485.638 and 485.639, a medical history and physical examination shall be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but in any event prior to surgery or a procedure requiring anesthesia services. When a medical history and physical examination has been completed within thirty (30) days before admission or registration, an updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but in any event prior to surgery or a procedure requiring anesthesia services.

B. The medical history and physical examination must be completed and documented by a Physician member of the Medical Staff, except that a history and physical that is completed prior to admission or registration may be completed by a Practitioner who is not privileged by the Hospital if an update is completed and documented by a Physician who is credentialed and privileged by the Hospital within the specified timeframes. In addition, all or part of the history and physical, or any updates thereto, may be delegated to other Practitioners in accordance with state law and Medical Staff Rules and Regulations (and any other applicable policy), but a Physician with Privileges at the Hospital must review, sign, and date the history and physical and/or update and assume full responsibility for the history and physical and/or update.

C. Medical history and physical examination requirements are addressed in more detail in the Medical Staff Rules and Regulations.

9.12 Professional Practice Evaluation: Focused and Ongoing.

A. *General Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Requirements.*

1. Initial Applicants. All initial applicants to the Medical Staff and initial Privilege requests, and all requests submitted by current Medical Staff members or Providers for modifications of Staff category and/or Privileges shall be subject to Focused Professional Practice Evaluation ("FPPE") in accordance with the Professional Practice Evaluation, Ongoing and Focused Policy.

2. Current Appointees. All Members of the Medical Staff and all individuals who are granted Privileges shall also be subject to FPPE and OPPE in accordance with applicable Medical Staff policies.

B. *FPPE and OPPE Requirements when Operating under the Emergency Operations Plan (EOP)*. In the event of a declared state of emergency when the Hospital's Emergency Operations Plans has been activated:

1. FPPE under EOP. The evaluation of Providers currently under FPPE should continue per the applicable Medical Staff policy. However, FPPE requirements do not apply to those Providers who have been granted disaster privileges.

2. OPPE under EOP. To the extent possible, Provider performance data collection for OPPE should continue based on the applicable Medical Staff policy. If gaps in data occur as a result of reallocation of resources, the Hospital should document the contributing factors leading to such gaps. If resources are unavailable to review the data within the defined time frames, the Hospital may temporarily modify the review process until such time resources can be re-allocated back to resume the process as provided in the applicable policy. Any modifications to the review process should allow the Medical Staff to detect and address downward trending performance. Examples may include review of incident reports, staff/patient complaints, post-procedure complications, sentinel or other events results in negative patient outcomes, etc. The Hospital shall periodically reassess the availability of resources to determine when the OPPE data collection and review process can resume as required under applicable policy.

ARTICLE X
ALLIED HEALTH PROFESSIONALS

10.1 <u>General Requirements, Eligibility, and Responsibilities.</u>

A. *General Requirements.*

1. Allied Health Professionals ("AHPs") are classes of health care professionals other than Physicians, Dentists, Podiatrists and APPs who deliver varying levels of patient care services. AHPs who wish to provide treatment to patients at the Hospital must apply for Clinical Privileges. Those AHPs who are granted Privileges may provide treatment in the Hospital within the scope of their licenses/certification and in accordance with individually granted Clinical Privileges. To the extent required by law, AHPs shall provide services under the supervision of, or in collaboration

with, a Physician. The specific categories of health care professionals that are eligible to provide clinical services as AHPs are outlined in Appendix B.

2. AHPs may attend Medical Staff meetings at the invitation of Medical Staff members, but shall not be considered members of the Medical Staff and shall not be entitled to vote on Medical Staff matters or in Medical Staff elections, nor shall they have any of the other prerogatives granted to Medical Staff members. AHPs may participate on committees as specifically allowed for by the Medical Staff Bylaws or Medical Staff policies or at the discretion of the Medical Executive Committee.

3. All eligible AHPs are required to submit a complete application for Clinical Privileges and demonstrate qualifications in accordance with those requirements in Sections 9.1 through 9.4 that are applicable to AHPs.

    a. To be eligible to apply for Privileges as an AHP, the individual seeking such Privileges must be able to satisfy the applicable threshold eligibility criteria outlined in Section 9.1(A). A waiver of one or more of the applicable threshold eligibility criteria may be granted in exceptional cases in accordance with the waiver process outlined in 9.1(B).

    b. An application for Clinical Privileges as an AHP must be complete before it can be processed. The applicant shall have the burden of adequately completing the application and of producing information in compliance with 9.3(G).

    c. All requests for Privileges and renewal/increase of Privileges from AHPs will be evaluated and processed pursuant to those provisions of Sections 9.3 and 9.4 that apply to AHPs. All applicable provisions of Sections 9.3 and 9.4 shall apply to this process, including but not limited to the immunity and release of liability outlined in Section 9.3(E).

4. Each AHP may perform patient care activities only within the scope of that AHP's Clinical Privileges as recommended by the MEC and approved by the Board.

5. All Privileges granted to or renewed for an AHP, shall be for a period of two (2) years, unless a shorter period of time is prescribed in the notice of granting or renewing Privileges.

6. AHPs may be granted temporary Privileges in accordance with Section 9.5.

7. AHPs may be granted emergency and disaster Privileges in accordance with Sections 9.6 and 9.7.

8. AHPs practice at the discretion of the Board. An AHP's Clinical Privileges may be suspended, modified, restricted, or terminated by the Board. AHPs are afforded only those hearing and appeal rights set forth in Section 10.2. AHPs are not entitled to the rights and privileges under Article XII.

9. All policies and procedures, as well as any applicable clinical protocols and guidelines governing the practice of individuals granted Privileges without membership, must be reviewed and approved by the medical director of the clinical service area in which the AHP is granted Privileges and by the MEC and the Board.

B. *Responsibilities.*

In addition to any other responsibilities outlined in these Medical Staff Bylaws, AHPs shall:

1. Provide to the MEC, with or without request and as it occurs, new or updated information pertinent to any question on the application form. Such responsibility includes the duty to immediately report to the CEO and Chief of Staff or their designees, any of the following upon occurrence: voluntary or involuntary relinquishment, revocation, limitation or suspension of professional license, registration or certification; the imposition of any limitation to practice by any state or other oversight agency; loss, relinquishment, suspension, revocation or restriction (voluntary or involuntary) of clinical privileges at any hospital or other health care institution or of the commencement of a formal investigation; filing of charges or the commencement of an investigation by any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin or any other state; any modification to, termination of or other change in professional liability insurance; if applicable, any loss or limitation on the AHP's ability to perform that individual's clinical duties; any report to the NPDB or licensing board; or any other event which has any bearing on the AHP's clinical competence or professional standing.

2. Provide, on a timely basis, proof of compliance with health testing requirements (e.g., results of tuberculosis testing).

3. Provide, as applicable and as requested, information regarding the applicant's supervision by or collaboration with a Physician.

4. Perform all services and conduct themselves at all times in a cooperative and professional manner.

5. Be included in the quality improvement/utilization process to the extent requested by the MEC or other members of the Medical Staff.

6. Participate in and cooperate with the Hospital’s obligation to conduct Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) in accordance with the applicable professional practice evaluation policy or policies.

7. Abide by the Hospital policies, Medical Staff Bylaws, Rules and Regulations and policies, and by all other lawful standards, protocols and rules of the Hospital.

8. Satisfy applicable continuing education and license or certification renewal requirements.

C. *Qualifications*. To be eligible to provide clinical services as an AHP, an applicant must:

1. Be a graduate of a recognized and qualified educational program relevant to the applicant's discipline;

2. Be legally qualified to practice in the given discipline in Wisconsin, including current license and/or certification/registration appropriate for the Clinical Privileges requested;

3. Have demonstrated clinical competence in the applicant's discipline consistent with the requested Clinical Privileges and be able to safely perform the Privileges requested;

4. Demonstrate the specific qualifications and requirements outlined in Article IX (as they apply to the AHP's scope of practice) and meet any other qualifications and requirements established by the Hospital or the Medical Staff;

5. Meet malpractice insurance coverage amounts and conditions required by the Hospital or applicable law; and

6. Agree to abide by the ethics of the profession and the rules, policies and procedures of the Hospital and the Medical Staff.

D. *Application*. Applications for Clinical Privileges for AHPs will be evaluated and processed in accordance with the credentialing process, to the extent applicable.

E. *Conditions of Practice*. AHPs shall provide patient care within the scope of their delineated Clinical Privileges, license, certification or registration, all applicable state and federal laws, and applicable Medical Staff policies. The care provided by all individuals granted Clinical Privileges will be monitored and evaluated through the Medical Staff quality monitoring and improvement processes and in accordance with applicable Physician supervising or collaborating relationships.

F. *Determination of Need.*

1. Whenever a health care professional of a type not included in Appendix B requests permission to practice at the Hospital, the Board, with input from the MEC, shall evaluate the need for that type of health care professional as an AHP, taking into consideration the following factors:

a. The nature of the services that could be offered;

b. Any state license or regulation that outlines the scope of practice for the health care professional;

c. The business and patient care objectives of the Hospital;

d. How well the community's needs are currently being met;

e. The type of training that is necessary to perform the services that could be offered and whether there are individuals with more training that are currently providing those services;

f. The availability of supplies, equipment, trained staff, and other necessary resources to support the health care professional;

g. Patient convenience; and

h. The ability to appropriately supervise performance.

2. Whenever the Board approves a new type of health care professional as an AHP, Appendix B shall be supplemented to reflect such approval, and the Chief of Staff will appoint a member of the Medical Staff and any other persons deemed necessary to develop qualifications and Privileges for the health care professional.

G. *Automatic Termination*. In addition to the circumstances for automatic suspension and termination provided elsewhere in these Bylaws, an AHP's Privileges shall automatically terminate in the event of the following:

1. Termination of employment with the AHP's employer, for any reason; or

2. Where the AHP's practice is dependent upon a given Practitioner, departure of that Practitioner or loss of that Practitioner's privileges without a clear and promptly identified replacement to oversee the AHP.

10.2 Hearing and Appeal Process for Allied Health Professionals.

A. *Triggering Events*. The following recommendations or actions shall, if taken on the basis of the AHP's competence or conduct and if deemed adverse under Section 10.2(B) below, entitle the AHP to a hearing and an appeal, as designated below, if timely and properly requested:

1. Denial or restriction of requested Clinical Privileges;

2. Reduction of Clinical Privileges;

3. Suspension of Clinical Privileges; or

4. Revocation of Clinical Privileges.

B. *When Deemed Adverse*. A recommendation or action listed in Section 10.2(A) above is adverse only when it relates to the AHP's competence and conduct and has been:

1. Recommended by the MEC to the Board; or

2. Taken by the Board under circumstances in which no prior right to request a hearing and appeal existed.

C. *Notice of Adverse Recommendation or Action*. The CEO shall promptly give the AHP Special Notice of an adverse recommendation or action taken pursuant to Section 10.2(B). The notice shall:

1. Advise the AHP of the recommendation or action and of the AHP's right to request a hearing pursuant to the provisions of this policy;

2. Specify that the AHP has thirty (30) days after receiving the notice within which to submit a request for a hearing;

3. Indicate that the right to the hearing may be forfeited if the AHP fails, without good cause, to appear at the scheduled hearing;

4. State that as part of the hearing, the AHP involved has the right to receive an explanation of the decision made and to submit any additional information the AHP deems relevant to the review and appeal of this decision; and

5. State that upon completion of the hearing, the AHP involved has the right to receive a written report of the Hospital's decision, including a statement of the basis of the decision.

D. *Request for Hearing*. The AHP has thirty (30) days after receiving notice under Section 10.2(C) to file a request for a hearing. The request must be delivered to the CEO either in person or by certified or registered mail.

E. *Waiver by Failure to Request a Hearing*. An AHP who fails to request a hearing within the time and in the manner specified in Section 10.2(D) waives the right to a hearing and appeal to which he might otherwise have been entitled. Such waiver applies only to the matters that were the basis for the adverse recommendation or action triggering the notice referenced in Section 10.2(C) above.

F. *Hearing Procedure*. When an AHP requests a hearing, the hearing shall consist of a single meeting attended by the AHP, the supervising/collaborating Physician, as applicable, the CEO, and the Chief of Staff. During this meeting, the basis of the decision adverse to the AHP, which gave rise to the hearing, will be reviewed with the AHP, and the AHP will have the opportunity to present any additional information the AHP deems relevant to the review of the decision. Following this meeting, the CEO and Chief of Staff will make a recommendation to the MEC or the Board, as appropriate, which will then determine if the adverse decision will stand, be modified, or be reversed. The AHP will receive a written report of the Hospital's decision stating the result of the hearing and the basis of the decision.

G. *Request for Appeal*. The AHP has thirty (30) days after receiving notice of the result of the hearing under Section 10.2(F) to file a request for an appeal. The request must be delivered to the CEO either in person or by certified or registered mail.

H. *Waiver by Failure to Request an Appeal*. An AHP who fails to request an appeal within the time and in the manner specified in Section 10.2(G) waives the right to an appeal to which he might otherwise have been entitled. Such waiver applies only to the matters that were the basis for the adverse recommendation or action triggering the notice referenced in Section 10.2(C) above.

I. *Appeal Procedure*. When an AHP requests an appeal, the appeal shall consist of a single meeting attended by the AHP, the Board chair and two (2) Board members appointed by the Board chair. During this meeting, the basis of the decision adverse to the AHP, which gave rise to the appeal, will be reviewed with the AHP, and he will have the opportunity to present any additional information deemed relevant to the review of the decision. Following this meeting, the Board chair and the other two (2) Board members hearing the appeal will make a recommendation to the full Board, which will then determine if the adverse decision will stand, be modified, or be reversed. The AHP will receive a written report of the Board's decision stating the result of the appeal and the basis of the decision.

J. *Sole Remedy*. This hearing and appeal process will be the sole remedy available to an AHP who qualifies for this hearing and appeal process who experiences an adverse decision as defined in Section 10.2(B) above.

K. *AHP's Right to Legal Counsel*. Nothing in this policy shall be deemed to deny an AHP the right to engage or be advised by legal counsel. However, participation by legal counsel at the hearing or appeal meeting shall be at the sole discretion of the Hospital.

ARTICLE XI

COLLEGIAL INTERVENTION AND AUTOMATIC ACTIONS

11.1 Collegial Intervention.

A. It is the policy of the Hospital and the Medical Staff to encourage the use of progressive steps by Medical Staff leadership and the Hospital, beginning with collegial and educational efforts, to address concerns regarding a Provider's clinical practice or professional conduct. The goal of collegial intervention is to arrive at voluntary, responsive actions by the Practitioner to resolve questions that have been raised.

B. Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, focused professional practice evaluation, additional training or education, or any of the steps outlined in the Unprofessional Behavior policy or any other applicable Medical Staff policy.

C. All collegial intervention efforts by the Medical Staff and Hospital are part of the Hospital's performance improvement and professional and peer review activities.

D. The Medical Staff leadership shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential peer review file. If documentation of collegial efforts is included in an individual's peer review file, he will have an opportunity to review it and respond in writing. The response shall be maintained in that individual's peer review file along with the original documentation.

E. Collegial intervention efforts are encouraged, but are not mandatory, and their use is within the discretion of the Medical Staff leadership.

F. The Chief of Staff, in conjunction with the CEO, shall determine whether to direct that a matter be handled in accordance with this Section or another applicable Hospital or Medical Staff policy.

11.2 Automatic Actions. Actions set forth in this Section 11.4 are not professional review actions and shall be final without giving rise to rights of hearing or appellate review under Article XII. Where a bona fide dispute exists as to whether the circumstances have occurred, the automatic action will stand unless and until the MEC determined that it is not applicable. The MEC will make such a determination as soon as possible. The invoking or lifting of an automatic action does not preclude initiation of corrective action.

A. *License*

1. Revocation: Action by a licensing authority revoking a Provider's professional license, or loss or lapse of the Provider's professional license for any reason (except for a lapse due to a temporary failure to renew), shall result in immediate and automatic revocation of the Provider's Medical Staff appointment (if applicable) and Clinical Privileges.

2. Restriction/Limitation/Suspension: Whenever a Provider's professional license is limited, restricted, or suspended by the applicable licensing authority, the Provider's Medical Staff appointment (if applicable) and Clinical Privileges are automatically subject to the limitation, restriction, or suspension. Upon reinstatement of the Provider's license without such restriction, limitation, or suspension (or removal of the restriction, limitation or suspension), the Provider's Medical Staff appointment (if applicable) and Clinical Privileges shall be automatically reinstated, subject to expiration or other ongoing process.

3. Lapsed: A temporary lapse of a Provider's professional license due to a failure to renew shall result in an automatic suspension of Medical Staff appointment (if applicable) and Clinical Privileges until such time as the license is reinstated in full and without restrictions, at which time the Provider's appointment (if applicable) and Clinical Privileges shall be reinstated.

4. Probation: Whenever a Provider is placed on probation by the applicable state licensing authority, that individual's Medical Staff appointment (if applicable) and Clinical Privileges shall be automatically suspended in the same manner, effective upon and for at least the term of the probation.

B. *Drug Enforcement Administration (DEA) Number:*

1. Revocation/Voluntary Surrender: Whenever a Practitioner's DEA number is revoked or voluntarily surrendered, that individual's Clinical Privileges to prescribe medications controlled by such registration number shall be immediately and automatically revoked.

2. Suspension: Whenever a Practitioner's DEA number is suspended, that individual shall be divested, at least, of that individual's right to prescribe medications controlled by such registration number at the Hospital, effective upon and for at least the term of the suspension.

3. Reduction: If a Practitioner has a DEA number that has a reduced or limited schedule of drugs, the Privileges granted to prescribe medications controlled by such registration number shall automatically reflect that reduced or limited schedule.

C. *Malpractice Insurance:* If at any time a Provider's professional liability insurance coverage lapses, falls below the minimum required by the Hospital, is terminated, or otherwise ceases to be in effect (in whole or in part), or is otherwise materially limited, the Provider's Medical Staff appointment (if applicable) and Clinical Privileges shall be automatically suspended, as of the date the coverage becomes insufficient and until sufficient coverage is restored. If the automatic suspension lasts longer than three (3) months, the Provider's Medical Staff appointment (if applicable) and Clinical Privileges shall be considered to have been automatically and voluntarily resigned.

D. *Health Screening:* The Clinical Privileges of a Provider who fails, without cause, to comply with health screening requirements imposed by the Hospital, Medical Staff policy, or applicable law shall immediately and automatically be suspended. Such suspension shall be lifted only after the Provider provides evidence that the individual has complied with all such screening requirements.

E. *Sanction by or Exclusion from Federal Health Care Programs:* Whenever a Provider is sanctioned by or excluded, terminated, or otherwise precluded from participation in a federal health care program, including but not limited to the Medicare or Medicaid programs, the Provider's Medical Staff appointment (if applicable) and Clinical Privileges shall be automatically terminated as of the date such action becomes effective.

F. *Criminal Activity:* A Provider's Medical Staff appointment (if applicable) and Clinical Privileges shall be automatically terminated upon conviction, indictment, or plea of guilty, no contest, or nolo contendere pertaining to:

1. Any felony;

2. Any misdemeanor substantially related to health care; or

3. Any misdemeanors involving: (a) controlled substances; (b) illegal drugs; (c) Medicare, Medicaid, or insurance or other health care fraud or abuse; or (d) violence against another.

G. Each Provider shall have the duty to notify the CEO (or designee) of any event, occurrence, or change in condition resulting in automatic suspension. Failure to report such action could result in the imposition of a summary suspension or other sanction.

H. The MEC may, if the CEO agrees, lift or modify any such automatic suspension pending final determination by the Board.

ARTICLE XII

CORRECTIVE ACTION AND SUMMARY SUSPENSION

12.1 Corrective Action Process.

A. *Criteria for Initiation.* Whenever any officer of the Medical Staff, the medical director of any clinical service area, the chair of any standing committee of the Medical Staff, the CEO, or the Board or any officer of the Board has any reason to believe that the actions, omissions, statements, demeanor, or professional conduct of a Practitioner calls into question the Practitioner's:

1. Clinical competence;

2. Care or treatment of any patient or patients or management of a case or cases;

3. Delivery of quality or efficient patient care;

4. Truthfulness or ethics (e.g., a misstatement in or omission in any representation by the Medical Staff Member to the Medical Staff or to any licensing or accrediting agency);

5. Ability to work cooperatively and harmoniously with all Providers and Hospital employees;

6. Compliance with Hospital or Medical Staff Bylaws, Rules and Regulations, or policies, or quality assessment, risk management or utilization programs; or

7. Likelihood of damaging the reputation of the Medical Staff, Hospital, or the medical profession.

Any member of the Medical Staff and any member of administration may initiate a request for corrective action. Initiation of corrective action pursuant to Section 11.2 does not preclude imposition of summary suspension as provided for in Section 11.3, nor does it require the immediate imposition of such a suspension.

B. *Requests and Notices.* All requests for corrective action shall be in writing, submitted to the MEC through the Chief of Staff, and supported by reference to the specific activities or conduct which constitute the grounds for the request. The Chief of Staff shall promptly notify the CEO in writing of all requests for corrective action received and shall continue to keep the CEO fully informed of all action taken in conjunction therewith.

C. Investigative Procedure.

1. The MEC shall meet as soon after receiving the investigation request as practical and shall determine in its sole discretion whether (a) the request contains sufficient information to warrant a recommendation for corrective action; (b) to immediately commence an investigation of the matter; (c) the matter should be handled by collegial intervention or in accordance with another Hospital or Medical Staff policy or procedure; or (d) the matter does not merit further action.

2. The MEC's investigation shall be performed either by the MEC or by an investigating committee appointed by the MEC. The investigating committee shall consist of at least three (3) Physicians, and may include other Practitioners as necessary. Members of the investigating committee are not required to be members of the Medical Staff. In addition, the investigating committee may use an outside consultant to assist with the investigation. When possible, the individuals performing the investigation shall not include partners of, associates of, relatives of, or individuals in direct economic competition with the affected individual.

3. The investigating committee shall have available the full resources of the Medical Staff and the Hospital to aid in its work, as well as authority to use outside consultants as necessary. The investigating group may also require a physical or mental examination of the Practitioner by a Physician (or more than one) satisfactory to the group and shall require the Practitioner to sign any authorization necessary to ensure that the results are made available for the group's, MEC's, Board's, and their representatives' consideration.

4. The individual with respect to whom an investigation has been requested will have the opportunity to meet with the investigating committee, and submit a written statement, before the investigating committee makes its report. At this meeting, the individual will be informed of the general nature

of the evidence supporting the investigation and shall be invited to discuss, explain, or refute it. This interview will not constitute a hearing, none of the procedural rules provided for in Article XII shall apply, and the individual will not have the right to be represented by legal counsel at the interview.

5. At any time during the investigation, a summary suspension may be invoked pursuant to Section 11.3.

D. *Report of Investigation.* The investigating committee shall make a reasonable effort to complete the investigation and issue its report within thirty (30) days after its creation or initiation. This timeframe is intended to serve as a guideline, and as such, shall not be deemed to create any right for an appointee to have an investigation completed within this time period.

Following the investigation, the investigating committee shall make a report of its investigation to the MEC, which shall include, without limitation and as relevant:

1. A reference to all documents and materials reviewed;

2. A summary of the interview with the Practitioner under investigation, or a reference to the fact that the Practitioner either waived the right to or failed to attend the interview;

3. A summary of any other interviews;

4. Factual findings and conclusions regarding the Practitioner's conduct or competence;

5. A recommendation regarding corrective action; and

6. A discussion of any other issues or matters relevant to the investigation.

The report shall be placed in the Practitioner’s permanent peer review file.

E. *MEC Action.* The MEC shall take action within thirty (30) days of receipt of the investigation report. Such action may include, without limitation, any one (1) or more of the following:

1. Rejection of the request for corrective action;

2. A verbal warning, a letter of admonition, or a letter of reprimand;

3. Performance monitoring or proctoring;

4. Terms of probation or a requirement of consultation;

5. Medical and/or behavioral health treatment;

6. Reduction, restriction, suspension or revocation of Clinical Privileges;

7. Reduction of Staff category or limitation of any Staff prerogatives;

8. Suspension or revocation of Staff appointment; or

9. Such other recommendation as it deems appropriate.

F. *Effect of MEC Action.*

1. A recommendation by the MEC that would entitle the Practitioner to a hearing under Article XII shall be forwarded to the CEO, who shall notify the Practitioner in accordance with Article XII. The CEO shall then hold the recommendation until after the individual has exercised or waived the right to a hearing. If the individual waives the right to a hearing, the CEO shall forward the recommendation of the MEC, along with supporting documentation, to the Board for action.

2. A requirement for consultation, monitoring, or similar action shall not be an adverse professional review action generating a right to a hearing unless such action limits or reduces the Practitioner's Clinical Privileges.

3. If the action of the MEC does not entitle the individual to a hearing, the action shall immediately take effect and a report of the action taken and the underlying reasons shall be made to the Board, and the action shall stand unless modified by the Board. If the Board subsequently considers a modification of the MEC's action that would entitle the individual to a hearing in accordance with Article XII, it shall so notify the affected individual through the CEO, and shall take no final actions thereon until the individual has exercised or waived the procedural rights provided. No action shall be considered final until the Practitioner has completed or waived hearing and appeal rights under Article XII.

12.2 <u>Summary Suspension Of Clinical Privileges.</u>

A. *Criteria for Initiation.* Whenever a Practitioner's conduct requires that immediate action be taken to protect the life of any patient(s), to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Hospital, or to maintain the orderly operation of the Hospital, any two (2) of the following individuals, acting together, shall have the authority to summarily suspend the Medical Staff appointment and/or all or any portion of the Clinical Privileges of such Practitioner: the Chief of Staff, the CEO or acting CEO (or designee), medical director of any clinical service area in which the individual has Privileges, any member of the MEC, or the Chair of the Board. Such summary suspension shall become effective immediately upon imposition, and the CEO or designee shall promptly give notice of the suspension to the Chief of Staff and all Hospital areas where that Practitioner exercises Clinical Privileges, and Special Notice to the Practitioner. A summary suspension may be imposed at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing. In the event of any such suspension, the Practitioner's patients in the Hospital shall be assigned to another Practitioner by the Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner. Any action required to be taken by a particular officer (or other individual) under this Section may be taken by an appropriately authorized designee.

B. *MEC Action.* As soon as possible after such summary suspension, but in any event within fourteen (14) days after the suspension, a meeting of the MEC shall be convened to review and consider the matter. The MEC shall invite the

Practitioner to discuss the matter at the meeting, although the meeting shall not constitute a formal hearing under Article XII, the individual shall not be entitled to have an attorney present at the meeting, and the Practitioner shall be dismissed prior to deliberations. The MEC may recommend a modification or continuation of the suspension, or it may terminate the suspension. Any procedural rights the Practitioner may have in connection with the summary suspension shall be governed by Article XII. The terms of the summary suspension as sustained or modified by the MEC shall remain in effect pending a final recommendation to and decision by the Board.

ARTICLE XIII
FAIR HEARING AND APPEAL PROCEDURES

13.1 Initiation of Hearing.

A. *Recommendations or Actions.* The following recommendations or actions shall, if based on the professional competence or professional conduct of the Practitioner and if deemed adverse pursuant to Section 13.1(B), entitle the affected Practitioner to a hearing upon timely and proper request, provided that the Practitioner is an appointee to the Medical Staff, holds Privileges at the Hospital, and/or is an applicant with a completed application:

1. Denial of initial Medical Staff appointment;

2. Denial of Medical Staff reappointment;

3. Revocation of Medical Staff appointment;

4. Denial of requested Medical Staff category;

5. Reduction in Medical Staff category;

6. Denial of requested Clinical Privileges;

7. Limitation of admitting Privileges;

8. Restriction, suspension, or limitation of some or all Clinical Privileges, except for a summary restriction or suspension of Privileges that lasts for fewer than fifteen (15) days;

9. Revocation of some or all Clinical Privileges;

10. Imposition of mandatory consultation or mandatory proctoring requirements, but only if the consultant or proctor must approve the course of treatment in advance; or

11. Denial of reinstatement from a leave of absence if the reason for the denial relates to professional competence or professional conduct.

No other recommendations or actions will entitle the Practitioner to a hearing.

B. *When Deemed Adverse.* A recommendation or action listed in Section 13.1(A) shall be deemed adverse only when it has been:

1. Recommended or undertaken by the MEC;

2. Taken by the Board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or

3. Taken by the Board on its own initiative without benefit of a prior recommendation by the MEC.

C. *Actions That Do Not Constitute Grounds for Hearing*. Notwithstanding any other provision of these Bylaws, the following recommendations or actions by the MEC, Board, or anyone else, without limitation, do not entitle a Practitioner to any of the hearing or appeal rights set forth in this Article XIII:

1. Issuance of a verbal warning, reprimand, or other collegial intervention;

2. Issuance of a letter of reprimand, warning, guidance, or counsel;

3. Denial, limitation, expiration, or termination of temporary Clinical Privileges;

4. Denial, limitation, expiration, or termination of emergency or disaster Clinical Privileges;

5. Automatic suspension or relinquishment of appointment or Clinical Privileges;

6. Suspension or limitation of Medical Staff appointment or Clinical Privileges for fewer than fifteen (15) calendar days;

7. Any of the actions or recommendations listed in Section 12.1(A) above when it is voluntary or accepted by the Practitioner, or not based on the Practitioner's professional competence or conduct;

8. Determination that an application is incomplete or that it cannot be processed for any reason, including but not limited to a misrepresentation or omission;

9. Determination of ineligibility based on failure to meet threshold eligibility criteria;

10. Denial of Medical Staff appointment, reappointment, or Clinical Privileges based on the lack of Hospital need or resources or because of an exclusive contract;

11. Imposition of monitoring or general consultation requirement where the Practitioner does not need prior approval of the consultant or monitor prior to initiating a course of treatment;

12. Denial of a requested leave of absence or denial of an extension of a leave of absence;

13. Imposition of a requirement for additional training or continuing education;

14. Routine assignment of a proctor to a Practitioner recently appointed to the Medical Staff or to a Practitioner with new Clinical Privileges; and

15. Denial of reinstatement after leave for reasons unrelated to professional competence or conduct.

D. *Notice of Adverse Recommendation or Action.* A Practitioner against whom an adverse recommendation or action has been taken pursuant to Section 12.1(B) shall be given Special Notice of such action by the CEO within ten (10) days of the action. Such notice shall:

1. Advise the Practitioner of the recommendation or proposed action and the basis of the recommendation or proposed action;

2. Advise the Practitioner of the right to a hearing as provided in this Article XIII;

3. Specify that the Practitioner shall have thirty (30) days following the receipt of such notice within which to request a hearing, such request to be delivered to the CEO either in person, certified or registered mail, or electronic mail;

4. State that failure to timely request a hearing within the specified time period, or to personally appear at the scheduled hearing or appellate review on any day during which proceedings are to occur, shall constitute a waiver of the Practitioner's right to a hearing and appellate review;

5. State that, if a hearing is requested, the hearing shall be held before a hearing committee or hearing officer appointed in accordance with Section 13.2(C);

6. State that upon receipt of the Practitioner's hearing request, the CEO will notify the Practitioner of the date, time and place of the hearing;

7. State that in the hearing the Practitioner involved has the right to:

a. Representation by an appointee to the Medical Staff in good standing, by a member of the Practitioner's local professional society, by an attorney, and/or by any other person chosen by the Practitioner;

b. Have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;

c. Call, examine, and cross-examine witnesses;

d. Present evidence determined to be relevant by the presiding officer, regardless of its admissibility in a court of law; and

e. Submit written statements in accordance with Section 13.3(G);

8. State that upon completion of the hearing, the Practitioner involved has the right to receive the written recommendation of the hearing committee, including a statement of the basis for the recommendation;

9. State that upon completion of the procedures outlined in this Article XIII, the Practitioner involved has the right to receive the written decision of the Board, including a statement of the basis for the decision; and

10. Include a copy of Article XII of these Bylaws.

E. *Request for a Hearing.* The Practitioner has thirty (30) days after receiving the notice of adverse recommendation or action to deliver a written request for a hearing. The request must be delivered to the CEO in person, by electronic mail or by certified or registered mail.

F. *Waiver by Failure to Request a Hearing.* A Practitioner who fails to request a hearing within the time and in the manner specified in Section 13.1(E) waives any right to such hearing and to any appellate review to which he might otherwise have been entitled. Upon determining that a Practitioner has waived the right to request a hearing and subsequent appellate review, the CEO shall promptly send the Practitioner notice, in person or by certified or registered mail, stating:

1. That the Practitioner has been deemed to waive the right to a hearing and to any appellate review; and

2. That such waiver in connection with:

a. An adverse recommendation by the MEC shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board; or

b. An adverse action by the Board shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board.

13.2 <u>Hearing Prerequisites.</u>

A. *Notice of Time and Place for Hearing.* Upon receipt of a timely request for a hearing, the CEO shall deliver such request to the Chief of Staff or to the Board, depending on whose recommendation or action prompted the request for hearing. The Chief of Staff or the Board shall promptly schedule and arrange for a hearing. Once the hearing has been scheduled and arranged, the CEO shall promptly send the Practitioner Special Notice of the time, place and date of the hearing. Unless the CEO and Practitioner agree to an earlier date, the hearing date shall be not fewer than thirty (30) days from the date of the notice of the hearing. For a Practitioner who is under suspension that has been continued in effect, at the Practitioner's specific request, a hearing shall be held as soon as arrangements for it may reasonably be made.

B. *Other Notice Requirements.* The notice of hearing required by Section 13.2(A) shall contain:

1. A concise statement of the Practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question (if applicable), and/or the other reasons or subject matter forming the basis for the adverse recommendation or action, which is the subject of the hearing. The Practitioner shall be notified in writing of any subsequent

modifications to the grounds for the adverse recommendation or action within a reasonable period of time before the hearing date;

2. A list of witnesses, if any, expected to testify on behalf of the MEC or the Board, depending on whose action prompted the request for the hearing. The Practitioner shall be notified in writing of any subsequent modifications to the list of expected witnesses within a reasonable period of time before the hearing date; and

3. The names of the hearing officer, or hearing committee members and presiding officer, if known.

C. *Appointment of Hearing Committee or Hearing Officer*. It is solely within the Hospital's discretion: (a) whether to utilize a hearing officer or a hearing committee, and (b) to appoint the hearing officer or members of the hearing committee. The CEO, after consultation with the Chief of Staff, shall appoint the hearing officer or members of the hearing committee. A hearing committee, if used, shall consist of at least three (3) impartial Physicians. The Chief of Staff shall designate one of the hearing committee members as chairperson of the committee. If the notice provided in Section 13.2(A) did not name the hearing officer, hearing committee members, or the presiding officer, a separate notice with this information shall be provided to the Practitioner promptly following the appointment. Any objection by the Practitioner to a hearing officer or member of the hearing committee shall be made in writing to the CEO within ten (10) days of receipt of notice of the appointment of the hearing officer or committee. The Chief of Staff shall be provided with a copy of the objection and shall have a reasonable opportunity to comment. The CEO shall rule on the objection and give notice to the Practitioner and to the Chief of Staff.

D. *Service on Hearing Committee or as Hearing Officer.* A Medical Staff appointee or Board member shall not be disqualified from serving on a hearing committee or as a hearing officer merely because that person has heard facts about the matter or has actual or presumed knowledge of the facts involved. A person shall be disqualified from serving on the hearing committee or as hearing officer if the person: (a) served on an investigating body in connection with the corrective action that triggered the Practitioner's hearing rights; (b) voted on the adverse recommendation or action that triggered the Practitioner's hearing rights; (c) materially involved in the matter giving rise to the corrective action that triggered the Practitioner's hearing rights; (d) is in direct economic competition with the Practitioner; or (e) is a close relative of the Practitioner. Employment by, a contract with, or other affiliation with the Hospital or an affiliate shall not preclude any individual from serving on the hearing committee or as the hearing officer. The Chief of Staff may appoint an individual or individuals with no affiliation to the Hospital or the Medical Staff as a hearing officer or as members of the hearing committee if such appointment is necessary in the interest of impartiality. All members of a hearing committee and any hearing officer shall be required to consider and decide the case with good faith objectivity.

13.3 <u>Hearing Procedure.</u>

A. *Personal Presence.* The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at any day on which the hearing is scheduled shall be deemed to have waived the rights in the same manner and with the same consequence as provided in Section 13.1(F).

B. *Presiding Officer.* The use of a specially appointed presiding officer to preside at a hearing is optional. The CEO may appoint a presiding officer, who may or may not be an attorney, after consultation with the Chief of Staff, to oversee the conduct of the hearing. If a presiding officer is not specially appointed, the hearing officer or chair of the hearing committee shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of procedure and the admissibility of evidence. The presiding officer may be advised by legal counsel to the Hospital with regard to hearing procedure. The presiding officer may participate in the private deliberations of the hearing committee and be a legal advisor to the committee or hearing officer. However, if the presiding officer is not the chairperson of the hearing committee or the hearing officer, he shall not be entitled to vote on the committee's recommendation.

C. *Representation.* The Practitioner who requested the hearing shall be entitled to be accompanied and represented at a hearing by an appointee to the Medical Staff in good standing, by a member of the Practitioner's local professional society, by an attorney, and/or by any other person chosen by the Practitioner. The Practitioner shall be solely responsible for the payment of any legal (or other representation) fees associated with such representation. The Practitioner shall notify the Chief of Staff if he will be represented by an attorney at the hearing. The MEC or the Board, depending on whose recommendation or action prompted the hearing, shall appoint an individual to represent it, who may be an attorney or any other individual. In order to maintain the hearing as a peer review process, in no event shall the Parties' attorneys be permitted to provide testimony in lieu of, or on behalf of, the Parties.

D. *Rights of Parties.* During a hearing, each of the Parties shall have the right to:

1. Be represented as provided in Section 13.3(C);

2. Call and examine witnesses;

3. Introduce exhibits and present evidence determined to be relevant by the presiding officer, regardless of its admissibility in a court of law;

4. Cross-examine any witness on any matter relevant to the issues;

5. Rebut any evidence;

6. Have a record made of the proceedings, as provided in Section 13.3(K);

7. Submit written statements in accordance with Section 13.3(G).

If the Practitioner who requested the hearing does not testify on the Practitioner's own behalf, he may be called and examined as if under cross-examination.

E. *Procedure and Evidence.*

1. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility

of such evidence in a court of law. The presiding officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation.

2. The hearing committee or hearing officer shall be entitled to consider any pertinent material contained on file in the Hospital and all other information that can be considered, pursuant to the Medical Staff Bylaws and policies, in connection with applications for appointment or reappointment to the Medical Staff and for Clinical Privileges. The focus of the hearing committee or hearing officer's deliberation and review shall be on the professional review action prompting the Practitioner's request for a hearing. However, the hearing committee or hearing officer shall be entitled to consider evidence of prior events and/or actions to the extent they are relevant to the professional review action under review.

F. *Pre-Hearing Procedure.*

1. At least fifteen (15) days prior to the scheduled hearing, the Practitioner and the Hospital shall each provide to the other, with a copy to the presiding officer, a written list of the names of witnesses expected to testify on the party's behalf. The witness list can be amended at any time up to five (5) days prior to the hearing. Changes can be made to witness lists within five (5) days of the hearing at the discretion of the presiding officer, provided that the other party receives notice of the changes prior to the hearing.

2. The presiding officer, at that officer's discretion, may require a pre-hearing conference for the purposes of document exchange, establishing basic rules concerning the number and type of witnesses who may be called, the length of testimony, the order or length of opening statements or closing arguments, as well as other matters deemed necessary to the conduct of a fair, orderly, and efficient hearing process.

G. *Written Submissions.* Each party shall have the right to submit a memorandum of points and authorities, and the hearing committee or hearing officer may request such a memorandum to be filed at the close of the hearing. The Parties shall also have the right to submit a written statement at the close of the hearing.

H. *Provision of Relevant Information*. At no time shall the Practitioner have the right to access the employment, peer review or similar files of other Practitioners or the medical records of patients whose treatment is unrelated to the subject matter of the hearing. Should the Practitioner wish to interview Hospital employees, members of the Medical Staff, or persons with Clinical Privileges prior to the hearing, the Practitioner shall arrange for such interview by contacting the presiding officer. Neither the Practitioner nor the Practitioner's representative shall contact such individuals directly. The Practitioner does not have the authority to subpoena or otherwise compel any individual to be interviewed or testify at the hearing.

I. *Official Notice.* In reaching a decision, the hearing committee or hearing officer may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state where the hearing is held. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record.

Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing committee or hearing officer.

J. *Burden of Proof.* The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of its position. The Practitioner shall thereafter be responsible for supporting a challenge to the adverse recommendation or action by clear and convincing evidence that the grounds for the recommendation or action lack any factual basis or that such basis or the conclusion drawn therefrom are either arbitrary, capricious, or unreasonable. The burden of proof shall at all times remain with the Practitioner.

K. *Record of Hearing*. A record of the hearing shall be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing committee or hearing officer may select the method to be used for making the record, such as a court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. The Hospital shall bear the costs of production of the record. Copies of the recording may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof.

L. *Presence of Hearing Committee Members and Vote*. A majority of the hearing committee must be present in person at all times throughout the hearing. In unusual circumstances when a hearing committee member must be absent from any part of the hearing, he shall read the entire transcript of that portion of the hearing from which he was absent. All members of the hearing committee must be present in person throughout deliberations, and no member may vote by proxy.

M. *Presence of Other Persons*. Presence at the hearing shall be restricted to those individuals involved in the proceeding, and Hospital representatives including but not limited to the CEO and Chief of Staff. The presiding officer may allow others to be present at the officer's sole discretion, within the confines of applicable legal protections of peer review records and protected health information.

N. *Postponement*. Requests for postponement of a hearing shall be granted by the presiding officer only upon a showing of good cause and only if the request is made as soon as is reasonably practical.

O. *Recesses and Adjournment*. The presiding officer may recess the hearing and reconvene the same, without additional notice or consent of the Parties, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation, provided such adjournment shall not extend the time within which any action is required to be taken pursuant to this Article XIII.

P. *Adjournment and Conclusion*. The presiding officer may adjourn the hearing and reconvene the same at the convenience of the Parties without Special Notice. The hearing shall reconvene within a timely manner but at least within thirty (30) days. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee or hearing officer shall thereupon, outside the presence of any other person except the hearing officer, conduct its deliberations and render a recommendation and accompanying report. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

13.4 Hearing Committee or Hearing Officer Report and Further Action.

A. *Hearing Committee or Hearing Officer Report.* Within twenty (20) days after receipt of the transcript of the hearing, the hearing committee or hearing officer shall render a recommendation of affirmation, reversal, or modification of the adverse recommendation or action. The recommendation shall be accompanied by a report, which shall contain a concise summary of the basis for the recommendation, and the recommendation and report shall be forwarded to the CEO.

B. *Notice and Effect of Result*.

1. Notice. The CEO shall promptly send a copy of the result to the Practitioner by Special Notice, and if the recommendation is unfavorable to the Practitioner, the CEO shall include the notice described in Section 13.4(B)(3) below. The CEO shall also promptly provide a copy of the report to the Chief of Staff, the MEC, and the Board.

2. Effect of Favorable Result. Where the hearing committee or hearing officer has recommended a resolution favorable to the Practitioner, within thirty (30) days of receipt of the hearing committee or hearing officer report, the Board shall issue a written report adopting, modifying, or rejecting the hearing committee or hearing officer's recommendation. If the Board's decision is also favorable to the Practitioner, it becomes the final decision. If the Board's decision is adverse to the Practitioner, the CEO shall promptly notify the Practitioner by Special Notice of the Practitioner's right to request an appellate review as provided in Section 13.5 below.

3. Effect of Adverse Result. Where the hearing committee or hearing officer has recommended a resolution adverse to the Practitioner, the CEO shall provide the Practitioner Special Notice of the right to request an appellate review as provided in Section 13.5 below. This Special Notice shall be sent together with the copy of the report contemplated in Section 13.4(A).

13.5 Initiation and Prerequisites of Appellate Review.

A. *Grounds for Appeal*. If the hearing committee or hearing officer has recommended a resolution adverse to the Practitioner, or the Board has rejected a favorable recommendation of the hearing committee or hearing officer, the Practitioner has the right to request an appeal of the adverse recommendation or action. The Practitioner's request for appeal must state specifically the grounds for appeal and the facts or circumstances that justify further review. The grounds for appeal shall be limited to the following: (1) substantial failure to comply with hearing procedures or the Bylaws during the hearing so as to deny a fair hearing; (2) the recommendation of the hearing committee or hearing officer, or the action of the Board under Section 13.4(B), was arbitrary, unreasonable or capricious; or (3) the recommendation of the hearing committee or hearing officer, or the action of the Board under Section 13.4(B), was not supported by the credible evidence.

B. *Request for Appellate Review.* A Practitioner shall have fifteen (15) days following the Practitioner's receipt of a notice pursuant to Section 13.4(B)(2) or (3) to file a written request for an appellate review. Such request shall be delivered to the CEO either in person or by certified or registered mail. The request must include a brief statement of the reasons for appeal, and may include a request for a copy

of the report and record of the hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse action or result.

C. *Waiver by Failure to Request Appellate Review.* A Practitioner who fails to request an appellate review within the time and in the manner specified in Section 13.5(B) above waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 13.1(F) of this Article XIII.

D. *Notice of Time and Place for Appellate Review.* Upon receipt of a timely request for appellate review, the CEO shall deliver such request to the Board. As soon thereafter as practical, the Board shall schedule and arrange for an appellate review, which shall be no more than thirty (30) days from the date of receipt of the appellate review. If the request for appellate review is from a Practitioner under a suspension then in effect, the appellate review shall be held as soon as arrangements for it may be reasonably made. At least fifteen (15) days prior to the appellate review, or as soon as is practicable for appeals by a Practitioner under a suspension then in effect, the CEO shall send the Practitioner Special Notice of the time, place and date of the review. The time for the appellate review may be extended by the appellate review body for good cause and if the request for such extension is made as soon as is reasonably practical. The appellate review can occur at a regular meeting of the Board.

E. *Appellate Review Body.* The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee of three (3) members of the Board appointed by the chairperson of the Board. If a committee is appointed, one of its members shall be designated as chairperson.

13.6 <u>Appellate Review Procedure.</u>

A. *Nature of Proceedings.* Subject to the provisions of this Section 13.6, the proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee or hearing officer, the report and recommendation of the hearing committee or hearing officer, and all subsequent results and actions thereon. The appellate review body shall also consider the written statements as may be presented and accepted under this Article. The proceedings by the appellate review body shall not be a new or additional hearing.

B. *Written Statements.* The Practitioner seeking the review may submit a written statement detailing the findings of fact, conclusions, and procedural matters with which he disagrees, and the Practitioner's reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review body through the CEO at least five (5) days prior to the scheduled date of the appellate review, unless that time limit is waived by the appellate review body in its discretion. A written statement in reply may be submitted by the MEC or by the Board, as appropriate, at least two (2) days prior to the scheduled date of the appellate review, and if submitted, the CEO shall provide a copy thereof to the Practitioner at least two (2) days prior to the scheduled date of the appellate review.

C. *Presiding Officer.* The chairperson of the appellate review body shall be the presiding officer, and shall determine the order of the procedure during the review, make all required rulings, and maintain decorum. The chairperson may be advised by legal counsel to the Hospital.

D. *Oral Statement.* The appellate review body, in its sole discretion, may allow the Parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to the party or representative by any member of the appellate review body. The chairperson of the appellate review body may impose reasonable time limits on the Parties' oral statements.

E. *Consideration of New or Additional Matters.* New or additional matters or evidence not raised or presented during the initial hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances. The appellate review body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted. Such additional evidence shall be accepted only if the party requesting consideration of the evidence shows that it could not have been discovered in time for the initial hearing, or if the party requesting consideration of the evidence demonstrates that the evidence is new and relevant or that any opportunity to have the evidence considered at the initial hearing was improperly denied. Submission of new evidence may necessitate postponement of the date of review, in the discretion of the appellate review body. The party requesting consideration of the evidence shall provide a written substantive description of the evidence, and the reasons for not presenting it earlier, to the appellate review body and the other party at least ten (10) days prior to the scheduled date of review.

F. *Recesses and Adjournment.* The appellate review body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

G. *Action Taken.* The appellate review body may recommend that the Board affirm, modify or reverse the adverse result or action taken by the MEC or by the Board, or, in its discretion, may refer the matter back to the hearing committee or hearing officer for further review and recommendation to be returned to it within forty-five (45) days and in accordance with its instructions. If the appellate review committee is comprised of the entire Board, the recommendation of the appellate review body (Board) shall constitute the final decision of the Board pursuant to Section 13.7 below and shall be immediately effective and not subject to further review.

H. *Conclusion.* The appellate review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

13.7 Final Decision of the Board.

A. *Board Action.* Within thirty (30) days after the conclusion of the appellate review or waiver thereof, the Board shall render its final decision in the matter in writing and shall send notice thereof to the Practitioner by Special Notice, to the Chief of Staff, and to the MEC. The Board's decision shall be considered final action and shall not be subject to any further process under these Bylaws.

B. Whenever required by law, a report of a final adverse action taken by the Board shall be filed within thirty (30) days to the National Practitioner Data Bank and State Medical Examining Board.

13.8 General Provisions.

A. *Number of Hearings and Reviews.* Notwithstanding any other provision of these Medical Staff Bylaws, no Practitioner shall be entitled as a right to more than one evidentiary hearing and one appellate review with respect to an adverse recommendation or action.

B. *Release.* By requesting a hearing or appellate review under these Bylaws, a Practitioner agrees to be bound by the provisions of Section 9.3(E) relating to immunity from liability in all matters relating thereto.

C. *Waiver.* If at any time after receipt of Special Notice of an adverse recommendation, action or result, a Practitioner fails to make a required request or appearance or otherwise fails to comply with this Article XIII or to proceed with the matter, the Practitioner shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he might otherwise have been entitled under the Medical Staff Bylaws then in effect with respect to the matter involved.

D. *Confidentiality.* Recommendations, actions or proceedings pursuant to this Article XII shall be strictly confidential. Individuals participating in any proceedings under this Article XIII shall not disclose the content of any discussions, documents or other information outside of the appropriate procedure, except:

1. Disclosures to another authorized member of the Medical Staff or authorized Hospital representative, for the purposes of carrying out actions under this Article XIII;

2. Disclosures authorized by a Medical Staff or Hospital policy;

3. Disclosures required by law; or

4. Disclosures authorized in writing by the CEO or the Hospital's legal counsel.

A Practitioner's breach of confidentiality may result in corrective action, appropriate legal action, or any other appropriate action.

E. *Exhaustion of Remedies*. If an adverse action described in this Article is taken or recommended, the Practitioner must exhaust the remedies afforded by these Bylaws before bringing a claim to any administrative agency or court.

ARTICLE XIV
POLICIES, RULES, AND REGULATIONS

Subject to approval by the Board, the Medical Staff shall adopt such policies, Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws. These shall relate to the proper conduct of the Medical Staff and shall embody the level of practice that is to be required of each Practitioner in the Hospital. Such policies, Rules and Regulations shall have the same force and effect as these Bylaws. Such policies, Rules and Regulations may be amended or adopted at any regular or special meeting of the Medical Staff at which there is a quorum, by a two-thirds (2/3) affirmative vote of the Active Staff members present. Such changes shall become effective when approved by the Board. As required by federal law,

policies shall be reviewed and updated as necessary at least biennially.

ARTICLE XV
AMENDMENTS AND REVISIONS

15.1 Medical Staff Approval. All proposed amendments to these Bylaws shall be submitted to the Chief of Staff, who shall then appoint an ad hoc committee, which may be made up of the MEC itself, to make recommendations on the proposed amendments. The Chief of Staff shall also be responsible for assigning and/or participating in the recurrent and thorough review of these Bylaws, regardless of recommendations from any other source to do so. The ad hoc committee's recommendations shall be presented at the annual Medical Staff meeting or any other regular or special meeting of the Medical Staff, provided that at least ten (10) days' written notice has been given to all Active Staff members of the intention to take such action. The proposed document or amendments should be presented in their original format as well as in the proposed changed format in writing with the written notice of the meeting. Medical Staff Bylaws may be amended at any regular or special meeting of the Medical Staff at which there is a quorum, by a two-thirds (2/3) affirmative vote of the Active Staff members present.

15.2 Board Approval. Amendments adopted by the Medical Staff shall become effective when approved by the Board.

15.3 Technical Corrections and Amendments. The Chief of Staff may make such amendments to the Bylaws as are, in the Chief of Staff's judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or errors of grammar or expression. Such amendments shall become effectively immediately and shall remain in effect unless rejected by the Medical Staff or Board within ninety (90) days. The amendments so adopted shall be transmitted in writing to the Medical Staff and to the Board within fifteen (15) days of adoption.

ARTICLE XVI
ADOPTION

These Bylaws shall be adopted at any regular or special meeting of the Medical Staff at which there is a quorum, by a two-thirds (2/3) affirmative vote of the Active Staff members present. These Bylaws shall replace any previous bylaws of the Medical Staff and shall become effective when approved by the Board.

ADOPTED BY the Active Medical Staff on November 3, 2021

Carol Martin, MD, Chief of Staff

Neil Cox, MD, Secretary, Medical Staff

ADOPTED BY the Board of Directors on November 23, 2021

Mary Beth White-Jacobs, Secretary, Board of Directors

APPENDIX A: ADVANCED PRACTICE PROFESSIONALS

1. Certified Advanced Practice Nurse Prescribers
2. Certified Registered Nurse Anesthetists (with APNP certification)
3. Physician Assistants

APPENDIX B: ALLIED HEALTH PROFESSIONALS

1. Licensed Clinical Social Workers
2. Licensed Psychologists
3. Licensed Optometrists
4. Audiologists
5. Physician Dependent RN
6. Physician Dependent Licensed Athletic Trainers