Policy Number: 0950

BYLAWS OF THE MEDICAL STAFF OF HUDSON HOSPITAL & CLINICS

December 2011

Table of Contents

Article
Page

Bylaws of the Medical Staff of Hudson Hospital & Clinics

PREAMBLE

WHEREAS, Hudson Memorial Hospital, Inc. d/b/a Hudson Hospital & Clinics is a non-profit corporation organized under the laws of the State of Wisconsin; and

WHEREAS, its purpose is to serve as a critical access hospital providing level IV trauma care, general hospital care, education, and research; and

WHEREAS, it is recognized that the Medical Staff (i) is responsible for the oversight of care, treatment, and services provided by practitioners with privileges, and provides for uniform quality of patient care, treatment, and services in the hospital (ii) shall accept and discharge this responsibility through self-governance of Medical Staff activities, (iii) reports to is accountable to the governing body, and (iv) that the cooperative efforts of the Medical Staff, the Chief Executive Officer, and the Board of Directors are necessary to fulfill the hospital's obligations to its patients;

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

DEFINITIONS

1. The term "Medical Staff" means all medical physicians and osteopathic physicians holding unlimited licenses and duly licensed dentists and podiatrists, who are granted and maintain privileges to attend to patients in the hospital in accordance with these Bylaws.

2. The term "Board of Directors" or "Board" means the Board of Directors of the hospital.

3. The term "executive committee" means the executive committee of the Medical Staff unless specific reference is made to the executive committee of the Board of Directors, in which case it means the executive committee of the Board of Directors.

4. The term "Chief Executive Officer" means the individual appointed by the Board of Directors to act in its behalf in the overall management of the hospital.

5. The term "practitioner" means an appropriately licensed medical physician, an osteopathic physician, an appropriately licensed dentist or podiatrist Or Allied Health Licensed Independent Practitioner or Allied Health Advance Practice Nurse Prescriber.

6. The term "medical director" means the Medical Staff member duly appointed to serve as the director of a hospital clinical area or department.

7. The term "hospital" means "Hudson Hospital & Clinics and the term "Hudson Hospital & Clinics" shall include all areas of the hospital.

8. Allied health professional means personnel other than physicians, podiatrists, and dentists who are licensed or certified by their respective licensing or certifying agencies, and who provide needed services to hospital patients at the request of and under the supervision of, or in collaboration with a physician staff member.

   - Allied Health Licensed Independent Practitioner: Licensed allied health professionals who can practice independently per state statutes (doctorate-level psychologists, advance practice social workers)
   - Allied Health Advance Practice Nurse Prescriber: An advanced practice nurse who has been granted a certificate to issue prescription orders under Wisconsin Statute (certified nurse midwife, CRNA, nurse practitioner).
   - Dependent Allied Health Professional: All other allied health professionals not otherwise defined above (physician assistants and other dependent professionals).

9. The term “telemedicine” means use of electronic communication or other communication technologies to provide or support clinical care at a distance.

10. Medical Staff year commences on the 1st day of January and ends on the 31st day of December of each year.

11. The term "days" shall mean calendar days, not business days, except that when the period at issue is 10 days or less, weekends and holidays shall not be counted.

ARTICLE I: NAME

SECTION 1.1: The name of this organization shall be the Medical Staff of Hudson Hospital & Clinics.

ARTICLE II: PURPOSES

SECTION 2.1: Purposes.

The purposes of this organization are:

1. To provide a broad range of progressive, high quality, and cost effective health care services to the people in and around the St. Croix Valley. We shall treat each other and the people we serve with dignity, care, respect, and professional excellence.

2. To ensure a high level of professional performance of all practitioners authorized to practice in the hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the hospital and through an ongoing review and evaluation of each practitioner’s performance in the hospital;

3. To initiate and maintain rules and regulations for self-government of the Medical Staff;

4. To provide Medical Staff representation and participation in any hospital deliberations affecting the discharge of Medical Staff responsibilities; and

5. To provide a means whereby issues concerning the Medical Staff and the hospital may be discussed by the Medical Staff with the Board of Directors and the Chief Executive Officer.

6. To provide a leadership role in organization performance improvement activities to improve quality of care, treatment, and services, and patient safety.

ARTICLE III: CONFLICT MANAGEMENT

It is recognized that the Board of Directors is ultimately responsible for the overall functioning of the organization, and for the quality of care provided to patients, and that collaboration between hospital administration and Medical Staff leaders is essential to the effectiveness of the organization. To that end, if conflict arises between the Medical Staff and hospital administration, an officer of the Medical Staff may bring the issue forward to a member of the Board of Directors who does not have a potential conflict of interest. The Board of Directors shall ensure that resources are made available to resolve the conflict to the satisfaction of all three bodies.

ARTICLE IV: MEDICAL STAFF MEMBERSHIP

SECTION 4.1: Nature of Medical Staff Membership

Membership on the Medical Staff of Hudson Hospital & Clinics is a privilege, which shall be extended only to professionally competent MD's, DO's, DDS's, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws.

SECTION 4.2: Qualifications for Membership

A. Only MD's, DO's, DDS's, and podiatrists licensed to practice in the State of Wisconsin, who can document their experience, and training, and demonstrate competence; adherence to the ethics of their professions; professional liability insurance coverage; physical and mental health as it relates to ability to perform the privileges requested; good reputation, and ability to work with others; with sufficient adequacy to assure the Medical Staff and the Board of Directors that any patient treated by them in the hospital will be given a high quality of medical care, shall be qualified for membership on the Medical Staff.

B. Acceptance of membership on the Medical Staff shall constitute the staff member's agreement that he/she will strictly abide by the Principles of Medical Ethics of the American Medical Association, the Code of Ethics of the American Osteopathic Association, the Code of Ethics of the American Dental Association, or the Code of Ethics of the American Podiatric Association, whichever is applicable and that he/she will pledge to provide for continuous care for his/her patients. The management and coordination of each patient's care, treatment, and services is the responsibility of a practitioner with appropriate privileges.

SECTION 4.3: Conditions and Duration of Appointment

A. Initial appointments and reappointments to the Medical Staff shall be made by the Board of Directors. The Board of Directors shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws; provided that in the event of unwarranted (100 days from the date the fully completed application has been received by the Medical Staff) delay on the part of the Medical Staff, the Board of Directors may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

B. Initial appointments shall be for a six-month period. Reappointments shall be for a maximum period of two years.

C. Appointment to the Medical Staff shall confer on the appointee only such delineated clinical privileges as have been granted by Board of Directors in accordance with these Bylaws.

D. Every application for staff appointment shall be completed in its entirety, signed by the applicant and shall contain the applicant's specific acknowledgement to provide continuous care and supervision of his/her patients, to abide by the Medical Staff Bylaws, rules and regulations, to accept committee assignments, and to accept consultation assignments. Every Medical Staff member is required to provide documentation of arrangements for alternate coverage.

ARTICLE V: CATEGORIES OF THE MEDICAL STAFF

SECTION 5.1: The Medical Staff shall be divided into honorary, active, courtesy, consulting, consulting/telemedicine, emergency department. New members will be designated as provisional appointees. The Allied Health staff shall be separate from the Medical Staff and shall have only those rights set forth in these Bylaws.

SECTION 5.2: The Honorary Medical Staff

The honorary Medical Staff shall consist of physicians, dentists and podiatrists who are not active in the hospital or who are honored by emeritus positions. These may be physicians, dentists and podiatrists who have retired from active practice or who are of outstanding reputation, not necessarily residing in the community. Honorary staff members shall not be eligible to admit patients or practice medicine at Hudson Hospital & Clinics, to vote, hold office, or to serve on standing Medical Staff committees. Honorary staff members are not required to have professional liability insurance, DEA, or medical license. These practitioners will be reviewed and reappointed every two years.

SECTION 5.3: The Active Medical Staff

The active Medical Staff shall consist of physicians dentists and podiatrists who consistently admit patients to the hospital and/or are actively involved in patient care, who are located closely enough to the hospital to provide continuous care to their patients, and who assume all the functions and responsibilities of membership on the active Medical Staff, including, where appropriate, emergency service and consultation assignments. One physician representative from each of the following services: Anesthesiology, Pathology, Radiology and Emergency Medicine service may be appointed to the active Medical Staff when all membership requirements are met with the exception of admitting patients to the hospital. Others in this category may be considered for active Medical Staff if their patient contacts exceed 100 per year.

Members of the active Medical Staff shall be eligible to vote, to hold office, and to serve on Medical Staff committees, and shall be strongly encouraged to attend Medical Staff meetings.

SECTION 5.4: The Courtesy Medical Staff

The courtesy Medical Staff shall consist of physicians, dentists and podiatrists qualified for staff membership who admit no more than twelve patients per year to the hospital or who act only as consultants. Members of the courtesy staff may neither vote nor hold office, but are welcome to attend Medical Staff meetings.

SECTION 5.5: The Consulting Medical Staff

The consulting Medical Staff shall consist of medical practitioners of recognized professional ability who are not members of another category of the Medical Staff and who have signified willingness to accept appointment to the consulting staff.

Members of the consulting staff may neither vote nor hold office, but are welcome to attend Medical Staff meetings. Consulting staff do not have admitting privileges.

SECTION 5.6: The Consulting/Telemedicine Medical Staff

The consulting/telemedicine Medical Staff shall consist of medical practitioners of recognized professional ability who are not members of another category of the Medical Staff and who provide "only occasional" telemedicine services. Members of the consulting/telemedicine staff may neither vote nor hold office, but are welcome to attend Medical Staff meetings. Consulting/telemedicine staff does not have admitting privileges. The Medical Staff recommends services to be provided via telemedicine.

SECTION 5.7: The Emergency Department Medical Staff

The emergency department Medical Staff shall consist of physicians qualified by training or experience to provide emergency care to patients. Members of the emergency department staff who are not members of the active staff will only be able to admit patients to the hospital with the consent of a member of the active staff. Patients will be admitted to the service of the appropriate member of the active staff. Members of the emergency department Medical Staff who are not members of the active staff shall be ineligible to vote or to hold office in the Medical Staff organization.

In accordance with the EMTALA laws, 42 CFR 489.20 and 489.24, physicians will be known as the qualified medical personnel designated to perform the appropriate medical screening examinations in the Emergency Department. Other qualified medical personnel shall include the following categories of persons when acting in their usual and customary settings and within the scope of their training and protocols; clinical psychologists, dentists, podiatrists, certified nurse midwives, nurse practitioners, registered nurses, and physician assistants.

SECTION 5.8: Allied Health Staff (AHS)

Allied health staff shall consist of certain health care professionals other than physicians, podiatrists, dentists, who are licensed or certified by their respective licensing or certifying agencies, are approved by the hospital and who provide needed services to patients either via sponsorship by, in collaboration with, or as employees of a practitioner/practitioner group presently appointed to the Medical Staff of Hudson Hospital & Clinics. Members of the AHS may neither vote nor hold office, but are welcome to attend Medical Staff meetings.

Licensed allied health professionals who can practice independently per state statutes (doctorate-level psychologists, advance practice social workers) shall be processed in accordance with these Bylaws and credentialing policies, and shall have the right to fair hearing as described in these Bylaws Allied health staff members, i.e. physician assistants, CRNA, APNP, and certified nurse midwives will be processed and granted privileges in accordance with these Bylaws and credentialing policies. Dependent allied health personnel, except physician assistants, who are not employed by the Hospital will be processed through review and evaluation by the medical director/sponsoring physician, quality director, chief nurse officer or designee, and hospital Chief Executive Officer. Two annual performance evaluations are completed on each allied health staff member: (i) one by the medical director/sponsoring physician and (ii) one by the appropriate Hudson Hospital & Clinics department manager. Dependent allied health personnel who are not credentialed through the medical staff credentialing process do not have access to the fair hearing process described in these Bylaws, but do have access to a separate process, which may be initiated through their sponsoring physician and the Chief Executive Officer or designee. Please refer to the Human Resources Grievance Procedure.

Members of the AHS will be limited to practice under the supervision of a physician, within the scope of their license and privileges or job description authorized by the Medical Staff and hospital. The services provided must be documented. AHS are subject to the Bylaws, rules and regulations, and applicable Hospital policies. They must also cooperate with and participate in quality monitoring and evaluation, as appropriate.

SECTION 5.9: Provisional Appointments

A. All initial appointments to any category of the Medical Staff shall be provisional for six months. Reappointments to provisional membership may not exceed two years, at which time the failure to advance to regular staff status shall be deemed a termination of his/her staff appointment. A provisional appointee whose membership is so terminated shall have the rights accorded by these Bylaws to a member of the Medical Staff who has failed to be reappointed.

B. Provisional staff members shall be assigned to a department where their performance shall be observed by the medical director of the department or his representative to determine the eligibility of such provisional members for regular staff membership and for exercising the clinical privileges that were provisionally granted.

C. Effective January 1, 2008, a period of focused professional practice evaluation is implemented for all initially requested privileges. The focused professional practice evaluation assigned can include generic performance and clinical indicators and/or proctoring and/or any other type of evaluation assigned by the Credentials Committee which is approved by the Medical Staff and the Board of Directors.

SECTION 5.10: Students – Medical, and Physician Assistant

A. All students must work within their curriculum under the direct supervision of a preceptor who is an active member of the Medical Staff.

SECTION 5.11 Residents

Third year emergency medicine residents, in an accredited emergency medicine program and in accordance with the institution's affiliation agreement, are allowed to do a clinical rotation in the Emergency Department. Emergency medicine residents must work within their curriculum under the direct supervision of a preceptor who is a member of the Medical Staff.

ARTICLE VI: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

SECTION 6.1: Application

A. All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the contracted credentials verification organization to the Board of Directors after consultation with the Medical Staff. Each applicant for appointment or reappointment to the Medical Staff will be given an opportunity to submit the name or names of outside physician reviewers that he/she would prefer to have review his/her inpatient or outpatient cases should an outside review of cases ever become necessary as part of the Medical Staff's quality review activities. The final decision of who will be the outside reviewer will rest with the executive committee of the Medical Staff.

B. The applicant shall have the burden of producing adequate information to evaluate his/her current competence. The application will be considered complete when all sections of the application/reappointment form have been completed and contain detailed information concerning the applicant's professional qualifications including primary source verification of current licensure, relevant training or experience, current competency, and ability to perform the privileges requested including the following:

1. information concerning the applicant's medical education, training, and continuing education;

2. information regarding the applicant's license to practice medicine in Wisconsin and DEA registration;

3. current and previous hospital experience;

4. delineation of specific requested privileges based on level of training and competence;

5. evidence that the applicant currently carries malpractice and liability insurance (minimum of $1,000,000 of malpractice insurance). This insurance shall be provided by a company licensed or approved by the state;

6. report from the National Practitioner Data Bank;

7. information concerning pending professional liability action and final judgments or settlements involving the applicant;

8. verification of health status as it relates to the practitioner's ability to perform the privileges requested ; testing for TB will be required as per hospital policy; vaccination or confirmed immunity against Rubella is required of all applicants;

9. names of at least three peers, in the same professional discipline, who have had experience working with and observing the applicant and who can provide adequate references pertaining to the applicant's professional competence relating to requested privileges and ethical character;

10. information as to whether there are challenges currently pending to the applicant's DEA registration, license to practice in any jurisdiction or whether they have ever been restricted, suspended, revoked, or voluntarily relinquished while the applicant was under investigation;

11. information as to whether the applicant's membership status or clinical privileges have ever been revoked, suspended, reduced or not renewed at another hospital or institution, or have been voluntarily relinquished or reduced;

12. Medicare/Medicaid sanction and exclusion status will be checked on all applicants.

13. caregiver criminal background checks as prescribed by Wisconsin law effective October 1, 1998.

14. proof of identity (copy of driver's license, passport photo, notarized photo, etc.).

15. relevant practitioner-specific data and aggregate data, and morbidity and mortality data, when available.

Practitioners applying for initial appointment after March 1, 2000 who are Board Eligible, making progress towards completion of their Boards, or Board Certified, may be fast tracked if they meet the remaining defined criteria (excludes general dentistry which has no certification).

Practitioners who are not Board Eligible, who are not making progress towards completion of their Boards, or who are not Board Certified, will not be fast tracked and will be reviewed by the Credentials Committee. The Credentials Committee will identify specific criteria that would qualify the candidate for Medical Staff membership and privileges at Hudson Hospital & Clinics in lieu of Board Eligibility, making progress towards completion of their Boards or Board Certification.

Transport and organ donation teams do not require hospital credentialing and privileging as they function under a contractual agreement to facilitate continuity of care.

Effective January 1, 2007, practitioners, for appointment and reappointment, in addition to meeting the credentialing requirements outlined above will be measured using the following six areas of general competencies: The competencies are listed by The Joint Commission language titles, followed by the Greeley language titles:

1. **Patient care (Service Quality/Patient Safety/Patient Rights))** is compassionate, appropriate, and effective for the treatment of health problems and promotion of health

2. **Medical/clinical knowledge (Technical Quality)** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavioral) sciences and the application of this knowledge to patient care

3. **Practice-based learning and improvement (Resource Use)** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

4. **Interpersonal and communication skills (Relationships)** that result in effective information exchange and teaming with patients, their families, and other health professionals

5. **Professionalism (Relationships)**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

6. **Understands and optimizes healthcare delivery (systems-based practice**),(**Citizenship)** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Effective, January 1, 2007, a practitioner's performance will continuously be evaluated. This ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

C. Each applicant will consent to the inspection of records and documents pertinent to his/her licensure, specific, training, experience, current competence, and ability to perform the privileges requested, and, if requested, will appear for an interview.

D. The completed application shall be submitted to the Chief Executive Officer. After collecting the references and other materials deemed pertinent, he/she shall transmit the application and all supporting materials to the credentials committee for evaluation.

E. Sex, race, creed, gender preference national origin, disability, economic status, or other status protected by applicable law are not used in making decisions regarding the granting or denying of clinical privileges.

SECTION 6.2: Appointment Process [1]

A. Within 90 days, after receipt of the completed application for membership, the credentials committee shall make a report of its investigation to the Medical Staff or its executive committee who then reports to the Board of Directors, including: i) its recommendation that the practitioner be provisionally appointed to the Medical Staff in a particular category, ii) that he/she be rejected for Medical Staff membership, or iv) that his/her application be deferred for further consideration. All recommendations to appoint shall also specifically recommend the clinical privileges to be granted, which may, where appropriate, be qualified by probationary conditions.

B. Prior to making this report and recommendation, the credentials committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the practitioner and shall determine, through information contained in references given by the practitioner and from other sources available to the committee, including an appraisal from the clinical service in which privileges are sought, whether the practitioner has established and meets all of the necessary qualifications for the category of staff membership and clinical privileges requested by him/her. Privileges sought by a practitioner shall be specific to this hospital. Procedures not done at Hudson Hospital & Clinics cannot be approved. Together with its report, the credentials committee shall transmit to the Medical Staff or its executive committee the completed application and all other documentation considered in arriving at its recommendation.

C. When the recommendation of the credentials committee is to defer the application for further consideration, with the approval of the Medical Staff or its executive committee, it shall be followed up within 60 days with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection for staff membership.

D. When the recommendation of the credentials committee is favorable to the practitioner, the recommendation, , together with all supporting documentation shall promptly be forwarded to the President of the Medical Staff for action by the Medical Staff or its executive committee within 60 days after receipt of such favorable recommendation and then to the Board of Directors. Whenever the Board of Directors does not concur in a Medical Staff or its executive committee recommendation relative to clinical privileges or membership, the recommendation shall be reviewed by a joint committee of at least two Medical Staff members and two members of the Board of Directors, before a final decision is reached by the Board.

E. When the recommendation of the Medical Staff or its executive committee is adverse to the practitioner either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Board of Directors until after the practitioner has exercised or has been deemed to waive his/her right to a hearing as provided in Article IX of these Bylaws.

[1] In Sections 6.2 and 6.3 of this Article VI, the documents will be transmitted to and the action taken by either the Medical Staff or the Medical Staff executive committee, depending on the meeting schedule of those respective groups.

F. If, after the Medical Staff or its executive committee has considered the report and recommendation of a hearing committee under Article IX, and the reconsidered recommendations are favorable to the practitioner, it shall be processed in accordance with subparagraph D. of this Section 6.2. If such recommendation continues to be adverse, the Chief Executive Officer shall promptly so notify the practitioner by certified mail, return receipt requested. The Chief Executive Officer and Board of Directors shall not take further action thereon until after the practitioner has exercised or has been deemed to have waived his/her right to an appellate review as provided in Article IX of these Bylaws.

G. At its next regular meeting after receipt of a favorable recommendation, in any event, after not more than 60 days, the Board of Directors or its executive committee shall act in the matter. If the Board's decision is adverse to the practitioner in respect to either appointment or clinical privileges, the Chief Executive Officer shall promptly notify him/her of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived his/her rights under Article IX of these Bylaws and until there has been compliance with subparagraph I. of this Section 6.2. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

H. At its next regular meeting after all of the practitioner's rights under Article IX have been exhausted or waived, the Board of Directors or its duly authorized committee shall act in the matter. The Board's decision shall be conclusive, except that the Board may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons, shall set a time limit within which a subsequent recommendation to the Board of Directors shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, and new evidence in the matter, if any, the Board shall make a decision either to provisionally appoint the practitioner to the staff or to reject him/her for staff membership. All decisions to appoint shall include a delineation of the clinical privileges that the practitioner may exercise.

I. Whenever the Board of Director's decision is contrary to the recommendation of the Medical Staff or its executive committee, the Board shall submit the matter to the President of the staff who will appoint a committee of the Medical Staff to meet with the Board of Directors for review and recommendation and shall consider such recommendation before making its decision final.

J. When the Board's decision is final, it shall give notice of such decision through the Chief Executive Officer to the President of the Medical Staff, to the chairman of the credentials committee, and by certified mail, return receipt requested, to the practitioner.

SECTION 6.3: Reappointment Process

A. Reappointments are completed according to an agreed upon cycle and will not exceed a period of two years. Upon receipt of the reappointment form and supplemental information, the credentials committee shall review all pertinent information available including verification of current licensure, relevant training or experience, current competence, and ability to perform the privileges requested on each practitioner scheduled for periodic appraisal, for the purpose of determining its recommendations for reappointments to the Medical Staff and for the granting of clinical privileges for the ensuing period. The Medical Staff or its executive committee evaluates individuals for their continued ability to provide quality care, treatment, and services for the privileges requested and shall transmit its recommendations to the Board of Directors.

B. Each recommendation concerning the reappointment of a member and the clinical privileges to be granted upon reappointment shall be based upon current licensure and DEA registration, evidence of adequate malpractice and liability insurance, national practitioner data bank reports, Board Certification status, health status as it relates to the practitioner's ability to perform the privileges requested, performance, judgment, clinical/technical skill, peer evaluations, maintenance of timely, accurate, and complete medical records, and participation on Medical Staff committees for active staff physicians, and continuing medical education in accordance with State of Wisconsin licensure requirements. Results of performance improvement and focused Peer Review activities (relevant practitioner-specific data and aggregate data, morbidity and mortality data) and other reasonable indicators of continuing qualifications shall be considered. The appraisal shall also include information relating to previously successful or currently pending challenges to any licensure or the voluntary relinquishment of such license or registration, voluntary or involuntary termination of Medical Staff membership, and limitation, reduction, or loss of clinical privileges at another hospital. An applicant for reappointment or renewal of clinical privileges is required to submit any reasonable evidence of current ability to perform privileges that may be requested.

C. Medicare/Medicaid sanction status will be checked and considered on all reappointments.

D. Verification of health status as it relates to the practitioner's ability to perform the privileges requested will be provided by evidence of a periodic physical exam. Periodic testing for TB will be required as per hospital policy. Vaccination or confirmed immunity against Rubella is required of all applicants. The Credentials Committee shall verify adequate physical and mental health status of the practitioner.

E. Thereafter, the procedure provided in Section 6.2 of this Article VI, relating to recommendations on applications for initial appointment, shall be followed.

SECTION 6.4: Expedited Appointment and Reappointment (Fast Track)

Hudson Hospital & Clinics utilizes a categorization system for individual applicants to facilitate the appointment/reappointment process of those applications meeting defined criteria. See attached Credentialing Policy. If a practitioner requests their application to be fast tracked through the credentials verification organization process, the cost for this fast tracking will be the responsibility of the practitioner.

SECTION 6.5: Appointment and Reappointment Process of Telemedicine Practitioners

All practitioners who diagnose or treat patients via telemedicine link or other forms of communication technologies are subject to the credentialing and privileging processes of Hudson Hospital & Clinics. Hudson Hospital & Clinics will credential and privilege by “proxy”, that is, by utilizing the credentialing and privileging decisions of the distant site organization if the distant site is a Joint Commission-accredited organization and if the practitioner is privileged at the distant site for those services to be provided at Hudson Hospital & Clinics. See attached Telemedicine Credentialing Policy. Privileges granted shall be based on training, experience, current competency, and the ability to perform the privileges granted.

SECTION 6.6 Leave Of Absence

Members of the Medical Staff may apply for a leave of absence not to exceed six months, renewable under appropriate conditions. Reinstatement to staff privileges may be requested through the Credentials Committee without formal re-application, and with concurrence of the Medical Executive Committee/Medical Staff and approval by the Board of Directors.

ARTICLE VII: CLINICAL PRIVILEGES

SECTION 7.1: Clinical Privileges

A. Every individual practicing at this hospital by virtue of Medical Staff membership shall~~,~~ be entitled to exercise only those clinical privileges specifically granted to him/her by the Board of Directors, except as provided in Sections 7.2 and 7.3 of this Article VII. Said privileges and services must be within the scope of the license, certificate, or other legal credentials authorizing practitioner to practice in this State and consistent with any restrictions thereon. Said privileges and services must be related to a practitioner's documented experience in categories of treatment areas or procedures~~;~~, the results of treatment~~;~~ and the conclusions drawn from organization performance improvement activities when available.

B. Every initial application for staff appointment shall contain a request for the specific clinical privileges desired by the applicant. The evaluation of such request shall be based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information, including a review and recommendation by the service in which such privileges are sought. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests

C. Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of patients treated in this or other hospitals, and review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care~~.~~ or receipt of other relevant information, including all elements of Article VI, Section B, regarding the member's qualifications for continued Medical Staff membership or clinical privileges.

Requests for additional clinical privileges shall be in writing. To assure uniformity, they should be submitted on a prescribed form, on which the type of clinical privileges desired and the applicant's relevant recent training and/or experience shall be stated. Such applications will be processed in the same manner as applications for initial appointment.

D. Privileges granted to dentists shall be based on their current licensure, training, experience, current competency, judgment, and ability to perform requested privileges. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the chief of surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member 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. Dentists are responsible for that part of their patient's history and physical examination related to dentistry. The patient will be admitted to the service of one of the active staff physicians. Initial orders for treatment will be countersigned by the attending staff physician. The medical records of each dentistry patient should document with a detailed description pertinent instructions for the patient and/or family at the time of discharge.

The dentist may write orders within the scope of his/her license, as limited by the applicable statutes and as consistent with the Medical Staff regulations. He/she shall agree to comply with all applicable Medical Staff Bylaws, rules and regulations at the time of application for clinical privileges. The delineation and granting of clinical privileges for dentists shall be accomplished in a manner consistent with the overall procedure established for the

Medical Staff as detailed in Article VI, the rules of procedure for corrective action as detailed in Article VIII, and the hearing procedure and appeal mechanism detailed in Article IX.

E. Qualified, licensed podiatrists may be granted privileges in podiatry by the Board of Directors based on the recommendation of the Medical Staff following the credentialing process. The delineation of their clinical privileges shall be based on the applicant's current licensure, training, experience, current competency, and ability to perform requested privileges. The scope and extent of surgical procedures that each podiatrist may perform shall be specifically defined and recommended in the same manner as for all other surgical privileges. The podiatrist is responsible for the podiatric care of the patient, including that part of the history and physical examination, which is related to podiatry. The medical records of each podiatry patient should document with a detailed description pertinent instructions for the patient and/or family at the time of discharge. Podiatrists may, within their scope of practice, complete and or update H&Ps on their surgical patients. The podiatrist may write orders within the scope of his/her license, as limited by the applicable statutes and as consistent with the Medical Staff regulations. He/she shall agree to comply with all applicable Medical Staff Bylaws, rules and regulations at the time of application for clinical privileges. The delineation and granting of clinical privileges for podiatrists shall be accomplished in a manner consistent with the overall procedure established for the Medical Staff as detailed in Article VI, the rules of procedure for corrective action as detailed in Article VIII, and the hearing procedure and appeal mechanism detailed in Article IX.

SECTION 7.2: Temporary Privileges

A. Temporary privileges can only be granted on a case-by-case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. Upon receipt of an application for Medical Staff membership from an appropriately licensed practitioner, the Chief Executive Officer, or designee, may, upon the basis of information then available which may reasonably be relied upon as to the current competence, relevant training or experience, qualification, ability, judgment, ability to perform the privileges requested, no current or previously successful challenge to licensure or registration, no subjection to involuntary termination of Medical Staff membership at another organization, no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges, and ethical standing of the applicant, and with the concurrence of the President of the Medical Staff, or designee, grant temporary admitting and clinical privileges to the applicant; but in exercising such privileges, the applicant shall act under the supervision of the medical director or their designee of the service to which he/she is assigned. Before temporary privileges can be granted the following documentation must be primary source verified: (i) current Wisconsin license, (ii) DEA registration, (iii) national practitioner data report, (iv) proof of adequate insurance, (v) peer evaluation, (vi) non-exclusion from Medicare/Medicaid, and (vii) written description of privileges requested. When feasible, a complete credentials file will be obtained from the applicant's affiliated hospital. An appropriately licensed applicant may be granted temporary privileges for an initial period of 30 days, with subsequent renewal of an additional 90 days during the pendency of the application process.

B. Temporary clinical privileges may be granted by the Chief Executive Officer, or designee, for the care of a specific patient to a practitioner who is not an applicant for membership in the same manner and upon the same conditions as set forth in subparagraph A. of this Section 7.2.

C. The Chief Executive Officer, or designee, may permit a physician serving as a locum tenens for a member of the Medical Staff to attend patients without applying for membership on the Medical Staff for a period not to exceed 90 days, providing all of his credentials have first been approved by the credentials committee and by the President of the Medical Staff.

D. Special requirements of supervision and reporting may be imposed by the President of the Medical Staff on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer, or designee, upon notice of any failure by the practitioner to comply with such special conditions.

E. The Chief Executive Officer, or designee, may at any time, upon the recommendation of the President of the Medical Staff terminate a practitioner's temporary privileges effective as of the discharge from the hospital of the practitioner's patient(s) then under his/her care in the hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to Section 8.2A of Article VIII of these Bylaws, and the same shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute practitioner.

SECTION 7.3: Disaster Privileges

A. Disaster Privileges may be granted, in response to a disaster, to providers of known competency, qualifications and quality, who hold Medical Staff membership and clinical privileges at another fully Joint Commission accredited or Medicare Certified hospital. These Disaster Privileges shall be in place as long as the hospital determines that it is in need of these providers to deal with the disaster.

B. Disaster privileges may be granted to a licensed independent practitioner to provide care when a disaster occurs that calls for the activation of the hospital's emergency management plan, and the hospital is unable to handle the immediate patient needs. Medical professionals who come to Hudson Hospital & Clinics to volunteer their services during the emergency will have credentials verified and will be granted temporary disaster privileges. See Emergency Management Plan (Policy #539).

C. During a disaster in which the emergency management plan has been activated and the Incident Commander has determined the need for volunteer providers, the Chief Executive Officer may grant disaster privileges on the recommendation of the Medical Staff President or his/her designee following a similar process as the temporary privileging process. Disaster privileges may be granted using one or more of the following:

1. Copy of the physician medical license, DEA, and driver's license (or two of the three);

2. Written verification of knowledge of physician by two active Medical Staff members

3. Verbal call affirmation made to facility where physician has active privileges;

4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or granted authority to render patient services in disaster circumstances by a federal, state, or municipal entity.

D. The disaster privilege verification process is high priority. If communication access is available, primary source verification of licensure, certification, or registration begins as soon as the immediate situation is under control. This is completed within 72 hours from the time the volunteer practitioner presents to the organization.

SECTION 7.4: Emergency Privileges

In the case of an emergency involving an inpatient or outpatient, any physician or dentist member of the Medical Staff, to the degree permitted by his license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such physician or dentist shall request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which not administering treatment would add to the danger.

ARTICLE VIII: CORRECTIVE ACTION[2]

SECTION 8.1: Procedure

A. The Board of Directors has responsibility for the establishment and organization of the Medical Staff to operate in accordance with the Board of Directors, Bylaws and regulations and the policies of the Medical Staff approved by the Board. The Board may delegate certain responsibilities to the Medical Staff as determined by the Board (Article VII Medical Staff, Hudson Hospital & Clinics, Inc.).

B. Whenever the activities or professional conduct of any practitioner with clinical privileges, including medico-administrative physicians, are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the hospital, corrective action against such practitioner may be requested by the President of the Medical Staff, by the chairman of any standing committee of the Medical Staff, by the Chief Executive Officer, or by the Board of Directors. All requests for corrective action must be in writing, to the executive committee of the Medical Staff, and be supported by reference to the specific activities or conduct which constitute the grounds for the request.

C. Whenever the corrective action could be a reduction or suspension of clinical privileges or the termination of a physician, dentist, or podiatrist in a medico-administrative position, the President of the Medical Staff shall immediately appoint an ad hoc committee to investigate the matter.

C. Within 30 days after the committee's receipt of the request for corrective action, the ad-hoc committee shall make a report of its investigation to the executive committee of the Medical Staff. Prior to the making of such report, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the ad hoc investigating committee. At such interview, he/she shall be informed of the general nature of the charges against him/her, and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such interview shall be made by the committee and included with its report to the executive committee of the Medical Staff.

E. Within 30 days following the receipt of a request for corrective action, or following receipt of a report from the ad-hoc committee following the committees' investigation of a request for corrective action involving reduction or suspension of clinical privileges, the executive committee of the Medical Staff shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from

[2] In Article VIII, the documents will be transmitted to and the action taken by either the Medical Staff or the Medical Staff executive committee, depending on the meeting schedule of those respective groups.

the Medical Staff, the affected practitioner shall be permitted to make an appearance before the executive committee/Medical Staff prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the executive committee.

F. The action of the executive committee of the Medical Staff on a request for corrective action may be to: reject or modify the request for corrective action, to issue a warning, to issue a performance improvement plan, a letter of admonition, or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that the practitioner's staff membership be suspended or revoked.

G. Any recommendation by the executive committee of the Medical Staff for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff shall entitle the affected practitioner to the procedural rights provided in Article VIX of the Bylaws, Hearing and Appellate Review Procedure.

H. The President of the Medical Staff shall promptly notify the Chief Executive Officer in writing of all requests for corrective action received by the executive committee/Medical Staff and shall continue to keep the Chief Executive Officer fully informed of all action taken in connection therewith. After the executive committee/Medical Staff has made its recommendation in the matter, the procedure to be followed shall be as provided in Article VI, Section 6.2, and in Article IX if applicable, of these Bylaws.

SECTION 8.2: Summary Suspension

A. Two (one from each group) of the following individuals must be in agreement to initiate Summary Suspension: Group I: the President of the Medical Staff, chair of MSQI committee, or the executive committee of the Medical Staff; Group II: the hospital's Chief Executive Officer, the Vice President of Medical Affairs, Administrator on Call, or the Executive Committee of the Board of Directors, whenever action shall be taken immediately in the best interest of patient care in the hospital, to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition.

B. A practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the executive committee of the Medical Staff hold a hearing on the matter within such reasonable time period thereafter as the executive committee may be convened in accordance with Article IX of these Bylaws.

C. The executive committee of the Medical Staff may recommend modification, continuance, or termination of the terms of the summary suspension. If, as a result of such hearing, the executive committee does agree with the summary suspension, the affected practitioner shall, also in accordance with Article IX, be entitled to request an appellate review by the Board of Directors, but the terms of the summary suspension as sustained or as modified by the executive committee shall remain in effect pending a final decision thereon by the Board of Directors.

D. Immediately upon the imposition of a summary suspension, the President of the Medical Staff shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

SECTION 8.3: Automatic Suspensions

The following shall result in automatic suspension, revocation or restriction (as outlined below) of Medical Staff membership and/or clinical privileges and shall not, unless otherwise expressly provided or required by law, entitle the affected practitioner to the rights provided for in Article IX of these Bylaws, or to any other procedural rights:

A. All completed medical records must be ready for filing within 30 days of discharge or corrective action shall be taken. For failure to complete medical records in timely fashion a practitioner's clinical privileges (except with respect to his/her patients already in the hospital) and his/her rights to admit patients and to consult with respect to patients shall, after written warning of delinquency, be automatically suspended by the Chief of Staff or his/her designee and shall remain suspended until medical records are satisfactorily completed. Refer to Hudson Hospital & Clinics Medical staff Rules and Regulations, Section 11.0, Incomplete/Delinquent Charts.

B. Action by the State Board of Medical Examiners revoking or suspending a practitioner's license, shall automatically suspend all of his/her Medical Staff privileges. If the State Board of Medical Examiners places a practitioner on probation, privileges shall be adjusted to comply with the terms of the probation.

C. If a practitioner is sanctioned, excluded, or suspended by Medicare/Medicaid, privileges will be adjusted to comply with the sanction terms.

D. Whenever a Medical Staff member's DEA certificate is revoked, suspended, stayed, restricted, or subject to probation, the action and its terms shall automatically apply to his/her right to prescribe, dispense, or administer medications covered by the certificate. Whenever a Medical Staff member's DEA certificate expires, the member's right to prescribe, dispense, or administer medications covered by the certificate shall be automatically suspended until there is evidence of a certificate renewal.

F. It shall be the duty of the President of the Medical Staff to cooperate with the Chief Executive Officer in enforcing all automatic suspensions.

G. Immediately upon the imposition of an Automatic Suspension under this Section 8.3, the President of the Medical Staff shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

ARTICLE IX: HEARING AND APPELLATE REVIEW PROCEDURE

SECTION 9.1: Right to Hearing and to Appellate Review

A. When any practitioner receives notice of a recommendation of the executive committee of the Medical Staff that, if ratified by decision of the Board of Directors, will adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, he/she shall be entitled to a hearing before an ad hoc committee of the Medical Staff. (Section 9.4) If the recommendation of the executive committee following such hearing is still adverse to the affected practitioner, he/she shall then be entitled to an appellate review by the Board of Directors before the Board makes a final decision on the matter.

B. When any practitioner receives notice of a decision by the Board of Directors that will affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, and such decision is not based

on a prior adverse recommendation by the executive committee of the Medical Staff with respect to which he/she was entitled to a hearing and appellate review, he/she shall be entitled to a hearing by a committee appointed by the Board of Directors. If such hearing does not result in a favorable recommendation, the practitioner will be afforded an appellate review by the Board of Directors before the Board makes a final decision on the matter.

C. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article IX to assure that the affected practitioner is accorded all rights to which he/she is entitled. All decisions shall be taken in a reasonable belief that the action is to maintain quality health care and in a reasonable belief that the action is warranted by the facts known after reasonable efforts to obtain the facts.

SECTION 9.2: Request for Hearing

A. The Chief Executive Officer shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected practitioner who is entitled to a hearing or to an appellate review, by certified mail, return receipt requested. The written notice to the affected practitioner will include:

1. the reasons for the proposed action;

2. notice that the practitioner has the right to request a hearing on the proposed action;

3. notice that he/she has 30 days within which to request such a hearing; and

4. a summary of the rights of the affected practitioner in a hearing pursuant to section 5 of this Article IX.

B. The failure of a practitioner to make a written request for a hearing to which he/she is entitled by these Bylaws within 30 days of the receipt of written notice shall be deemed a waiver of his/her right.

C. When the waived hearing or appellate review relates to an adverse recommendation of the executive committee of the Medical Staff or of a hearing committee appointed by the Board of Directors, the same shall thereupon become and remain effective against the practitioner pending the Board of Director's decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Board of Directors, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the Board provided for in Section 9.7 of this Article IX. In either of such events, the Chief Executive Officer shall promptly notify the affected practitioner of his/her status by certified mail, return receipt requested.

SECTION 9.3: Notice of Hearing

Within 10 days after receipt of a request for hearing from a practitioner entitled to the same, the executive committee of the Medical Staff or the Board of Directors, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the Chief Executive Officer, notify the practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The hearing date shall be not less than 30 days, nor more than 45 days from the date of the notice of hearing. In the case of summary suspension, the hearing date shall not be more than 14 days from the date of the notice of the hearing. The notice to the practitioner shall include a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Staff executive committee or the Board of Directors.

The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.

SECTION 9.4: Composition of Hearing Committee

A. When a hearing relates to an adverse recommendation of the executive committee of the Medical Staff, such hearing shall be conducted by an ad hoc hearing committee of not less than 3 members of the Medical Staff appointed by the President of the Medical Staff in consultation with the executive committee, and one of the members so appointed shall be designated as chairman. The committee shall be composed of persons who are not in direct economic competition with the practitioner. No staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee unless it is otherwise impossible to select a representative group due to the size of the Medical Staff. This committee shall include no more than one member from the same clinical practice as the practitioner.

In the event a disinterested panel of physicians, who meet these criteria, cannot be acquired from the Medical Staff, physicians from other communities, who do meet these criteria, may be appointed as members of the ad hoc committee.

B. When a hearing relates to an adverse decision of the Board of Directors that is contrary to the recommendation of the executive committee of the Medical Staff, the Board shall appoint a hearing committee composed of a minimum of 3 members. The committee shall be composed of persons who are not in direct economic competition with the practitioner, and no more than one member who is in the same clinical practice as the practitioner. The Board shall designate one of the members of this committee as chairman. At least one representative from the Medical Staff shall be included on this committee when feasible.

SECTION 9.5: Conduct of Hearing

A. There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy. The hearing shall be closed.

B. An accurate record of the hearing shall be kept. The practitioner shall have a right to a copy of the record of the proceedings upon payment of any reasonable charges associated with the preparation thereof.

C. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 9.2 of this Article IX and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Section 9.2.

D. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the ad hoc hearing committee. Granting of such postponements shall only be for good cause shown, and are at the sole discretion of the hearing committee.

E. The affected practitioner shall be entitled to be accompanied by and/or represented at the hearing by his/her attorney or another person of his or her choice.

F. Either a hearing officer, if one is appointed, or the chairman of the hearing committee or his/her designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

G. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any matter determined to be relevant by the member presiding over the hearing shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held, shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

H. The executive committee of the Medical Staff, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff member, or its attorney, to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Board of Directors, when its action has prompted the hearing, shall appoint one of its members or its attorney to represent them at the hearing, to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision. The affected practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable, or capricious.

I. The affected practitioner shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness, and to rebut any evidence. If the practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination. The affected practitioner has the right to submit a written statement at the close of the hearing.

J. The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

K. Within 10 days after final adjournment of the hearing, the hearing committee shall make a written report and recommendations, including a statement of the basis for the recommendations, and shall forward the same together with the hearing record and all other documentation to the executive committee of the Medical Staff or to the Board of Directors, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the executive committee or decision of the Board of Directors. The hearing committee shall send to the practitioner its written recommendation, including a statement of the basis for the recommendations.

SECTION 9.6: Appeal to the Board of Directors

A. Within 10 days after a notice to an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, the affected practitioner may, by written notice to the Board of Directors delivered to the Chief Executive Officer by certified mail, return receipt requested, request an appellate

review by the Board. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

B. If such appellate review is not requested by the affected practitioner in writing within 10 days, the affected practitioner shall be deemed to have waived his/her right of the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 9.2 of this Article IX.

C. Within 10 days after receipt of such notice of request for appellate review, the Board of Directors shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall through the Chief Executive Officer, by written notice sent certified mail, return receipt requested, notify the affected practitioner of the same. The date of the appellate review shall not be less than 15 days, nor more that than 21 days, from the date of the notice to the practitioner of the appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may be reasonably made, but not more than 21 days from the date of receipt of such notice.

D. The appellate review shall be conducted by the Board of Directors or by a duly appointed appellate review committee of the Board of not less than 3 members. No member of the review committee shall be in direct economic competition with the practitioner and no more than one member shall be in the same clinical practice as the practitioner.

E. The affected practitioner shall have access to the report and record (and transcription, if any) of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him. He/she shall have the right to submit a written statement on his/her own behalf, in which those factual and procedural matters with which he/she disagrees, and his/her reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statements shall be submitted to the Board of Directors through the Chief Executive Officer by certified mail, return receipt requested, at least 5 days prior to the scheduled date for the appellate review. A similar statement may be submitted by the executive committee of the Medical Staff or by the chairman of the hearing committee appointed by the Board, and if submitted, the Chief Executive Officer shall provide a copy thereof to the practitioners at least 5 days prior to the date of such appellate review by certified mail, return receipt requested.

F. The Board of Directors or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph E. of this Section 9.6, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, may be represented by counsel or a person of his choosing and either practitioner or such representative shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him/her by any member of the appellate review body. The executive committee or the Board of Directors, whichever is appropriate, shall also be represented by an individual, including its attorney, who shall be permitted to speak in favor of the adverse recommendation of decision and who shall answer questions put to him/her by any member of the appellate review body.

G. New or additional matters not raised during the original hearing or in the hearing committee report, not otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Board or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

H. If the appellate review is conducted by the Board of Directors, it may affirm, modify or reverse its prior decision, or, in its discretion, refer the matter back to the executive committee of the Medical Staff for further review and recommendation within 10 days. Such referral may include a request that the executive committee of the Medical Staff arrange for a further hearing to resolve specified disputed issues.

I. If the appellate review is conducted by a committee of the Board of Directors, such committee shall, within 10 days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Board of Directors affirm modify or reverse its prior decision, or refer the matter back to the executive committee of the Medical Staff for further review and recommendation within 10 days. Such referral may include a request that the executive committee of the Medical Staff arrange for a further hearing to resolve disputed issues. Within 10 days after receipt of such recommendation after referral, the committee shall make its recommendation to the Board of Directors as above provided.

J. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 9.6 have been completed or waived. Where permitted by the hospital Bylaws, all action required of the Board may be taken by a committee of the Board of Directors duly authorized to act.

SECTION 9.7: Final Decision by Board of Directors

A. Within 10 days after the conclusion of the appellate review, the Board of Directors shall make its final decision in the matter and shall send notice thereof to the executive committee of the Medical Staff and, through the Chief Executive Officer, to the affected practitioner, by certified mail, return receipt requested. If this decision is in accordance with the executive committee's last recommendation in the matter it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If this decision is contrary to the Medical Staff's last such recommendation, the Board shall refer the matter to the President of the Medical Staff who will appoint representatives of the Medical Staff to meet with members of the Board as a joint conference committee for further review and recommendation within 10 days, and shall include in such notice of its decision a statement that a final decision will not be made until the joint conference committee's recommendation has been received. At its next meeting after receipt of the joint conference committee's recommendation, the Board of Directors shall make its final decision with like effect and notice as first above provided in this section 7.

B. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the executive committee of the Medical Staff, or by the Board of Directors, or by a duly authorized committee of the Board, or by both.

ARTICLE X: LICENSED INDEPENDENT PRACTITIONER HEALTH PROGRAM

SECTION 10.1: Overview of Licensed Independent Practitioner Health Program.

A process is in place to provide education about licensed independent practitioner health issues to address prevention of physical, psychiatric, or emotional illness; facilitate confidential diagnosis, treatment and rehabilitation of licensed

independent practitioners who suffer from a potentially impairing condition or who display significant disruptive behavior. The purpose of this process is assistance and rehabilitation, rather than discipline, to aid the practitioner in retaining or regaining optimal professional functioning, consistent with protection of patients. The Ad Hoc Licensed Independent Practitioner Health Committee is responsible for carrying out the process.

The Licensed Independent Practitioner Health Committee membership includes, but is not limited to, two physicians appointed by the President of the Medical Staff and the CEO/President of the Hospital.

ARTICLE XI: STANDARDS OF CONDUCT

SECTION 11.1: Expectations

Each Medical Staff member and Allied Health Professional will act in an ethical and professional manner with other members, employees, patients, and visitors. No member of the Medical Staff or Allied Health Professional Staff may engage in disruptive behavior. This behavior is defined as:

A. Verbal or physical conduct of any sort that creates a hostile, intimidating, or offensive work environment for another individual.

B. Verbal or physical conduct, including comments or illustrations in a medical record that maliciously denigrates that quality of care provided by the hospital or another individual associated with the hospital.

SECTION 11.2: Complaints and Concerns Related to Conduct

Reported incidents of unprofessional and/or disruptive behavior will be assessed and addressed through the Medical Staff Quality Improvement Committee and/or the President of the Medical Staff.

ARTICLE XII: FOCUSED REVIEW/FOCUSED PROFESSIONAL PRACTICE EVALUATION OF PRACTITIONER'S PERFORMANCE

SECTION 12.1: Definition of a Peer

For purposes of any activity classified as peer review under Wisconsin law, the term "peer" shall have the broadest meaning afforded under Wisconsin law; nonetheless, the peers included in the peer review process shall include at least one individual from the same discipline, with essentially equal qualifications.

SECTION 12.2: Focused Review/Focused Professional Practice Evaluation Process

Focused review is the process by which the diagnosis, care, and/or treatment of patients is reviewed and evaluated by those who have training and experience similar to the practitioner whose work is being evaluated. The purpose is to determine whether action is required to improve the practitioner's performance. Situations in which focused review is utilized may include but is not limited to: quality of care and patient safety evaluation triggered by significant individual variations from standard clinical practice; from the rules and regulations and/or delineated privileges; complaints/concerns from a patient/family or via occurrence reports; any additional triggers deemed appropriate by the Medical Staff. *Physician members of other Medical Staff committees may be utilized in the focused/clinical case review process. In general, this review process should be completed within 60 working days, or less.*

External focused review by a peer may require additional time. External review will be considered in the following circumstances: (a) when there is no other practitioner with similar training and experience, and the issue involves highly specialized clinical care, and (b) when the only practitioner with similar training and experience is a direct competitor or has a conflict of interest.

The detailed focused review process by peers may be found in a separate Medical Staff Quality Improvement Committee policy.

ARTICLE XIII: OFFICERS

SECTION 13.1: Officers of the Medical Staff

A. The officers of the Medical Staff shall be:
   1) Chief of Staff
   2) Vice Chief
   3) Secretary – Treasurer

SECTION 13.2: Qualifications of Officers

Officers shall be members of the Active Medical Staff at the time of nomination and election and shall remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

SECTION 13.3: Election of Officers

A. Officers shall be elected by mailed ballot in November. Only members of the Active Medical Staff shall be eligible to vote.

B. The Nominating Committee shall offer one or more nominees for each office.

C. Write-in nominations on ballots are also accepted.

SECTION 13.4: Term of Office

Officers shall take office on the first day of the Medical Staff year.

The term of office of the President is for a minimum of two years and re-elected annually thereafter for a maximum of four years. The term of office of the Vice President is understood to be one but may serve an additional one-year term if nominated and agreed to. The Secretary-Treasurer will serve a one year term. The Medical Staff President may be re-elected after a two-year break from office.

SECTION 13.5: Removal from Office

A. Any officer, whose election is subject to these Bylaws, may be removed from office for valid cause including, but not limited to, gross neglect or malfeasance in office, or serious acts of moral turpitude. Except as otherwise provided,

recall of a Medical Staff officer may be initiated by the executive committee or shall be initiated by a petition signed by at least one-third of the members of the Medical Staff eligible to vote.

B. Medical staff officers may be removed from their positions by vote of a majority of the members of the active Medical Staff. The affected physician should be notified in writing and the procedure described in Article VIII, Corrective Action, should be followed.

SECTION 13.6: Vacancies in Office

A. Vacancies in office during the Medical Staff year, except for the presidency, shall be filled by the executive committee of the Medical Staff. If there is a vacancy in the office of the President, the Vice President shall serve out the remaining term.

SECTION 13.7: Duties of Officers

A. President: the President shall serve as the chief administrative officer of the Medical Staff to:
   1) Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the hospital;
   2) Develop recommendations for committee chairpersons and member assignments, prior to assuming office, with consideration of member interests.
   3) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
   4) Chair the Medical Staff executive committee;
   5) Serve as ex officio member of all other Medical Staff committees without vote;
   6) Be responsible for the enforcement of Medical Staff Bylaws, rules, and regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
   7) Appoint committee members to all standing, special, and multi-disciplinary Medical Staff committees except the executive officer;
   8) Represent the views, policies, needs, and grievances of the Medical Staff to the Board of Directors and to the Chief Executive Officer;
   9) Receive, and interpret the policies of the board to the Medical Staff and report to the Board of Directors on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
   10) Be responsible for the educational activities of the Medical Staff;
   11) Be the spokesperson for the Medical Staff in its external professional and public relations; and
   12) Reviews all appropriate appointments and reappointments for Medical Staff membership and delineation of clinical privileges.
   13) Appoint Medical Director of Service Dyad leaders

B. Vice Chief: in the absence of the President, the Vice President shall assume all the duties and have the authority of the President. He/she shall be a member of the executive committee of the Medical Staff. He/She shall automatically succeed the President when the latter fails to serve for any reason.

C. Secretary – Treasurer: The Secretary shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the President, attend to all correspondence, and perform such other duties as ordinarily pertain to his/her office. He/she shall be a member of the executive committee of the Medical Staff.

D. Past-Chief: he/she shall be a member of the executive committee of the Medical Staff, and shall perform other such duties as assigned.

ARTICLE XIV: NON-DEPARTMENTALIZATION

SECTION 14.1: Organization

This is a non-departmentalized Medical Staff. There shall be services of but not limited to: Community medicine, emergency, surgery, adult inpatient, pediatric inpatient, and obstetrics in name only until staff membership increases and service delineation becomes practical. At such time as the Medical Staff determines that service delineation is practical, each service will be headed by a dyad leadership team including the Medical Director of service and a hospital-employed operational leader and will function under the Medical Staff executive committee. The Dyad leaders of each service shall maintain authority to ensure high quality service and care within their service.

SECTION 14.2: Qualification, Selection, and Tenure of Medical Directors of Services

A. Each director is certified by an appropriate specialty board or affirmatively establishes comparable competence through the credentialing process.

B. Each director shall be appointed for a one-year term, subject to approval of the Board of Directors.

C. Responsibilities of directors are defined in the Medical Staff Rules and Regulations.

D. Removal of a director during his/her term of office may be for valid cause including, but not limited to, gross neglect or malfeasance in office, or serious acts of moral turpitude. Except as otherwise provided, recall of a director may be initiated by the executive committee or shall be initiated by a petition signed by at least one-third of the members of the Medical Staff eligible to vote. Directors may be removed from their positions by vote of a majority of the members of the active Medical Staff. The affected physician will be notified in writing

ARTICLE XV: COMMITTEES

SECTION 15.1: Executive Committee

A. This committee shall consist of: Chief of Staff, Vice Chief of Staff; Secretary-Treasurer of Staff; Past Chief; Vice President of Medical Affairs, Chairperson of either Pharmacy and Therapeutics or Medical Records/Utilization Review, Chair of Medical Staff Quality Improvement, Chair of Credential Committee, Medical Staff Dyad leaders ; Quality Director, and Chief Nurse Officer or designee (without votes). Committee members may represent more than one Medical Staff committee or dyad and/or serve as an officer while at the same time representing a particular committee or service, but not more than two positions. The Chief Executive Officer of the hospital or his or her designee attends each executive committee meeting on an ex-officio basis without vote. The President of Staff is authorized to appoint one additional medical staff member to the medical executive committee as he/she deems appropriate. No member actively practicing in the hospital is ineligible for membership on the executive committee solely because of his or her professional discipline or specialty. A majority of voting committee members are fully licensed physician members of the Medical Staff actively practicing in the hospital. The Medical Staff delegates authority to the medical executive committee (MEC) to carry out basic Medical Staff responsibilities between Medical Staff meetings. The MEC has the primary authority for activities related to self-governance of the

Medical Staff and for the Medical Staff process[1], which includes oversight for the quality of professional services provided by individuals with clinical privileges.

B. Functions: the functions of the Medical Staff executive committee shall include, but are not limited to:

1. acting on behalf of the Medical Staff between Medical Staff meetings;
2. reviewing and acting on reports of Medical Staff committees and other assigned activity groups;
3. requesting evaluations of practitioners privileged through the Medical Staff process in instances where there is doubt about an applicant's ability to perform the privileges requested;
4. organizing the Medical Staff's performance improvement and patient safety activities and establishing a mechanism designed to conduct, evaluate, and revise such activities;
5. developing the mechanism by which Medical Staff membership may be terminated; and
6. creating the mechanism designed for use in fair hearing procedures.

The executive committee is responsible for making Medical Staff recommendations directly to the governing body for its approval. Such recommendations pertain to at least the following:

- the Medical Staff's structure
- the mechanism used to review credentials and to delineate individual clinical privileges
- recommendations of individuals for Medical Staff membership;
- recommendations for delineated clinical privileges for each eligible individual;
- the participation of the Medical Staff in organization performance improvement and patient safety activities;
- the mechanism by which Medical Staff membership may be terminated; and
- the mechanism for fair hearing procedures.

C. For purposes of fast track credentialing, the President of the Medical Staff and the Credentials Committee Chair are authorized to act on behalf of the Medical Staff executive committee to make recommendations of individuals for Medical Staff membership and delineated clinical privileges if defined criteria are met as outlined in the fast track policy.

D. Duties: In addition to functional responsibilities listed in B, the duties of the officers of the Medical Staff, in collaboration with the other members of the medical executive committee, shall be:

1) To ensure that all Medical Staff committee responsibilities are fulfilled, to seek input from colleagues and from non-medical disciplines when decisions made will impact those individuals and/or areas/departments, and to communicate in a timely manner to members.
2) To ensure Medical Staff representation in any hospital deliberation affecting the discharge of Medical Staff responsibilities, and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
3) To implement policies of the Medical Staff not otherwise the responsibility of designated committees;
4) To make recommendations on medico-administrative and Hospital management matters to include assessing and recommending off-site and/or contracted sources for needed patient care services;
5) To fulfill the Medical Staff's accountability to the Board of Directors for quality medical care rendered to patients in the hospital through the monitoring and evaluation of the safety, quality and appropriateness of patients' care and to seek opportunities to improve that care, as well as recommendations on the mechanism used to conduct, evaluate, and revise performance improvement activities;
6) To ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital;

[1] Joint Commission: Hospital Accreditation Standards, 2004: 301.

7) To provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;
8) To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in the Medical Staff, corrective or review measures to withhold privileges, terminate membership in the Medical Staff, and assure that fair hearing procedures are carried out.
9) To designate the time and place for all regular Medical Staff meetings.

E. Meetings: The medical executive committee will meet a minimum of six times per year. Additional meetings may occur at the request of the President of the staff, the Chief Executive Officer or when requested by two or more active staff members.

F. Removal from Executive Committee: Any executive committee member may be removed from the executive committee for valid cause including, but not limited to, gross neglect or malfeasance in office, or serious acts of moral turpitude. Except as otherwise provided, recall of an executive committee member may be initiated by the executive committee or shall be initiated by a petition signed by at least one-third of the members of the Medical Staff eligible to vote. The executive committee member may be removed from their position by vote of a majority of the members of the active Medical Staff. The affected physician should be notified in writing and the procedures described in Article VIII, Corrective Action, should be followed.

SECTION 15.2: Medical Staff Bylaws Committee

The committee will be an Ad Hoc Committee appointed by the President of the Medical Staff. The committee shall be responsible for making recommendations relating to revisions to and updating of the Bylaws, rules, and regulations of Medical Staff and shall meet as the need occurs.

SECTION 15.3: Nominating Committee

The committee will be an Ad Hoc Committee appointed by the President of the Medical Staff. The committee shall be responsible for developing nominations for the slate of officers. The committee ensures that each September, an opportunity is provided for all Medical Staff members to indicate their interest in serving during the next year as an officer, committee chair, or committee member. This information is compiled by the Medical Staff coordinator who makes it available for use in developing nominations for officers, and later for the incoming chief of staff to consider in developing recommendations for medical director, committee chair and member appointments.

SECTION 15.4: Credentials Committee

The committee shall consist of, but not be limited to, three physicians from the Medical Staff, Chief Executive Officer, chief nurse officer, and director of quality improvement. The function of this committee is to review the credentials of all applicants to the Medical Staff and to make recommendations for staff membership and delineation of clinical privileges. The committee will also review the applications for reappointment and make recommendations relating to any changes requested in clinical privileges. All recommendations will be reported to the executive committee and the Board of Directors, for approval. This committee shall meet a minimum of four times a year and more frequently as necessary.

SECTION 15.5: Medical Staff Quality Improvement Committee (MSQI)

The purpose of the committee is to continually improve patient safety, satisfaction and quality of care. The committee shall consist of, but not be limited to, three physicians, the Chief Executive Officer or designee, and the Director of Quality Improvement and Mission Effectiveness, President of the Medical Staff, Chief Nurse Officer, and Vice President of Medical Affairs. The physician members shall serve two-year terms, and the committee shall meet at least nine times a year. The committee membership shall consist of a majority of physicians and the peer/clinical case review is conducted and performed by physician members only.

The Committee shall perform the following functions:

- Peer/clinical case review
- Overseeing the peer/clinical case review process and monitoring of that process for timeliness and effectiveness.
- Reviewing patterns or trends related to an individual's performance, and determining these patterns/trends use in peer review; determining and monitoring of a Performance Improvement Plan and/or and communicating the results to the Credentials Committee to be used in the reappointment and privileging processes.
- Improvement of clinical practice, patient safety and communication among the care givers.
- Maintaining a leadership role in the measurement, assessment and improvement of processes which are dependent primarily on the activities of one or more individuals with clinical privileges. Unless delegated to another committee, this includes, but is not limited to: medical assessment and treatment, medication use, blood use, operative and other invasive procedures, effectiveness of clinical practice patterns, and significant departures from established patterns of clinical practice.
- Participating in the measurement, assessment, and improvement of other patient care processes (patient education, chart documentation, coordination of care), and processes having an impact on the delivery of care.
- Communicating the findings, conclusions, recommendations and actions taken to improve patient safety and organizational performance to the medical executive committee and appropriate Medical Staff members. This committee reports regularly to the medical executive committee.

SECTION 15.6: Infection Prevention and Control Committee

The Infection Prevention and Control Committee shall consist of, but not be limited to, the pathologist, the infection control coordinator (who is the designated 'infection control officer'), and the following representatives from the hospital staff: chief nurse officer or designee or administrative designee, clinical managers from OB and OR, and the laboratory manager or designee. Others areas, such as housekeeping, maintenance, and human resources, will be involved as necessary. This is a joint hospital and Medical Staff committee, which is responsible for overseeing a coordinated process to prevent and/or reduce the risks of healthcare associated infections (HAI) in patients, employees, Medical Staff members, volunteers, and visitors. The Committee shall meet at least quarterly. It shall perform the following functions:

- ensuring that the infection control process is based on sound epidemiological principles and research;
- complying with all state, federal, and other applicable regulatory requirements;
- defining those issues that are epidemiologically important to the hospital;
- establishing policies for the surveillance, prevention and control of infection and procedures, including those employee health policies related to infectious diseases;
- provide for orientation and continuing education of employees and others as appropriate;
- ensuring that the infection control program is connected with the local health department(s) for required reporting and appropriate follow-up within the community;
- establishing the plan for identifying and isolating HAI infections and monitoring of other infection prevention and control activities;
- receiving surveillance and other data, including observations of environmental conditions and staff practices having potential impact on infection rates;

- identifying opportunities to improve and taking action to prevent or reduce the risk of HAI infections in patients, employees, Medical Staff members, volunteers, and visitors;
- reporting to the Medical Staff executive committee at least twice a year.

SECTION 15.7: Pharmacy and Therapeutics Committee

The committee shall consist of, but not be limited to, one member of the Medical Staff, director of pharmacy, chief nurse officer or designee, clinical nurse manager, and QI Director or designee. This committee will meet at least quarterly. The P&T Committee shall perform the following functions:

- formulary management;
- development and/or review of medication-related policies and procedures, especially those that minimize errors;
- compliance with applicable regulatory requirements;
- recommending or assisting in the development of methods to meet the educational needs of medical and hospital staff related to medication use;
- ensuring that information relating to drug interactions and drug therapy is available to the professional staff;
- monitoring and assessment, opportunity identification, recommending or taking action to improve medication use and safety; and
- follow-up to ensure the effectiveness of actions taken to improve; and;
- reporting to the Medical Staff executive committee at least twice a year.

SECTION 15.8: Medical Records and Utilization Review Committee

The medical records and utilization review committee shall consist of at least two members of the Medical Staff, chief nurse officer or designee, chief financial officer or designee, social services, nurse manager, utilization representative, health information manager, quality director or designee, and coding specialist. The committee will meet quarterly.

This is a joint hospital and Medical Staff committee which is responsible for overseeing the timeliness and quality of medical record documentation and the utilization review process. Its functions include, but are not limited to:

- Monitoring of the timeliness, accuracy and completeness of medical records, including quarterly record reviews;
- Ensuring that the utilization review plan remains current;
- Monitoring of utilization outcomes and identification of potential areas of opportunity;
- Provision of information to hospital and Medical Staff relative to areas of responsibility;
- Ensuring compliance with regulatory requirements relative to medical records and utilization;
- Making recommendations to the Medical Staff and/or Senior Hospital Leadership;
- Reporting to the Medical Staff executive committee quarterly.

SECTION 15.9: Safety Committees

The Medical Staff shall receive regular reports from the safety environment of care committee and patient safety committee. The Chief of the Medical Staff shall assign a member to be a liaison with each committee. This committee will report to the full Medical Staff executive committee at least twice a year.

SECTION 15.10: Board of Directors Quality Committee

The Medical Staff shall actively participate in the Board of Directors Quality Committee by representation of the President of the Medical Staff and two physicians appointed by the President of the Medical Staff. The President of the Medical Staff will report to the full Medical Staff on activities of this committee, as appropriate.

ARTICLE XVI: MEDICAL STAFF MEETINGS

SECTION 16.1: Regular Meetings

A. Medical staff meetings shall be held a minimum of twice a year. The staff meeting at the end of each Medical Staff year shall be the annual staff meeting at which the results of elections of officers for the ensuring period shall be announced. Committee chairperson and member appointments are also presented for ratification by the membership at the annual staff meeting or an immediately following meeting.

B. Minutes of all deliberations of the Medical Staff are available for review by members.

SECTION 16.2: Special Meetings

A. The President of the Medical Staff, the officers, or not less than one-fourth of the members of the active Medical Staff may at any time file a written request with the President that within 10 days of the filing of such request, a special meeting of the Medical Staff be called. The President and/or officers shall designate the time and place of any such special meeting.

B. Written or printed notice stating the place, day, and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, to each member of the active staff not less than 3 ~~nor~~or more than 14 days before the date of such meeting, or at the direction of the President. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his/her address as it appears on the records of the hospital. Notice may also be sent to members of other Medical Staff groups who have so requested. The attendance of a member of the Medical Staff at the meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

SECTION 16.3: Quorum

Fifty percent of the total membership, in person or by proxy prior to the regular or special meeting, of the active Medical Staff at any regular or special meeting shall constitute a quorum for purposes of amendment of these Bylaws, rules and regulations, and the presence of twenty-five percent of such membership a quorum for all other actions.

SECTION 16.4: Attendance Requirements

Each member of the active Medical Staff is strongly encouraged to attend all assigned committee and regular Medical Staff meetings. Physicians unable to attend will receive copies of the minutes as soon as completed.

SECTION 16.5: Agenda

A. The agenda at regular Medical Staff meeting shall include:
   1. Acceptance of the minutes of the regular and special meetings;
   2. Performance improvement updates, monitoring results, and/or MSQI Report;

3. Other Committee Reports, as required;
4. Review of unfinished business;
5. Chief executive officer report;
6. Patient care executive report;
7. New business (including elections, where appropriate);
8. Chief of Staff Report on Board activities.

B. The agenda at special meetings shall be:
1. Reading of the notice calling the meeting
2. Transaction of business for which the meeting was called
3. Adjournment

ARTICLE XVII: COMMITTEE MEETINGS

Committee chairs and members are appointed by the President of Staff, and are ratified by the executive committee. Existing committees continue to function until the newly appointed chairs are approved by the Board.

SECTION 17.1: Regular Meetings

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

SECTION 17.2: Special Meetings

A special meeting of any committee may be called by or at the request of the chairperson or chief thereof, by the President of the Medical Staff, or by one-third (but not less than two) of the group's members.

SECTION 17.3: Notice of Committee Meetings

Written or oral notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be provided to each member of the committee not less than two days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his/her address as it appears on the records of the hospital with postage thereon paid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

SECTION 17.4: Quorum

Fifty percent of the active staff members of a committee shall constitute a quorum at any meeting. There shall be at least one physician from the active staff present at a committee meeting for a quorum.

SECTION 17.5: Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote.

SECTION 17.6: Rights of Ex Officio Members

Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum and they shall not vote.

SECTION 17.7: Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and shall be reviewed at the next Medical Staff meeting. Copies of the Medical Staff minutes will also be distributed to the Board of Directors. The Administrative Office or their designee shall maintain a permanent file of the Medical Staff minutes of each meeting. The appropriate department manager shall maintain a permanent file of committee minutes for each meeting, and forward a copy of each to the Quality Department.

SECTION 17.8: Committee Attendance

Each committee member shall be strongly encouraged to attend not less than one-half of all meetings of his/her committees in each year. This is a responsibility of Medical Staff membership and is an opportunity to have one's voice heard. Absences by members shall be shown in the minutes.

ARTICLE XVIII: IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at this hospital:

First, that any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

Second, that such privilege shall extend to members of the hospital's Medical Staff and of its Board of Directors, its other practitioners, its Chief Executive Officer and his representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XVIII, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Board or of the Medical Staff.

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

Fourth, that such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to: 1) applications for appointment or clinical privileges, 2) periodic reappraisals for reappointment or clinical privileges, 3) corrective action, including summary suspension, 4) hearings and appellate reviews, 5) medical care evaluation, 6) utilization reviews, and 7) other hospital, service, or committee activities related to quality patient care and interprofessional conduct.

Fifth, that the acts, communications, reports, recommendations and disclosures referred to in this Article XVIII may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Sixth, that in furtherance of the foregoing, each practitioner shall upon request of the hospital execute a release in accordance with the tenor and import of this Article XVIII in favor of the individuals and organizations specified in the second paragraph, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state.

Seventh, that the consents, authorizations, releases, rights, privileges and immunities provided by Sections 6.1 and 6.2 of Article VI of these Bylaws (Procedure for Appointment and Reappointment) for the protection of this hospital's practitioners, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XVIII.

ARTICLE XIX: RULES AND REGULATIONS

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Board of Directors. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations shall be a part of these Bylaws. The Rules and Regulations may be amended only in accordance with procedures set forth in these Bylaws. Such changes shall become effective when approved by the Board of Directors. The rules and regulations should be reviewed at least every three years and revised as necessary to reflect current practices.

ARTICLEXX: AMENDMENTS

These Bylaws, rules and regulations may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. A proposed amendment may be referred to a special committee, which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. To be adopted, an amendment shall require a fifty percent vote of the active Medical Staff, in person or by proxy prior to the meeting. Amendments so made shall be effective when approved by the Board of Directors. Neither the Medical Staff nor the Board of Directors may unilaterally amend the Medical Staff Bylaws. The Bylaws should be reviewed at least every three years and revised as necessary to reflect current practices.

ARTICLE XXI: ADOPTION

These Bylaws together with the appended rules and regulations, shall be adopted at any regular or special meeting of the active Medical Staff, shall replace any previous Bylaws, rules and regulations and shall become effective when approved by the Board of Directors of the hospital. Copies of the revised Bylaws shall be provided to all members of the Active Medical Staff and any other members of the Medical Staff or allied health staff as applicable.

ADOPTED AS AMENDED by the active Medical Staff on December 13, 2011.

_____ President of Medical Staff

_____ Secretary of Medical Staff

APPROVED by the Board of Directors on December 13, 2011.

_____ Secretary of the Board of Directors