MEDICAL STAFF BYLAWS:
Credentialing Manual

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions set forth in the Medical Staff Bylaws: Medical Staff Governance and Organization Manual apply to all Medical Staff governing documents unless otherwise indicated.

1.B. TIME LIMITS

Time limits referred to in the Bylaws and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.B.1 Nature of Medical Staff Membership and Clinical Privileges

Membership on the Medical Staff is a privilege which shall be extended only to those physicians, dentists, oral surgeons, and podiatrists who have demonstrated professional competence and meet and continue to meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and as may be established by the Medical Staff and the Board. Every patient treated at the Hospital must be under the care of a member of the Medical Staff or appropriately privileged PHP. No physician, dentist, oral surgeon, podiatrist, or PHP shall provide services to patients in the Hospital unless such provider has been appropriately granted clinical privileges to do so. A doctor of medicine (MD) or osteopathy (DO) shall be responsible for the care of each patient with respect to any medical or psychiatric condition that is not within the scope of practice and clinical privileges of a non-MD/DO.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1 Threshold Eligibility Criteria:

Only those physicians, dentists, oral surgeons, podiatrists, and PHPs who can document their licensure, certification, background, education, training, experience, professional competence, health status, adherence to the ethics of their profession and Hospital and Medical staff policies, good reputation, character, judgment, and ability to work with others shall be qualified for Medical Staff membership and/or clinical privileges. Additionally, to be considered for and to obtain and to maintain membership, all applicants must meet the requirements of any Medical Staff development plan adopted by the Board and in effect at the time of application and as may be amended from time to time. With the exception of Honorary Staff, only those providers who can continuously demonstrate or provide evidence of the following qualifications to the satisfaction of the MEC and Board will be eligible for appointment or reappointment to the Medical Staff and/or the granting of clinical privileges:

(a) have a current, unrestricted license to practice in Wisconsin and have not had a license, certification, or registration to practice revoked, suspended, or limited by any state licensing agency in the last five (5) years;

(b) have a current, unrestricted DEA registration if the provider's practice involves prescribing controlled substances;

(c) be located (office and residence) close enough to the Hospital to fulfill applicable responsibilities and to provide timely and continuous care for patients in the Hospital;

(d) have or agree to make appropriate coverage arrangements (as determined by the Credentials Committee) with other care providers for those times when the provider is unavailable;

(e) be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of patients in a prompt, efficient, and conscientious manner consistent with granted clinical privileges. ("Appropriate coverage" means coverage by another member of the Medical Staff with specialty-specific privileges equivalent to the provider for whom the Medical Staff member is providing coverage.) Compliance with this eligibility requirement means that the provider must document willingness and ability to:

(1) respond ASAP, but at least within 15 minutes, via electronic messaging or phone, to urgent or emergent electronic messaging from the Hospital and respond within 30 minutes, via electronic messaging or phone, to all other electronic messaging from the hospital;

(2) appear in person to attend to a patient within 60 minutes of being requested to do so; and

(3) fulfill responsibilities regarding assigned call coverage for such provider's specialty;

(f) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital and participate in the Injured Patients and Families Compensation Fund;

(g) have not been convicted of or entered a plea of guilty, an Alford plea, or a plea of no contest to Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same within the last five (5) years;

(h) are not currently excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care programs;

(i) have not had Medical Staff appointment, clinical privileges, or status as a participating provider denied, revoked, restricted, suspended, or otherwise affected by any health care facility, health plan, or other organization for reasons related to clinical competence or professional conduct within the last five (5) years;

(j) have not resigned affiliation or Medical Staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation within the last five (5) years;

(k) have never been convicted of or entered a plea of guilty, an Alford plea, or a plea of no contest to any felony or to any misdemeanor relating to controlled substances, illegal drugs, violence, abuse or neglect of a child, or any other offense that would serve as a bar to the individual acting as a caregiver pursuant to the Wisconsin Caregiver Law;

(l) have satisfied all additional eligibility qualifications relating to the provider's specific area of practice that may be established by the Hospital;

(m) have demonstrated acceptable clinical activity in the areas of practice in which the provider is requesting privileges;

(n) have met any current eligibility requirements and will meet any future eligibility requirements that are applicable to the clinical privileges being sought;

(o) have met the specific conditions and requirements set forth in that contract if applying for clinical privileges in an area that is covered by an exclusive contract;

(p) have provided proof of compliance with all applicable communicable disease and/or vaccination requirements;

(q) have a written agreement with a Sponsoring Member, which must meet all applicable requirements of state law and Hospital policy, if seeking clinical privileges as a PHP Category 2 or 3;

(r) have successfully completed (for those seeking appointment to the Medical Staff):

(1) a residency training program approved by the Accreditation Council for Graduate Medical Education ("ACGME"), the American Osteopathic Association ("AOA"), or equivalent training, in the specialty in which the applicant seeks clinical privileges;

(2) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"); or

(3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;

(s) be board certified in the provider's primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties or ABMS International ("ABMS"), the AOA, or a certification board equivalent to the ABMS or AOA; the American Board of Oral and Maxillofacial Surgery; the American Board of Dental Specialties ("ABDS"); the Royal College of Physicians and Surgeons of Canada; or the American Board of Podiatric Surgery; as applicable if seeking appointment to the Medical Staff, and unless otherwise provided for in these Bylaws.

A provider who is not board certified at the time of application but who has completed residency or fellowship training must obtain and maintain board certification within the time period required by the certifying board.

Providers who were appointed to the Medical Staff prior to December 1, 2007, and who were not board certified shall not be required to become board certified as a condition of continued Medical Staff membership and/or clinical privileges, provided they otherwise meet the established competency requirements and other relevant criteria established by the Medical Staff and Board. As of January 1, 2019, if board certified, every provider must maintain board certification in the provider's primary area of practice as a condition of continuing membership and/or clinical privileges.

2.A.2 Exceptional Circumstances:

(a) In exceptional circumstances, the MEC and Board may consider a potential initial or reappointment/renewal applicant who does not meet one or more of the threshold eligibility criteria outlined above but who possesses alternative credentials that the MEC or Board has reason to find that the potential applicant would serve an identified benefit to the Hospital, Medical Staff, and the applicant's patients. The applicant requesting the acceptance of alternative criteria bears the burden of demonstrating exceptional circumstances and that the applicant's alternative credentials are

equivalent to, or exceed, the criteria in question. In these exceptional circumstances, the Board may accept such alternative information upon recommendation of the MEC, if the provider demonstrates, at the MEC's and Board's sole discretion, equivalent training, education, experience, and ability to competently perform the clinical privileges requested. All such determinations must take into consideration documented Hospital and/or community need. The MEC shall document the exceptional circumstances supporting any such recommendation and forward such documentation with its recommendation. Any recommendation to accept alternative information must include the specific basis for the recommendation. An exceptional circumstance decision based on alternative information for a given applicant does not alter or modify applicable eligibility criteria. A determination of exceptional circumstances and acceptance of alternative credentials or information by the MEC and Board is conditioned upon the provider continuously satisfying the alternative, which may be reviewed at the discretion of the MEC and Board at recredentialing or at intervals as otherwise determined by the MEC and Board.

(b) No applicant is entitled to a hearing if the Board determines not to accept alternative information.

(c) A determination that an applicant is not entitled to an alternative criteria determination is not considered a denial of appointment or clinical privileges.

2.A.3 Factors for Evaluation:

The following factors will be evaluated as part of the request for clinical privileges, appointment, and reappointment processes, as applicable:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of the provider's profession, continuous professional development, an understanding of and sensitivity to diversity, and a responsible attitude toward patients and the provider's profession;

(c) good reputation and character;

(d) ability to safely and competently perform the requested clinical privileges;

(e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable the provider to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, the Hospital's mission and commitment to quality and safe care and a recognition that interpersonal skills and collegiality are essential to the provision of quality and safe patient care.

2.A.4 No Entitlement to Appointment and/or Clinical Privileges:

No individual is entitled to receive an application, to be appointed or reappointed to the Medical Staff, or to be granted particular clinical privileges merely because such individual

(a) is licensed to practice a profession in this or any other state;

(b) is a member of any particular professional organization;

(c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;

(d) resides in the geographic service area of the Hospital; or

(e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5 Nondiscrimination:

No individual will be denied clinical privileges or a scope of practice, appointment, or reappointment on the basis of gender, race, creed, sexual orientation, ethnicity, disability, age, or national origin.

2.B. GENERAL CONDITIONS OF PRACTICE, APPOINTMENT & REAPPOINTMENT

2.B.1 Duties and Responsibilities:

As a condition of being granted clinical privileges, as a condition of consideration for appointment, reappointment, and/or clinical privileges, and as a condition of continued appointment and/or clinical privileges, each provider specifically agrees to the following:

(a) to provide continuous and timely care to all patients for whom the individual has responsibility;

(b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed or has been granted clinical privileges;

(c) to participate in Medical Staff affairs through committee service;

(d) to meaningfully participate in Hospital- or Medical Staff-sponsored quality improvement initiatives, utilization management, and PPE activities, and by performing such other reasonable duties and responsibilities as may be assigned;

(e) within the scope of the provider's privileges, to provide emergency service call coverage, consultations, and care for unassigned patients;

(f) to comply with clinical practice protocols and guidelines pertinent to the provider's medical specialty, as may be adopted by the Medical Staff or the Medical Staff Leaders, or clearly document the clinical reasons for variance;

(g) to comply with clinical practice protocols and guidelines that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or to clearly document the clinical reasons for variance;

(h) to inform the CMO or the President of the Medical Staff, in writing, of any change in the provider's status or any change in the information provided on the provider's application form. This information will be provided with or without request, at the time the change occurs, and will include, but not be limited to:

(1) any and all complaints regarding, or changes in, licensure status or DEA controlled substance authorization;

(2) changes in professional liability insurance coverage or the filing of a professional liability claim, lawsuit, request for mediation against the provider, settlement, or order of a final judgment, including dismissal;

(3) changes in the provider's Medical Staff status (appointment and/or privileges) at any health care facility, health plan, or other organization as a result of peer review activities;

(4) any arrest, charge, indictment, conviction, Alford plea, or plea of guilty or

no contest in any criminal matter;

(5) exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed; and

(6) any changes in the provider's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction, and any charge of, or arrest for, driving under the influence ("DUI"). (Any DUI incident will be reviewed by the President of the Medical Staff and the CMO so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review as provided for in this Manual or applicable Medical Staff policies.)

(i) to immediately submit to an appropriate evaluation, at the provider's expense, which may include diagnostic testing (such as blood and/or urine test) or to a complete physical, mental, and/or behavioral evaluation, if at least two (2) Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital leadership team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations will be determined by Medical Staff Leadership, and the Medical Staff member will execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;

(j) to maintain a current e-mail address with Medical Staff Services, which will be the official mechanism used to communicate all Medical Staff information to the member or individual;

(k) to appear for personal or phone interviews in regard to an application for practice or for initial appointment or reappointment, if requested;

(l) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(m) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised for Medical Staff;

(n) to refrain from deceiving patients as to the identity, status, or profession of any individual providing treatment or services;

(o) to seek consultation whenever necessary;

(p) to complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital;

(q) to perform all services and conduct oneself at all times in a cooperative and professional manner, and to resolve in a timely manner any validated complaints received from patients or staff;

(r) to comply with all communicable disease and/or vaccination requirements as set forth in applicable Medical Staff policies;

(s) to pay any applicable dues, assessments, and/or fines promptly;

(t) to satisfy continuing medical education and training requirements;

(u) to participate in an Organized Health Care Arrangement with the Hospital and abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital;

(v) to authorize the Hospital to obtain a Caregiver Background Check as necessary; and

(w) that any misstatement in or omission from the application is grounds for the Hospital to stop processing the application. If clinical privileges or appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished. In either situation, there will be no entitlement to the procedural rights in Article 8 of this Manual.

2.B.2 Burden of Providing Information:

(a) An applicant seeking appointment, reappointment, and/or clinical privileges has the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts about the qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the applicant's practice, information from insurers or managed care organizations in which the applicant participates, and/or receipt of confidential evaluation forms completed by referring providers.

(b) Providers seeking appointment, reappointment, and/or clinical privileges have the burden of providing evidence to the satisfaction of the MEC and/or Board that all the statements made and information given on the application are accurate and complete.

(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete thirty (30) days after the applicant has been notified of the additional information required will be considered withdrawn.

(d) The provider seeking appointment, reappointment, and/or clinical privileges is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

2.C. APPLICATION

2.C.1 Information:

(a) Applications for appointment, reappointment, and/or clinical privileges must contain a request for specific clinical privileges (as applicable) and will require detailed information concerning the applicant's professional qualifications. The template application for initial appointment, reappointment, and/or clinical privileges in effect and as may be revised from time to time is incorporated by reference and made a part of this Manual.

(b) In addition to other information, a completed application must contain the following:

(1) information as to whether the applicant's scope of practice, medical staff appointment, or clinical privileges have been voluntarily or involuntarily

relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed by any other hospital, health care facility, or other organization, or are currently being investigated or challenged;

(2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, limited, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience, including past and pending claims, requests for mediation, lawsuits, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the MEC, or the Board may request;

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and

(5) a copy of a government-issued photo identification, which must be verified in person or via use of a telecommunications link that includes both audio and video capabilities prior to providing care, treatment, or services for patients.

(c) The applicant will sign the application and certify that the applicant is able to perform the requested clinical privileges and the responsibilities of membership.

ARTICLE 3

PROCEDURE FOR APPOINTMENT AND/OR CLINICAL PRIVILEGES

3.A. PROCEDURE FOR APPOINTMENT AND GRANTING OF CLINICAL PRIVILEGES

3.A.1 Application:

(a) Applications for membership and/or clinical privileges at the Hospital will be in writing and will be on forms approved by the Board, upon recommendation by the MEC and Credentials Committee.

(b) Applicants will be sent a letter that

(1) outlines the threshold eligibility criteria for clinical privileges or appointment outlined earlier in this Manual,

(2) outlines the applicable criteria for the clinical privileges being sought, and

(3) encloses the application form.

(c) Any applicant who is ineligible for membership and/or clinical privileges, who is seeking clinical privileges not recognized, or who is in a discipline of providers that has not been approved by the Board to practice at the Hospital will not receive an application. A determination of ineligibility does not entitle the provider to the procedural rights provided for in these Bylaws.

(d) Applications may be provided to residents or fellows who are in the final nine

months of their training. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.

3.A.2 Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to Medical Staff Services. The application fee must accompany the application.

(b) As a preliminary step, the application will be reviewed by Medical Staff Services (and CMO, if necessary) to determine that all questions have been answered and that the applicant satisfies all threshold criteria. Incomplete applications will not be processed. Any applicant who fails to return a completed application or fails to meet the threshold eligibility criteria will be notified that the applicant's application will not be processed. A determination of ineligibility does not entitle the applicant to the hearing and appeal rights outlined in this Manual.

(c) Medical Staff Services will oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received.

3.A.3 Steps to Be Followed for All Initial Applicants:

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application and obtained from references and other available sources, including the applicant's past or current department chiefs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(b) One or more interview(s) with the applicant may be conducted. The purpose of the interview(s) is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. The interview(s) may be conducted by any of the following: the department chief, the section chief, the Credentials Committee, a Credentials Committee representative, the MEC, the President of the Medical Staff, the CMO, and/or the COO.

3.A.4 Review by Department Chief/Section Chief:

(a) Medical Staff Services will transmit the complete application and all supporting materials to the chief of each department or section (as appropriate) in which the applicant seeks clinical privileges. Each chief will complete a report stating whether the applicant has satisfied all of the qualifications for appointment and the requested clinical privileges, as applicable, on a form provided by Medical Staff Services.

In preparing this report, the department or section chief has the right to meet with the applicant (and the Sponsoring Member, if applicable) to discuss any aspect of the application, qualifications, and requested clinical privileges. The department or section chief may also confer with experts within the department and outside of the department (e.g. other providers, appropriate supervisors within the department, and/or nurse managers) in preparing the report.

(b) The department or section chief will be available to the reviewing committees to answer any questions that may be raised with respect to that chief's report and findings.

3.A.5 Credentials Committee Procedure:

(a) The Credentials Committee will review and consider the report prepared by the department or section chief and may interview the applicant. Thereafter, the Credentials Committee will make a recommendation to the MEC.

(b) The Credentials Committee may use the expertise of the department chief, any member of the department, or an outside consultant if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise eligible for appointment and privileges, the Credentials Committee will determine if there is any question about the applicant's ability to practice, perform the privileges requested, or undertake the responsibilities of appointment. If questions or concerns are identified, the Credentials Committee may require the applicant to undergo a physical, mental, and/or behavioral examination by a physician(s) or recognized physicians' health program satisfactory to the Credentials Committee. The results of this examination will be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee will be considered a voluntary withdrawal of the application and all processing of the application will cease. The cost of the health assessment will be borne by the applicant.

(d) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior or to clinical issues (e.g. general consultation requirements, proctoring, or completion of CME and other education requirements). The Credentials Committee may also recommend that clinical privileges or appointment be granted for a period of less than two years in order to permit closer monitoring of an applicant's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) of this Manual, such conditions do not entitle an applicant to request the procedural rights set forth in Article 8 of this Manual.

(e) The Credentials Committee's recommendation will be forwarded to the MEC.

3.A.6 Medical Executive Committee Recommendation:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the MEC will:

(1) adopt the findings and recommendation of the Credentials Committee as its own;
(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or
(3) state its reasons in its report with recommendations, along with supporting information, justifying its disagreement with the Credentials Committee's recommendation.

(b) If the recommendation of the MEC is to appoint and/or grant clinical privileges, the recommendation will be forwarded to the Board through the President of the Medical Staff.

(c) If the recommendation of the MEC would entitle the applicant to request a hearing, the MEC will forward its recommendation to the COO, who will promptly send special notice to the applicant within thirty (30) days. The COO will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7 Board Action:

(a) The Board may delegate to a committee, consisting of at least three (3) Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the MEC and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any health care facility, health plan, or other organization;

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a settlement or final judgment against the applicant;

(4) unfavorable peer evaluations; or

(5) Department of Justice or criminal background reports indicating prior behavior relevant to appointment.

Any decision reached by the Board committee to grant clinical privileges or appoint will be effective immediately and will be forwarded to the Board for ratification at its next meeting.

(b) When there has been no delegation to a Board committee, upon receipt of a recommendation that the applicant be granted clinical privileges and appointment, the Board may:

(1) appoint the applicant and grant clinical privileges as recommended;

(2) refer the matter back to the Credentials Committee or MEC or to another source inside or outside the Hospital for additional research or information;

or

(3) reject or modify the recommendations

If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the President of the Medical Staff. If the Board's determination remains unfavorable to the applicant, the COO will promptly send special notice to the applicant within 30 days that the applicant is entitled to request a hearing.

Any final decision by the Board to grant, deny, revise, or revoke appointment and/or clinical privileges will be disseminated to the applicant within thirty (30) days of the decision and, reported to appropriate entities as required.

3.A.8 Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 4
CLINICAL PRIVILEGES

4.A CLINICAL PRIVILEGES

4.A.1 General:

(a) Appointment or reappointment will not confer any clinical privileges or right to admit or manage patients at the Hospital. Providers are entitled to exercise only those clinical privileges specifically granted by the Board.

(b) In order for a request for privileges to be processed, the applicant must satisfy any applicable threshold eligibility criteria.

(c) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with the contract.

(d) Requests for clinical privileges that have been grouped into core privileges will not be processed unless the applicant has applied for the full core privileges and satisfied all threshold eligibility criteria.

(e) Clinical privilege determinations will be based upon consideration of the following factors:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) information resulting from PPE and other performance improvement activities as applicable;

(5) provider-specific data as compared to aggregate data, when available;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Hospital's available resources and personnel;

(8) any previously successful or currently pending challenges to any licensure or registration or the voluntary or involuntary relinquishment of such licensure or registration;

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at any health care facility, health plan, or other organization;

(10) availability of qualified staff members to provide coverage in the case of the applicant's illness or unavailability;

(11) morbidity and mortality data related to the specific applicant, when statistically and qualitatively significant and meaningful and when available; and

(12) professional liability actions, especially any such actions that reflect an

unusual pattern or excessive number of actions.

(f) The applicant has the burden of establishing the applicant's qualifications and current competence for all clinical privileges requested.

(g) The report of the chief of the clinical department or section (as appropriate) in which privileges are sought will be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

(h) Clinical privileges, if granted, will be valid for a period of not more than two (2) years.

4.A2 Provisional Period to Confirm Competence:

All initially-granted clinical privileges, whether at the time of granting clinical privileges, at initial appointment, at reappointment, or during the term of appointment, will be subject to PPE in order to confirm competence. The PPE process for these situations is outlined in the Professional Performance Evaluation Policy.

4.A.3 Privilege Modifications and Acceptance of Alternative Criteria:

(a) Scope. This section applies to all requests for modification of clinical privileges (increases and relinquishments) during the term of appointment, resignation from the Medical Staff, and acceptance of alternative criteria for eligibility criteria for privileges.

(b) Submitting a Request. Requests for privilege modifications and acceptance of alternative criteria must be submitted in writing to Medical Staff Services.

(c) Increased Privileges:

(1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in the applicable criteria.

(2) If the applicant is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges. Peer validation of competency specifically related to the request for increased privileges must be provided.

(3) All approved increased privileges will be subject to focused PPE.

(d) Alternative Criteria.

(1) Any applicant who does not satisfy one or more eligibility criteria for clinical privileges may request a determination of exceptional circumstances as described above. The applicant making the request bears the burden of demonstrating exceptional circumstances and that the applicant's qualifications are equivalent to, or exceed, the criterion in question.

(2) If the applicant is requesting an exception to the requirement that each applicant or member apply for the full core of privileges in the applicant's specialty, the request must indicate the specific patient care services within the core that the applicant does not wish to provide, state a good cause basis for the request, and include evidence that the applicant does not provide the patient care services at issue in any health care facility.

(3) By applying for a determination of exceptional circumstances related to limiting the scope of core privileges, the applicant nevertheless agrees to

participate in the general on-call schedule for the relevant specialty and to maintain sufficient competency to assist other physicians or providers on the Medical Staff in assessing and stabilizing patients who require services within that specialty. If, upon assessment, a patient needs a service that is no longer provided by the applicant pursuant to the acceptance of alternative criteria, the applicant will work cooperatively with the other physicians or providers in arranging for another applicant with appropriate clinical privileges to care for the patient or, if such an applicant is not available, in arranging for the patient's transfer.

(4) Requests for exceptions due to exceptional circumstances in this section will be processed in the same manner as requests for acceptance of alternative criteria of appointment criteria as described in Section 2.A.2 of this Manual and will consider the factors outlined in Paragraph (f) below.

(e) Relinquishment and Resignation of Privileges.

(1) Relinquishment of Clinical Privileges. A request to relinquish or resign any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of privileges. All such requests will be processed in the same manner as a request for acceptance of alternative criteria, as described above.

(2) Resignation of Appointment and Clinical Privileges. A request to resign Medical Staff appointment and relinquish all clinical privileges must specify the desired date of resignation, which must be at least 30 days after the date of the request, and be accompanied by evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient who is under the provider's care at the time of resignation. After consulting with the President of the Medical Staff, the CMO will act on the resignation request and report the matter to the Credentials Committee.

(f) Factors for Consideration. The Medical Staff Leaders and Board may consider the following factors, among others, when deciding whether to recommend or grant a modification (increases and/or relinquishments) or acceptance of alternative criteria related to privileges:

(1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;

(2) whether sufficient notice has been given to provide a smooth transition of patient care services;

(3) fairness to the provider requesting the modification or acceptance of alternative criteria, including past service and the other demands placed upon the provider;

(4) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them;

(5) the expectations of other members of the Medical Staff who are in different specialties but who rely on the specialty in question in the care of patients who present to the Hospital;

(6) any perceived inequities in modifications or acceptance of alternative criteria being provided to some, but not others;

(7) any gaps in call coverage that might/would result from an provider's removal from the call roster for the relevant privilege and the feasibility and safety of transferring patients to other facilities in that situation; and

(8) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

(g) Effective Date. If the Board grants a modification or accepts alternative criteria related to privileges, it will specify the date that the modification or acceptance of alternative criteria will be effective. Failure of a member to request privilege modifications or acceptance of alternative criteria in accordance with this section shall, as applicable, result in the member retaining Medical Staff appointment and clinical privileges and all associated responsibilities.

(h) Procedural Rights. No provider is entitled to a modification or acceptance of alternative criteria related to privileges. Providers are also not entitled to a hearing or appeal or other process if an acceptance of alternative criteria or a modification is not granted.

4.A.4 Clinical Privileges for New and/or Additional Procedures.

(a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (hereafter, "new and/or additional procedure") will not be processed until

(1) a determination has been made that the procedure will be offered by the Hospital and

(2) criteria to be eligible to request those clinical privileges have been established. The recommendation regarding whether a change in a procedure should be considered a new procedure will be made by the Credentials Committee and subject to approval of the MEC.

(b) As an initial step in the process, the provider seeking to perform the new and/or additional procedure will prepare and submit a report to the Credentials Committee addressing the following:

(1) minimum education, training, and experience necessary to perform the new and/or additional procedure safely and competently;

(2) clinical indications for when the new and/or additional procedure is appropriate;

(3) whether there is empirical evidence of improved patient outcomes with the new and/or additional procedure or other clinical benefits to patients;

(4) whether proficiency for the new and/or additional procedure is volume-sensitive and if the requisite volume would be available;

(5) whether the new and/or additional procedure is being performed at other similar hospitals and the experiences of those institutions; and

(6) the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new and/or additional procedure.

The Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new and/or additional procedure should be offer

(c) If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those providers who are eligible to request the clinical privileges at the Hospital. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the procedure or service

(2) the clinical indications for when the procedure or service is appropriate;

(3) the time frame and mechanism of PPE that should occur if the privileges are granted; and

(4) the manner in which the procedure would be reviewed as part of the Hospital's professional performance evaluation activities.

(d) The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

(e) The Board will make a reasonable effort to render the final decision within sixty (60) days of receipt of the MEC's recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that a provider must demonstrate in order to be eligible to request the clinical privileges in question. Any final decision by the Board to grant, deny, revise, or revoke appointment and/or clinical privileges will be disseminated to the applicant within thirty (30) days of the decision and, reported to appropriate entities as required.

(f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members and providers who wish to perform the procedure or service may be processed.

4.A.5 Clinical Privileges That Overlap Different Specialties:

(a) Requests for clinical privileges that previously at the Hospital have been exercised only by providers from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the provider's eligibility to request the clinical privileges in question.

(b) As an initial step in the process, the provider seeking the privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the provider's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.

(c) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g. department chiefs and providers on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g. other hospitals, residency training programs, and specialty societies).

(d) The Credentials Committee may or may not recommend that providers from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the clinical privileges in question;

(2) the time frame and mechanism of PPE that should occur if privileges are granted;

4.A.6 Clinical Privileges for Dentists, Oral and Maxillofacial Surgeons and Podiatrists:

(a) Dentists, oral and maxillofacial surgeons and podiatrists may provide care consistent with the specific clinical privileges granted to them. They may write orders within the scope of their licenses and consistent with the Medical Staff Rules and Regulations.

(b) Regarding sedation privileges for dentists and oral and maxillofacial surgeons, please refer to the Medical Staff Services Policy and Procedure: Online Verification of Sedation permit for Dental Providers.

4.A.7 Physicians in Training

A physician in training may only hold appointments to the Medical Staff or be granted specific privileges for patient care or procedures after having satisfactorily completed training and with the written permission of the physician in training's program director. With respect to training activities, the program director and/or clinical faculty shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the MEC or its designee. The applicable program director shall be responsible for evaluating the qualifications of each physician in training.

4.A.8 Telemedicine Privileges:

(a) Telemedicine privileges are outlined in the Telehealth Remote Care Policy ("Telehealth Policy".)

(b) All providers holding clinical privileges at the Hospital are privileged to provide telehealth visits via direct to patient services.

(c) Distant Site (as defined in the Telehealth Policy) providers who will provide Telehealth services to Hospital patients are required to obtain Telemedicine privileges from the Hospital. Such privileging will be completed under rules and regulations as outlined by applicable accrediting/governing bodies (e.g. CMS and TJC).

(1) Distant Site providers will not be given Medical Staff membership unless a complete application for membership is requested, completed, and approved via the current credentialing and privileging process.

(2) Distant Site providers granted Telemedicine privileges will be subject to the Hospital's performance improvement and PPE activities in relationship to Hospital patients.

4.B. TEMPORARY CLINICAL PRIVILEGES

Providers with temporary privileges are not granted membership, and temporary privileges will not entitle the provider to the procedural rights set forth in Article 7.

4.B.1 Eligibility to Request Temporary Clinical Privileges:

(a) Applicants. Temporary privileges may be granted by the CMO in consultation with the applicable Department Chair, upon recommendation of the President of the Medical Staff and the applicable department or section chief, under the following conditions:

(1) the applicant has submitted a complete application, along with the application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Provider Data Bank, from a criminal background check, and from Office of the Inspector General (OIG) queries;

(3) the applicant demonstrates that

(i) there are no current or previously successful challenges to the applicant's licensure, certification, or registration and

(ii) the applicant has not been subject to involuntary termination of affiliation or medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility;

(4) the application is pending review by the Credentials Committee, the MEC, and/or the Board; and

(5) temporary privileges for applicants will be granted for a specific period of time, not to exceed 120 days, and will expire at the end of the time period for which they are granted.

(b) Locum Tenens. The CMO, upon recommendation of the President of the Medical Staff and the applicable department or section chief, may grant temporary privileges (admitting and/or treatment) to a provider serving as a locum tenens for a member of the Medical Staff who is on vacation, attending an educational seminar, or ill and/or otherwise needs coverage assistance for a period of time, under the following conditions:

(1) the applicant has submitted a complete application, along with the application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence (verification of good standing in all hospitals where the provider practiced for at least the previous two years), ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Provider Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that

(i) there are no current or previously successful challenges to his or her licensure or registration and

(ii) the applicant has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility;

(4) the applicant has received a favorable recommendation from the applicable department or section chief and the Credentials Committee Chair;

(5) the applicant will be subject to any professional performance requirements established by the Hospital; and

(6) the provider may exercise locum tenens privileges for a maximum of 120 days, consecutive or not, any time during the 24-month period following the date they are granted.

(c) Visiting. Temporary privileges may also be granted to providers in other limited situations by the COO or CMO, upon recommendation of the President of the Medical Staff and the applicable department or section chief, when there is an important patient care, treatment, service, research, or education need. Specifically, temporary privileges may be granted for situations such as the following:

(1) the care of a specific patient;

(2) when a consulting physician or provider is needed but is otherwise unavailable;

(3) when necessary to prevent a lack or lapse of services in a needed specialty area or given patient;

or

(4) when necessary to proctor or to provide education, research support, or training for or to providers, as applicable.

The following factors will be considered and verified prior to the granting of temporary privileges in these situations: current licensure, relevant training or experience, current competence (verification of good standing in all hospitals where the provider practiced for at least the previous two years), current professional liability coverage acceptable to the Hospital, and results of a query to the National Provider Data Bank, from a criminal background check, and from OIG queries. The grant of clinical privileges in these situations will not exceed 60 days. In exceptional situations, this period of time may be extended at the discretion of the COO or CMO and the President of the Medical Staff.

(d) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the provider must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures, and protocols of the Medical Staff and the Hospital.

4.B.2 Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any provider granted temporary clinical privileges. Any such requirement shall not be construed as restrictive or adverse in nature.

4.B.3 Termination of Temporary Clinical Privileges:

(a) The CMO may, at any time after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, the department chief, or the section chief, terminate temporary admitting privileges. Clinical privileges will be terminated when the provider's inpatients are discharged.

(b) If the care or safety of patients might be endangered by continued treatment by the provider granted temporary privileges, the CMO, the department chief, the section chief, or the President of the Medical Staff may immediately terminate all

temporary privileges. The department chief or the President of the Medical Staff will assign to another member of the Medical Staff responsibility for the care of such provider's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

(c) The granting of temporary privileges is a courtesy. Neither the denial nor the termination of temporary privileges will entitle the provider to the procedural rights set forth in Article 7.

4.C. EMERGENCY SITUATIONS

(a) For purposes of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(b) In an emergency situation, a provider may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.

(c) When the emergency situation no longer exists, the patient will be assigned by the department chief or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

(a) For purposes of this section, a "disaster" is defined as any officially declared local, state, or national emergency in which the Hospital's emergency management plan has been activated. In such a situation, when the immediate needs of patients in the facility cannot be met, the COO or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to providers willing to assist who are eligible to be Medical Staff members or PHP but who do not possess clinical privileges at the Hospital ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(b) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

(1) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

(2) A volunteer's license may be verified in any of the following ways:

(iii) current Hospital picture ID card that clearly identifies the provider's professional designation;

(iv) current license to practice;

(v) primary source verification of the license;

(vi) identification indicating that the provider has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or

(vii) identification by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the provider's ability to act as a volunteer during a disaster.

(3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

(4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following:

(i) the reason primary source verification could not be performed in the required time frame;

(ii) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and

(iii) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff will oversee the care provided by volunteers granted disaster privileges. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

(6) A volunteer's disaster privileges will be immediately terminated in the event that any information received through the verification process or oversight is adverse or suggests the volunteer is not capable of rendering services. Otherwise, disaster privileges will continue for the duration of the disaster only and will terminate once the Hospital determines the services are no longer required.

4.E. CONTRACTS FOR SERVICES

(a) From time to time, the Hospital may enter into contracts with providers and/or groups of providers for the performance of clinical and administrative services at the Hospital. All providers providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Manual.

(b) To the extent that:

(1) any such contract confers the exclusive right to perform specified services to one or more providers or groups of providers, or

(2) the Board by resolution limits the providers who may exercise privileges in any clinical specialty to employees of the Hospital or its affiliates, no other provider except those authorized by or pursuant to the contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized providers are eligible to apply for appointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.

(c) If any such exclusive contract or resolution would have the effect of preventing an existing provider from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice procedures:

(1) The affected provider will be given at least thirty (30) days' advance written notice of the exclusive contract or Board resolution.

(2) The written notice shall inform the affected provider that such provider is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board resolution. The ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or Board resolution is in effect.

(3) The affected provider will not be entitled to the procedural rights outlined in Article 7 of this Manual with respect to the Board's decision or the effect of the decision on such provider's clinical privileges.

(4) The inability of a provider to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the Wisconsin licensure board or to the National Provider Data Bank.

(7) Except as provided in paragraph (1), in the event of any conflict between this Manual or the Medical Staff Bylaws and the terms of any contract, the terms of the contract will control.

ARTICLE 5
PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT AND RENEWAL OF PRIVILEGES

All threshold criteria, terms, conditions, requirements, and procedures relating to initial approval of practice or appointment, as applicable, will apply to continued appointment, reappointment, and the renewal of clinical privileges.

5.A.1 Eligibility for Reappointment and Renewal of Clinical Privileges:

To be eligible to apply for reappointment and/or renewal of clinical privileges, a provider must have, during the previous appointment term or term in which such provider was granted clinical privileges:

(i) completed all continuing education and training requirements;

(ii) continuously satisfied and remained current on all threshold criteria, general conditions, responsibilities, and qualifications the appointment and clinical privileges requested;

(iii) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested if applying for clinical privileges. Any provider seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (e.g. a copy of the provider's confidential quality profile from the provider's primary hospital, clinical information from the provider's primary hospital, clinical information from the provider's private office practice, and/or a quality profile from a managed care organization or insurer) before the application will be considered complete and processed further, and

(iv) paid the reappointment processing fee, if applicable.

5.A.2 Factors for Evaluation:

In considering an applicant's application for reappointment, the factors listed in Section 2.A.3 of this Manual will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

(a) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;

(b) participation in Medical Staff duties and provider duties, as applicable, including committee assignments, assigned call, and consultation requests; participation in quality improvement, utilization management, and professional performance evaluation activities; and such other reasonable duties and responsibilities as assigned;

(c) the results of the Hospital's performance improvement and PPE activities, taking into consideration provider-specific information compared to aggregate information concerning other applicants in the same or similar discipline or specialty (provided that other providers will not be identified);

(d) any focused professional performance evaluations and the applicant's cooperation with the PRC in these situations;

(e) validated complaints received from patients, families, and/or staff; and

(f) other reasonable indicators of continuing qualifications.

5.A.3 Reappointment and Renewal Application:

(a) An application for reappointment will be furnished to each member at least four months prior to the expiration of the member's current appointment term. A completed reappointment/renewal application must be returned to Medical Staff Services within thirty (30) days.

(b) Failure to submit a complete application at least two months prior to the expiration of the provider's current term will result in the automatic expiration of appointment and clinical privileges at the end of the current term of appointment unless the application can still be processed in the normal course without extraordinary effort on the part of Medical Staff Services and the Medical Staff Leaders.

(c) Reappointment and/or renewal will be for a period of not more than two (2) years.

(d) In those situations where the Board has not acted on a pending application for reappointment and there is an important patient care need that mandates an immediate authorization to practice, including but not limited to an inability to meet on-call coverage requirements or denying the access to needed medical services, the CMO will have the authority to grant temporary clinical privileges until such time as the Board can act on the application. Prior to granting temporary privileges, the CMO will consult with the chief of the applicable department or section, the Chair of the Credentials Committee, and/or the President of the Medical Staff. The temporary clinical privileges will be for a period not to exceed one hundred twenty (120) days.

(e) The application will be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(f) Medical Staff Services will oversee the process of gathering and verifying relevant information. The applicant will be responsible for confirming that all relevant information has been received.

(g) In addition to the above, an assessment prepared by the Sponsoring Member(s) may be requested for PHPs.

5.A.4 Processing Applications for Reappointment and Renewal:

(a) Medical Staff Services will forward the completed application to the relevant department or section chief and the application for reappointment will be processed in a manner consistent with applications for initial appointment.

(b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

(c) If it becomes apparent to the Credentials Committee or the MEC that it is considering a recommendation to deny reappointment or a requested change in staff category or to reduce clinical privileges, the chair of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At that meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and will be invited to discuss, explain, or refute it. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual requesting reappointment shall not have the right to be represented by legal counsel at this meeting. The committee will indicate as part of its report whether such a meeting occurred and will include a summary of the meeting with its minutes.

5.A.5 Conditional Reappointments and Renewals:

(a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g. performance improvement plan for behavior) or to clinical issues (e.g. general consultation requirements, proctoring, or completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Manual, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article 7 of this Manual.

(b) In addition, reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.

(c) In the event that the applicant for reappointment is the subject of an unresolved professional performance evaluation concern, a formal investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.A.6 Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within one hundred twenty (120) days unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6

SPECIAL CONDITIONS FOR PROFESSIONAL HEALTH CARE PROVIDERS

Professional Health Care Providers are those licensed or certified individuals whom the Board has determined to be eligible to apply for clinical privileges consistent with the minimum eligibility and qualification requirements established by the Board as described in Article 2 of the Governance and Organizational Manual and this Credentialing Manual, which will include their recognized scope of practice, licensure, certification, education, and demonstrated competency. PHPs who are eligible for and have been granted clinical privileges will be classified as Category 1, 2, or 3 as identified in the corresponding appendices to these Bylaws. The appendices may be modified or supplemented by action of the Board, after receiving the recommendation of the MEC, without the necessity to further amend this Manual.

6.A. ADDITIONAL REQUIREMENTS FOR PHP CATEGORIES 2 AND 3

(a) Category 2 and 3 PHPs may function in the Hospital only so long as they have a Sponsoring Member.

(b) If the practice focus of the PHP changes to a different clinical area, a new Sponsoring Member agreement needs to be completed.

(c) Any activities permitted to be performed at the Hospital by a Category 2 or 3 PHP must be performed only under the oversight of, and pursuant to a written agreement with, the Sponsoring Member.

(d) The clinical privileges of a PHP shall terminate immediately, without right to procedural rights, in the event that: 1) the provider's employment or the required Sponsoring Member's membership or privileges are terminated for any reason or 2) the required supervision of or collaborative agreement with the PHP's Sponsoring Member is terminated for any reason. However, the clinical privileges of a PHP shall not be terminated if timely alternative arrangements are made with a qualifying Medical Staff Member.

(e) Each Category 2 or 3 PHP and the Sponsoring Member must provide the Hospital with notice of any revisions or modifications that are made to the agreement between them. This notice must be provided to the CMO within three (3) days of any such change.

(f) Should any member of the Medical Staff, PHP, or employee of the Hospital who is licensed or certified by the state have a reasonable question regarding the clinical competence or authority of a Category 2 or 3 PHP to act or issue instructions outside the presence of the Sponsoring Member, such individual will have the right to request that the Sponsoring Member validate, either at the time or later, the instructions of the Category 2 or 3 PHP. Any act or instruction of the Category 2 or 3 PHP will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges granted to the PHP.

(g) Any question regarding the conduct of a PHP will be reported to the President of the Medical Staff, the Chair of the Credentials Committee, the relevant department or section chief, the CMO, or the COO for appropriate action. The individual to whom the concern has been reported will also discuss the matter with the Sponsoring Member, if applicable.

6.B. RESPONSIBILITIES OF SPONSORING MEMBER

(a) Physicians who wish to collaborate with or supervise a PHP at the Hospital must notify Medical Staff Services in advance and must ensure that the individual has

been appropriately credentialed in accordance with this Manual before the PHP participates in any clinical or direct patient care of any kind in the Hospital.

(b) The Sponsoring Member will ensure that if such Member is not immediately available, another appropriately credentialed Medical Staff member is available to the PHP for consultation at all times.

(c) The number of PHPs acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Sponsoring Member will make all necessary filings with the appropriate state licensing agency regarding the supervision and responsibilities of the PHP, to the extent that such filings are required.

ARTICLE 7
CORRECTIVE ACTION

7.A. CORRECTIVE ACTION INVOLVING MEDICAL STAFF MEMBERS & PHP CATEGORIES 1 & 2

7.A.1 Collegial Intervention:

(a) The Medical Staff encourages the use of progressive steps by Medical Staff Leaders, the PRC, and Hospital leadership, beginning with collegial and educational efforts, to address questions relating to a provider's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(b) Collegial intervention efforts are a part of PPE activities and shall be conducted in accordance with the Professional Performance Evaluation Policy.

(c) Documentation of collegial intervention efforts will be included in an individual's confidential file, and the individual will have an opportunity to review the documentation and respond in writing. Any response will be maintained in that individual's file along with the original documentation.

(d) Collegial intervention efforts are encouraged but are not mandatory and will be within the discretion of the appropriate Medical Staff Leaders and Hospital leadership.

7.A.2 Professional Performance Evaluations:

All professional performance evaluations for members of the Medical Staff and PHP Categories 1 and 2 will be conducted in accordance with the Professional Performance Evaluation Policy. The Professional Performance Evaluation Policy does not apply to PHP Category 3. Matters that cannot be appropriately resolved through collegial intervention or through the professional performance evaluation process will be referred to the MEC for its review in accordance with Section 7.A.3 below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

7.A.3 Investigations:

(a) Initial Review:

(1) Whenever a serious question has been raised, or where collegial or PPE efforts have not resolved an issue, the matter may be referred to the

President of the Medical Staff, the CMO, or the COO. Such circumstances include but are not limited to:

(a) the clinical competence or clinical practice of any provider, including the care, treatment, or management of a patient or patients;

(b) the safety of or proper care being provided to patients;

(c) the known or suspected violation by any provider of applicable ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; and/or

(d) conduct by any provider that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the failure of the member to work harmoniously with others.

(2) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any provider, the matter will be referred to the President of the Medical Staff, the CMO, or the COO for review and appropriate action in accordance with this Manual.

(3) The person to whom the matter is referred will conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, will forward it in writing to the MEC.

(4) No action taken pursuant to this Section will constitute an investigation.

(b) Initiation of Investigation:

(1) When a question involving clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC will review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy, or to proceed in another manner. In making this determination, the MEC may discuss the matter with the individual. An investigation will begin only after a formal determination by the MEC to do so.

(2) If an investigation is initiated, the MEC may investigate the matter itself, request that the CMO conduct the investigation, or appoint an ad hoc committee to conduct the investigation (collectively referred to as the "investigating committee" for the remainder of this section). The investigating committee will not include relatives or financial partners of same profession providers or the provider's Sponsoring Member (where applicable). At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.

(3) The MEC will inform the individual that an investigation has begun. Notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

(c) Investigative Procedure:

(1) Once a determination has been made to begin an investigation, the MEC will investigate the matter itself, request that the CMO conduct the investigation, or appoint an ad hoc committee to conduct the investigation,

keeping in mind the conflict of interest guidelines outlined in Article 11. Any ad hoc committee may include individuals not on the Medical Staff. Whenever the questions raised relate to clinical competence of the individual under review, the ad hoc committee will include a peer of the individual (i.e., a physician, dentist, oral surgeon, podiatrist, or PHP).

(2) The CMO or the investigating committee will have the authority to review relevant documents and interview individuals. The CMO or the investigating committee will also have available to them the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that:

(a) the clinical expertise needed to conduct the review is not available on the Medical Staff;

(b) the individual under review is likely to raise, or has raised, questions about the objectivity of other providers on the Medical Staff; or

(c) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations were unfounded.

(3) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by a health care professional(s) acceptable to it. The individual being investigated will execute a release (in a form approved or provided by the investigating committee) allowing

(i) the investigating committee (or its representative) to discuss with the health care professional(s) the reasons for the examination and

(ii) the health care professional(s) to discuss with and provide documentation of the results of such examination directly to the investigating committee. The cost of the health examination will be borne by the individual.

(4) The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions and/or concerns that gave rise to the investigation. A summary of the interview will be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual being investigated will not have the right to be represented by legal counsel at this meeting.

(5) The investigating committee will make a reasonable effort to complete the investigation and issue its report within thirty (30) days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within thirty (30) days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

(6) At the conclusion of the investigation, the investigating committee will prepare a report for the MEC with its findings, conclusions, and recommendations.

(7) In making its recommendations, the investigating committee will strive to achieve a consensus as to what is in the best interest of patient care and the smooth operation of the Hospital while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(i) relevant literature and clinical practice guidelines, as appropriate;

(ii) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);

(iii) any information or explanations provided by the individual under review; and

(iv) other information deemed relevant, reasonable, and necessary by the investigating committee.

(d) Recommendation

(1) The MEC may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the MEC may:

(i) determine that no action is justified;

(ii) issue a letter of guidance, counsel, warning, or reprimand;

(iii) impose conditions for continued appointment;
(iv) impose a requirement for monitoring, proctoring, or consultation;
(v) recommend or impose a requirement for additional training, education, or coaching;

(vi) recommend reduction of clinical privileges;

(vii) recommend suspension of clinical privileges for a term;

(viii) recommend revocation of appointment and/or clinical privileges;

or

(ix) make any other recommendation that it deems necessary or appropriate.

(2) A recommendation by the MEC that would entitle the individual to request a hearing will be forwarded to the COO, who will promptly inform the individual by special notice. The COO will hold the recommendation until the individual has completed or waived a hearing and appeal.

(3) If the MEC makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.

(4) In the event that the Board considers a modification to the recommendation of the MEC which would entitle the individual to request a hearing, the COO will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

(5) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal will be monitored by Medical Staff

Leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies.

7.B. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

7.B.1 Grounds for Precautionary Suspension or Restriction:

(a) The President of the Medical Staff, the CMO, the COO, and the MEC will each have the authority, in their sole discretion, to suspend or restrict all or any portion of an individual's clinical privileges whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital.

(b) A precautionary suspension or restriction can be imposed at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing.

(c) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It will not imply any final finding of responsibility for the situation that caused the suspension or restriction.

(d) A precautionary suspension or restriction will become effective immediately upon imposition, will immediately be reported in writing to the CMO and the President of the Medical Staff, and will remain in effect unless it is modified by the CMO, the MEC, or the Action Subcommittee of the MEC.

(e) The individual in question will be provided a brief written description of the reason(s) for the precautionary suspension, including the names and medical record numbers of the patient(s) involved (if any), within seven days of the imposition of the suspension.

7.B.2 Review of Precautionary Suspension:

(a) The MEC or Action Subcommittee will review the matter resulting in a precautionary suspension or restriction (or the individual's agreement to voluntarily refrain from exercising clinical privileges) within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC or Action Subcommittee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees, and/or the orderly operation of the Hospital, depending on the circumstances. Neither the MEC nor the individual shall be represented by counsel at this meeting.

(b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the MEC or Action Subcommittee will determine whether there is sufficient information to warrant a final recommendation or it is necessary for the MEC or Action Subcommittee to commence an investigation. The MEC or Action Subcommittee will also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

(c) Upon receipt of notice of the imposition of an administrative suspension, the COO and the President of the Medical Staff will forward the matter to the MEC, which

will review and consider the question(s) raised and thereafter make a recommendation to the Board.

7.B.3 Care of Patients:

(a) Immediately upon the imposition of a precautionary suspension or restriction, the President of the Medical Staff or the CMO will assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients or responsibility to aid in implementing the precautionary restriction, as appropriate. The assignment will be effective until the patients are discharged. The wishes of the patient will be considered in the selection of a covering physician.

(b) All providers have a duty to cooperate with the President of the Medical Staff, the CMO, the department chief, the MEC, and the COO in enforcing precautionary suspensions or restrictions.

7.C. CORRECTIVE ACTION INVOLVING PHP CATEGORY 3

7.C.1 No entitlement to Medical Staff Correction Action and Fair Hearing Plan.

The PHP Category 3 shall not be entitled to the hearing and appeals procedures as set forth above.

7.C.2 Investigation.

Once a determination has been made to begin an investigation by applicable Department Leadership or the CMO, one or more designees may be requested to investigate the matter. The reviewing individual(s) shall have the authority to review relevant documents, interview individuals, and retain external consultants or peer reviewers. Within a reasonable time period after commencement of the investigation, the reviewing individuals will make a recommendation to Department Leadership or the CMO about the proposed disposition of the matter, which shall set forth the basis for the recommendation. Department Leadership or the CMO, as applicable, may accept, modify, or reject any recommendation and may take any action determined to be appropriate under the circumstances.

7.D. ADMINISTRATIVE SUSPENSION OF MEMBERSHIP AND/OR PRIVILEGES FOR MEDICAL STAFF MEMBERS OR PHPS.

7.D.1 Failure to Complete Medical Records:

Failure to complete medical records in a timely manner will result in the administrative suspension of all clinical privileges after notification of the delinquency by the health information management department. The administrative suspension will continue until all delinquent records are completed, and reinstatement will be accomplished in accordance with applicable Rules and Regulations. Failure to complete the medical records that caused the administrative suspension within the time required by applicable Rules and Regulations will result in automatic resignation from the Medical Staff.

7.D.2 Failure to Satisfy Threshold Eligibility Criteria and Action by Government Agency or Insurer:

(a) Any action taken by any licensing board, professional liability insurance company, court, or government agency regarding any of the matters set forth below, or failure to satisfy any of the threshold eligibility criteria set forth in this Manual, must be

promptly reported by the provider to the CMO and the President of the Medical Staff.

(b) A provider's appointment and clinical privileges will be administratively suspended if any of the following occur:

(1) Failure to satisfy threshold criteria: The provider fails to satisfy or fulfill any of the other threshold eligibility criteria, general conditions, or responsibilities set forth in the Bylaws

(2) Licensure: Revocation, expiration, suspension, limitation, or the placement of restrictions on an individual's license.

(3) Controlled substance authorization: Revocation, expiration, suspension, or the placement of restrictions on an individual's DEA controlled substance authorization if needed to perform clinical privileges.

(4) Insurance coverage: Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Hospital or to cease to be in effect, in whole or in part. Proof of professional liability insurance coverage is not required during a leave of absence.

(5) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(6) Criminal activity: Conviction or an Alford plea, a plea of guilty, or a plea of no contest pertaining to any felony or to any misdemeanor involving:

(i) controlled substances;

(ii) illegal drugs;

(iii) Medicare, Medicaid, or insurance or health care fraud or abuse;

(iv) violence against another;

(v) abuse or neglect of a child; or

(vi) any other offense that serves as a bar to the individual acting as a caregiver pursuant to the Wisconsin Caregiver Law.

(c) The administrative suspension will take effect immediately upon notice to the Hospital and continue until the matter is resolved and the individual is reinstated, if applicable.

(d) Requests for reinstatement will be reviewed by the relevant department or section chief, the Chair of the Credentials Committee, the President of the Medical Staff, and the CMO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those will be noted and the reinstatement request will be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

(e) Failure to resolve the underlying matter within 90 days of the date of the administrative suspension shall result in the individual's voluntary resignation of Medical Staff membership and clinical privileges without right of appeal or hearing.

7.D.3 Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for appointment, reappointment, or clinical privileges and as a condition of continued appointment and clinical privileges in response to a written request from the Credentials Committee, the Professional Review Committee, the MEC, the CMO, the COO, or any other committee authorized to request such information will result in the administrative suspension of all clinical privileges. The information must be provided within thirty (30) days of the request. The administrative suspension will continue to be in effect until the information is provided to the satisfaction of the requesting party.

Failure to resolve the underlying matter within ninety (90) days of the date of the administrative suspension shall result in the individual's voluntary resignation of Medical Staff membership and clinical privileges without right to an appeal or hearing.

7.D.4 Failure to Attend Special Meeting:

(a) Whenever there is a concern regarding the clinical practice or professional conduct of any individual, the Medical Staff Leaders may require the individual to attend a special meeting with one or more of the Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff.

(b) Special notice to the individual regarding this meeting will be given at least three days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.

(c) Failure of the individual to attend the meeting will be reported to the MEC. Unless excused by the MEC upon a showing of good cause, such failure will result in the administrative suspension of all the individual's clinical privileges or such portion as the MEC may direct. Such administrative suspension will remain in effect until the matter is resolved.

(d) Failure to resolve the underlying matter within ninety (90) days of the date of the administrative suspension shall result in the individual's voluntary resignation of Medical Staff membership and clinical privileges or voluntary suspension of such portion of the individual's clinical privileges as the MEC may direct without right to an appeal or hearing.

7.E. ADDITIONAL CIRCUMSTANCES FOR ADMINISTRATIVE SUSPENSION OF CLINICAL PRIVILEGES OR SCOPE OF PRACTICE FOR PHPs

(a) The clinical privileges of a PHP will be administratively suspended, without entitlement to the procedural rights outlined in this Manual, in the following circumstances:

(1) the provider's employment is terminated;

(2) a determination is made that there is no longer a need for the services of a particular discipline of provider;

(3) the PHP fails, for any reason, to maintain an appropriate relationship with a Sponsoring Member as defined in this Manual; or

(4) the Hospital enters into a contract for services which limits the performance of certain privileges to an exclusive group of which the provider is not a member.

(b) Requests for reinstatement will be reviewed by the relevant department or section chief, the Chair of the Credentials Committee, the President of the Medical Staff, and the CMO. If all these individuals make a favorable recommendation on reinstatement, the provider may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those will be noted and the reinstatement request will be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

(c) Failure to resolve the underlying matter within ninety (90) days of the date of the administrative suspension shall result in the individual's voluntary resignation of clinical privileges without right to an appeal or hearing.

7.F. LEAVES OF ABSENCE

(a) Any provider may request a leave of absence by submitting a written request to th CMO. Except in extraordinary circumstances, this request must be submitted at least thirty (30) days prior to the anticipated start of the leave in order to permit adjustment of the call roster and ensure adequate coverage of clinical and/or administrative activities. The request must state the beginning and ending dates of the leave, which will not exceed one year, and the reasons for the leave.

(b) Except for parental leaves of twelve (12) weeks or less, members of the Medical Staff and PHPs must report to the CMO any time they will be away from Medical Staff and/or patient care responsibilities for longer than thirty (30) days and the reason for such absence.

(c) If the absence is related to the provider's physical or mental health or otherwise to the provider's ability to care for patients safely and competently, the CMO, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence.

(d) The CMO will determine whether a request for a leave of absence will be granted. In determining whether to grant a request, the CMO will consult with the President of the Medical Staff and the relevant department or section chief. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(e) During the leave of absence, the individual will not exercise any clinical privileges. In addition, the individual will be excused from all Medical Staff responsibilities (e.g. meeting attendance, committee service, and emergency service call obligations) during this period.

(f) An individual requesting reinstatement following a leave of absence must meet all threshold eligibility requirements and will submit a written summary of such individual's professional activities during the leave as well as any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant department or section chief, the Chair of the Credentials Committee, the President of the Medical Staff, and the CMO. If these individuals all make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee and the MEC for review and

recommendation and the Board for decision. If a request for reinstatement is not granted for reasons related to clinical competence or professional conduct, the individual will be entitled to request a hearing and appeal.

(g) If the leave of absence was for health reasons (except for standard parental leave), the request for reinstatement must be accompanied by an appropriate report from the individual's health care provider indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(h) Absence for longer than one year will result in the administrative resignation of Medical Staff appointment and clinical privileges unless an extension is granted by the CMO. Extensions will be considered only in extraordinary cases in which the extension of a leave is in the best interest of the Medical Staff and Hospital.

(i) If a provider's current appointment is due to expire during the leave, the provider must apply for reappointment, or the provider's appointment and clinical privileges will lapse at the end of the appointment period.

(j) Leaves of absence are matters of courtesy, not of right. If it is determined that an individual has not demonstrated good cause for a leave, or if a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

ARTICLE 8
HEARING AND APPEAL PROCEDURES FOR MEDICAL STAFF MEMBERS

8.A. INITIATION OF HEARING

8.A.1 Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations:

(1) denial of initial appointment to the Medical Staff;

(2) denial of reappointment to the Medical Staff;

(3) revocation of appointment to the Medical Staff;

(4) denial of requested clinical privileges;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges for more than thirty (30) days (other than precautionary suspension);

(b) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or

(c) denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.

(1) No other recommendations will entitle the individual to a hearing.

(2) If the Board makes any of these determinations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse

recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MEC" will be interpreted as a reference to the "Board."

8.A.2 Actions Not Grounds for Hearing:

None of the following actions will constitute grounds for a hearing, and they will take effect without hearing or appeal, provided that the individual will be entitled to submit a written explanation to be placed into such individual's file:

(a) issuance of a letter of guidance, counsel, warning, or reprimand;

(b) imposition of conditions, proctoring, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment)

(c) termination of temporary privileges;

(d) administrative suspension of appointment or privileges;

(e) imposition of a requirement for additional coaching, training, or continuing education;

(f) precautionary suspension;

(g) denial of a request for leave of absence, for an extension of a leave, or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;

(h) determination that an application is incomplete;

(i) determination that an application will not be processed due to a misstatement or omission; or

(j) determination of ineligibility based on a failure to meet threshold eligibility criteria or a lack of need or resources or because of an exclusive contract.

8.B. THE HEARING

8.B.1 Notice of Recommendation:

The COO will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within thirty (30) days of receipt of the notice; and

(c) a copy of this Article.

8.B.2 Request for Hearing:

An individual has thirty (30) days following receipt of the notice to request a hearing. The request will be in writing to the COO and will include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

8.B.3 Notice of Hearing and Statement of Reasons:

(a) The COO and the President of the Medical Staff will schedule the hearing and provide, by special notice, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer), if known; and

(4) a statement of the reasons for the recommendation, including a list of patient records (if applicable) and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.

(b) The hearing will begin no sooner than thirty (30) days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

8.B.4 Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The COO, after consulting with the President of the Medical Staff, will appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel will consist of at least three (3) members of the Medical Staff, provided the members have not actively participated in the matter at any previous level. The Hearing Panel may also include providers or lay persons not on the Medical Staff.

(2) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Panel.

(3) Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude a Medical Staff member from serving on the Panel.

(4) The Panel will not include any individual who is in direct economic competition with the individual requesting the hearing.

(5) The Panel will not include any individual who is professionally associated with, related to, or involved in a referral relationship with the individual requesting the hearing.

(6) The Panel will not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(b) Presiding Officer:

(1) The COO, after consulting with the President of the Medical Staff, will appoint a Presiding Officer who may be an attorney. The Presiding Officer will not act as an advocate for either side at the hearing. The Presiding Officer will be compensated by the Hospital, but the individual requesting the hearing may participate in that compensation should the individual wish to do so.

(2) The Presiding Officer shall:

(a) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(b) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive or that causes undue delays;

(c) maintain decorum throughout the hearing;

(d) determine the order of procedure;

(e) rule on all matters of procedure and the admissibility of evidence;

(f) conduct arguments by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.

(3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it but will not be entitled to vote on its recommendations.

(c) Hearing Officer

(1) As an alternative to a Hearing Panel in cases not relating to the quality of care, treatment, and services, the COO, after consulting with the President of the Medical Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing, nor may the Hearing Officer represent clients in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" will be deemed to refer to the "Hearing Officer."

(d) Objections:

Any objection to any member of the Hearing Panel or to the Hearing Officer or the Presiding Officer will be made in writing to the COO within ten days of receipt of notice. A copy of such written objection must be provided to the President of the Medical Staff and must include the basis for the objection. The President of the Medical Staff will be given a reasonable opportunity to comment. The COO will rule on the objection and give notice to the parties. The COO may request that the Presiding Officer make a recommendation as to the validity of the objection.

8.B.5 Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney-at-law who is licensed to practice, in good standing, in Wisconsin.

8.C. PRE-HEARING PROCEDURES

8.C.1 General Procedures:

The pre-hearing and hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply.

8.C.2 Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, will govern the timing of pre-hearing procedures:

(a) the pre-hearing conference will be scheduled at least fourteen (14) days prior to the hearing;
(b) the parties will exchange witness lists and proposed documentary exhibits at least ten (10) days prior to the pre-hearing conference; and
(c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five (5) days prior to the pre-hearing conference.

8.C.3 Witness List:

(a) At least ten (10) days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on such individual's behalf.

(b) The witness list will include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

8.C.4 Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that such individual's counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the MEC;

(3) copies of relevant minutes (with portions regarding other providers and unrelated matters deleted); and

(4) copies of any other documents relied upon by the MEC.

The provision of this information is not intended to waive any privilege under the Wisconsin peer review/health care services review protection statute.

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other providers on the Medical Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(d) Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits. All objections to documents or witnesses will also be submitted in writing in advance of the pre-hearing conference. The Presiding Officer will not entertain

subsequent objections unless the party offering the objection demonstrates good cause.

(e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded.

(f) Neither the individual nor any other person acting on behalf of the individual may contact Hospital employees or Medical Staff members whose names appear on the MEC's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing until the Hospital has been notified and has contacted those individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

8.C.5 Pre-Hearing Conference:

The Presiding Officer will require the individual or a representative (who may be counsel) for the individual and the MEC to participate in a pre-hearing conference, which will be held no later than fourteen (14) days prior to the hearing. At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing will last no more than fifteen (15) hours, with each side being afforded approximately seven and a half (7 ½) hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their cases so that a hearing will be concluded after a maximum of fifteen (15) hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

8.C.6 Stipulations:

The parties and counsel, if applicable, will use their best efforts to develop and agree upon stipulations so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

8.C.7 Provision of Information to the Hearing Panel:

The following documents will be provided to the Hearing Panel in advance of the hearing:

(a) a pre-hearing statement that either party may choose to submit;

(b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and

(c) stipulations agreed to by the parties.

8.D. HEARING PROCEDURES

8.D.1 Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides will have the following rights, subject to reasonable limits as determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

(4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and

(5) to submit proposed findings, conclusions, and recommendations to the Hearing Panel after the conclusion of the hearing.

(b) If the individual who requested the hearing does not testify, such individual may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

8.D.2 Record of Hearing:

The Hospital will make a record of the hearing. Transcription of the record and copies of the transcript will be available at the individual's expense. Oral evidence will be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

8.D.3 Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing will constitute a waiver of the right to a hearing and the matter will be transmitted to the Board for final action.

8.D.4 Presence of Hearing Panel Members:

A majority of the Hearing Panel will be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, such member will read the entire transcript of the portion of the hearing from which the member was absent.

8.D.5 Persons to be Present:

The hearing will be restricted to those individuals involved in the proceeding, the President of the Medical Staff, the CMO, the Hospital's Vice President and General Counsel, and the COO. In addition, various administrative personnel may be present as requested by the COO or the President of the Medical Staff.

8.D.6 Order of Presentation:

The MEC will first present evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the hearing to present evidence.

8.D.7 Admissibility of Evidence:

The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle will be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

8.D.8 Post-Hearing Statement:

Each party will have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

8.D.9 Postponements and Extensions:

Postponements and extensions of time may be requested by anyone but will be permitted only by the Presiding Officer or the COO on a showing of good cause.

8.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

8.E.1 Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that the individual satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges, the Hearing Panel will recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

8.E.2 Deliberations and Recommendation of the Hearing Panel:

Within twenty (20) days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel will conduct its deliberations outside the presence of any other person except the Presiding Officer. Thereafter, the Hearing Panel will render a recommendation, accompanied by a report, which will contain a concise statement of the basis for its recommendation.

8.E.3 Disposition of the Hearing Panel Report:

The Hearing Panel will deliver its report to the COO. The COO will send by special notice a copy of the report to the individual who requested the hearing. The COO will also provide a copy of the report to the MEC.

8.F. APPEAL PROCEDURE

8.F.1 Time for Appeal:

(a) Within ten (10) days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the COO in person or by certified mail with return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within ten (10) days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

8.F.2 Grounds for Appeal:

The grounds for appeal will be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Manual and/or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; and/or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

8.F.3 Notice of Time and Place of the Appeal:

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board (or the COO on behalf of the Chair) will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

8.F.4 Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three (3) persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.

(b) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first, and the other party will then have ten (10) days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral arguments not to exceed thirty (30) minutes.

(c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross- examination provided at the Hearing Panel proceedings. Such additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant new evidence that could not have been presented at the hearing or that any opportunity to admit it at the hearing was improperly denied.

8.G. BOARD ACTION

8.G.1 Final Decision of the Board:

(a) Within thirty (30) days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board will consider the matter and take final action.

(b) The Board may review any information that it deems relevant, including but not limited to the findings and recommendations of the MEC, the Hearing Panel, and the Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

(c) The Board will render its final decision in writing, including specific reasons, and will send special notice to the individual. A copy will also be provided to the MEC for its information.

8.G.2 Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board will be effective immediately and will not be subject to further review. If the matter is referred for further action and recommendation, such recommendation will be promptly made to the Board in accordance with the instructions given by the Board.

8.G.3 Right to One Hearing and One Appeal Only:

No member of the Medical Staff will be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment or reappointment to the Medical Staff or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five (5) years unless the Board provides otherwise.

8.H. REPORTING REQUIREMENTS

Professional review actions based on reasons related to professional competency or conduct adversely affecting clinical privileges that require reporting to the Data Bank will be reported electronically by Medical Staff Services to the Data Bank and the state licensing board. All reports will be approved by legal counsel prior to submission.

ARTICLE 9
PROCEDURAL RIGHTS OF PROFESSIONAL HEALTH CARE PROVIDERS

Any and all hearing and appeals rights to which non-member providers are entitled are set forth in this Article.

9.A. PROCEDURAL RIGHTS FOR PHP CATEGORIES 1 AND 2.

Only PHP Categories 1 and 2 are entitled to hearing and appeals rights.

9.A.1 Recommendations or Actions that Trigger Hearing Rights:

(a) Where any of the following recommendations are made or actions are taken with regard to PHP by the MEC, and where such recommendation or action is based on the quality of care, treatment, and services by the PHP Category 1 or 2, the affected PHP shall be entitled to a hearing on timely and proper request, provided that the provider either holds clinical privileges or is an applicant for privileges as a PHP Category 1 or 2 with a completed application:

1. denial of requested clinical privileges;
2. reduction in clinical privileges;
3. revocation of some or all clinical privileges;
4. suspension or other restriction of clinical privileges for a period of more than 30 days, other than a precautionary suspension; and
5. denial of reinstatement from a leave of absence.

(b) No other recommendations or actions will entitle a PHP Category 1 or 2 to a hearing or appeal.

(c) Notwithstanding any other provision of the Medical Staff Bylaws or this Manual, the following recommendations or actions, without limitation, does not entitle a PHP Category 1 or 2 provider to any of the hearing or appeal rights set forth in this Article 9:

(1) issuance of a verbal or written warning, reprimand, or other collegial intervention;

(2) denial, limitation, expiration, or termination of temporary privileges;

(3) suspension of clinical privileges lasting thirty (30) or fewer days;

(4) automatic or administrative suspension, limitation, or relinquishment of clinical privileges;

(5) any of the recommendations or actions listed in Section 7.A.1(a) when such recommendation or action is voluntary or accepted by the applicant or PHP or is not based on the quality of care, treatment, and services;

(6) determination that an application is incomplete or cannot be processed for any reason, including but not limited to misstatement or omission;\

(7) determination of ineligibility based on failure to meet threshold eligibility criteria;

(8) denial of privileges or refusal to process an application based on a lack of Hospital need or resources, an exclusive contract, or a lack of approval by the Board of persons in the applicant's professional discipline to practice at the Hospital;

(9) suspension or termination of employment; and

(10) denial, reduction, or revocation of clinical privileges or denial of reinstatement following a leave of absence for reasons that do not relate to the quality of care, treatment, and services.

9.A.2 Notice of Recommendation and Hearing Rights:

(a) In the event that a recommendation is made or an action is taken that, according to Section 9.A.1(a), entitles the PHP to a hearing, the individual will receive special notice of the recommendation. The special notice will include a general statement of the reasons for the recommendation and will advise the individual that such individual may request a hearing.

(b) The rights and procedures in this Section will also apply if the Board, without a prior adverse recommendation from the MEC, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated, or not renewed. In this instance, all references in this Article to the MEC will be interpreted as a reference to the Board.

(c) If the PHP requests, the request must be in writing, directed to the COO, within thirty (30) days after receipt of written notice of the adverse recommendation.

(d) The hearing will be convened as soon as is practical but no sooner than thirty (30) days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

9.A.3 Hearing Committee:

(a) If a timely request for a hearing is made, the COO, in consultation with the President of the Medical Staff, will appoint a Hearing Committee composed of up to three (3) providers (including but not limited to members of the Medical Staff, PHP, Hospital leadership, laypersons, or any combination of these individuals). The Hearing Committee will not include anyone who previously participated in the recommendation or any relatives, practice partners, or competitors of the provider or PHP or any other individual with a potential conflict of interest.

(b) The COO, in consultation with the President of the Medical Staff, will appoint a Presiding Officer, who may be legal counsel to the Hospital. The role of the Presiding Officer will be to allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination. The Presiding Officer will maintain decorum throughout the hearing.

9.A.4 Hearing Process:

(a) A record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the individual's expense.

(b) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.

(c) At the hearing, a representative of the MEC will first present the reasons for the recommendation. The PHP will then be invited to present information to refute the reasons for the recommendation.

(d) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.

(e) The PHP and the MEC may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.

(f) The PHP will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the MEC was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the efficient operation of the Hospital will be the paramount considerations.

(g) The PHP and the MEC will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

9.A.5 Hearing Committee Report:

Within twenty (20) days after the later of the conclusion of the proceeding or the submission of the post-hearing memoranda, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, to the COO, who will send a copy of the written report and recommendation by special notice to the PHP, the MEC, and the Board.

9.A.6 Final Board Action:

(a) The COO will forward the report, recommendation, and supporting documentation to the Board.

The Board will then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital. The PHP will receive special notice of the Board's action. A copy of the Board's final action will also be sent to the MEC for information. Any final decision by the Board to grant, deny, revise, or revoke appointment and/or clinical privileges will be disseminated to the applicant within thirty (30) days of the decision and, reported to appropriate entities as required.

9.B. PROCEDURAL RIGHTS FOR PHP CATEGORY 3

(a) Prior to making an adverse recommendation regarding a PHP Category 3, the Medical Staff encourages the use of progressive steps by Medical Staff Leaders, the PRC, and Hospital leadership, beginning with collegial and educational efforts, to address questions relating to the provider's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the provider to resolve questions that have been raised.

(b) In the event that a recommendation is made by the MEC that a PHP Category 3 not be granted clinical privileges or that clinical privileges previously granted be restricted for a period of more than thirty (30) days, terminated, or not renewed, the

individual will receive special notice of the recommendation. The notice will include a general statement of the reasons for the recommendation and will advise the individual that such individual may request a meeting with the MEC.

(c) If a meeting is requested, the meeting will be scheduled to take place within a reasonable time frame. The meeting will be informal and will not be considered a hearing. The Sponsoring Member and the PHP will both be permitted to attend this meeting. However, no counsel for either party will be present.

(d) Following this meeting, the MEC will make a final recommendation to the COO, who will make a final decision in the matter.

ARTICLE 10

HOSPITAL EMPLOYEES

10.A The employment of providers by the Hospital will be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. To the extent that the Hospital's employment policies or manuals or the terms of any applicable employment contract conflict with this Manual, the employment policies, manuals, and descriptions and the terms of the individual's employment relationship and/or written contract will apply.

10.B All Hospital-employed providers must meet the same qualifications that are required for non-employed providers.

ARTICLE 11

CONFLICT OF INTEREST GUIDELINES

11.A. CONFLICT OF INTEREST GUIDELINES

11.A.1 General Principles:

(a) All those involved in credentialing and PPE activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review process.

(b) It is also essential that peers participate in credentialing and PPE review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

11.A.2 Immediate Family Members:

No immediate family member (spouse, parent, child, sibling, or in-law) of a provider whose application or care is being reviewed will participate in any aspect of the review process, except to provide information.

11.A.3 Employment by or Contractual Relationship With the Hospital:

Employment by or other contractual arrangement with the Hospital or an affiliate will not in and of itself preclude an individual from participating in credentialing and PPE activities. Rather, participation by such individuals will be evaluated as outlined in the paragraphs below.

11.A.4 Actual or Potential Conflict Situations:

With respect to a provider whose application or care is under review, actual or potential conflict situations involving other members of the Medical Staff include but are not limited to the following:

(a) membership in the same group practice;

(b) having a direct or indirect financial relationship; being a direct competitor;

(c) close friendship;

(d) history of personal conflict;

(e) personal involvement in the care of a patient which is subject to review;

(f) raising the concern that triggered the review; or

(g) prior participation in review of the matter at a previous level.

Any such individual will be referred to as an "Interested Member" in the remainder of this Article for ease of reference.

11.A.5 Guidelines for Participation in Credentialing and Professional Performance Evaluation Activities:

When an actual or potential conflict situation exists as outlined in the paragraph above, the following guidelines will be used:

(a) Individual Reviewers. An Interested Member may participate as an individual reviewer as long as there is a check and balance provided by subsequent review by a Medical Staff committee. This applies to but is not limited to the following situations:

(1) participation in the review of applications for appointment, reappointment, and clinical privileges, because of the Credentials Committee's and MEC's subsequent review of credentialing matters, and

(2) participation as case reviewers in PPE activities because of the Professional Review Committee's subsequent review of peer review matters.

(b) Credentials Committee or Professional Review Committee Member. An Interested Member may fully participate as a member of these committees because these committees do not make any final recommendation that could adversely affect the clinical privileges of a provider, which is only within the authority of the MEC. However, the chairs of these two committees always have the discretion to recuse an Interested Member in a particular situation, in accordance with the rules for recusal outlined below.

(c) Ad Hoc Investigating Committee. Once a formal investigation has been initiated, additional precautions are required. Therefore, an Interested Member may not be appointed as a member of an ad hoc investigating committee but may be interviewed and provide information to the ad hoc investigating committee if necessary for the committee to conduct a full and thorough investigation.

(d) MEC. An Interested Member will be recused and may not participate as a member of the MEC when the MEC is considering a recommendation that could adversely affect the clinical privileges of a provider, subject to the rules for recusal outlined below.

11.A.6 Guidelines for Participation in Development of Privileging Criteria:

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular providers, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for privileges that cross specialty lines or criteria for new and/or additional procedures, may:

(a) provide information and input to the Credentials Committee or an ad hoc committee charged with development of such criteria and

(b) serve on the Credentials Committee or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the Chair of the Credentials Committee or ad hoc committee always has the discretion to recuse an Interested Member in a particular situation, in accordance with the rules for recusal outlined below) but

(c) not serve on the MEC when it is considering its final recommendation to the Board regarding the criteria.

11.A.7 Rules for Recusal:

(a) When determining whether recusal in a particular situation is required, the President of the Medical Staff or committee chair will consider whether the Interested Member's presence would inhibit full and fair discussion of the issue before the committee or would skew the recommendation or determination of the committee.

(b) Any Interested Member who is recused from participating in a committee meeting must leave the meeting room prior to the committee's final deliberation and determination, but may answer questions and provide input before leaving,

(c) Any recusal will be documented in the committee's minutes.

(d) Whenever possible, an actual or potential conflict should be brought to the attention of the President of the Medical Staff or committee chair, a recusal determination made, and the Interested Member informed of the recusal determination prior to the meeting.

11.A.8 Other Considerations:

(a) Any member of the Medical Staff who is concerned about a potential conflict of interest on the part of any other member, including but not limited to the situations noted in the paragraphs above, must call the conflict of interest to the attention of the CMO (or to the President of the Medical Staff if the CMO is the person with the potential conflict) or the applicable committee chair. The member's failure to notify will constitute a waiver of the claimed conflict. The CMO or the applicable committee chair has the authority to make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Member if necessary.

(b) No staff member has a right to compel the disqualification of another staff member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders, guided by this Article.

(c) The fact that an individual chooses to refrain from participation or is excused from participation in any credentialing or peer review activity will not be interpreted as a finding of actual conflict that inappropriately influenced the review process.

ARTICLE 12
CONFIDENTIALITY AND PEER REVIEW PROTECTION

12.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Manual and related Medical Staff documents will be strictly confidential. Individuals participating in, or subject to, credentialing and PPE activities will make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

1. when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of researching, investigating, implementing, or otherwise conducting legitimate credentialing and PPE activities;
2. when the disclosures are authorized by a Medical Staff or Hospital policy; or
3. when the disclosures are authorized, in writing, by the COO or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any member of the Medical Staff who becomes aware of a breach of confidentiality must immediately inform the COO, the CMO, or the President of the Medical Staff (or the President-Elect of the Medical Staff if the President of the Medical Staff is the person committing the claimed breach).

12.B. PEER REVIEW PROTECTION

All credentialing and PPE activities pursuant to this Manual and related Medical Staff documents will be performed by "Peer Review Committees" in accordance with Wisconsin law. These Committees include but are not limited to:

1. all standing and ad hoc Medical Staff and Hospital committees, including but not limited to multidisciplinary review committees;
2. all departments and sections;
3. hearing panels;
4. the Board and its committees; and
5. any individual acting for or on behalf of any such entity, including but not limited to department chiefs, section chiefs, committee chairs and members, officers of the Medical Staff, and experts or consultants retained to assist in peer review activities.

All oral or written communications, reports, recommendations, actions, and minutes made or taken by these Committees are confidential and covered by the provisions of Wisconsin law. (Wis. Stat. Ann. §§146.37 and 146.38.)

(a) All such Committees will also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq. and the Wisconsin Health Care Services Review Act. (Wis. Stat. Ann. §§146.37 and 146.38.)

ARTICLE 13

GRANT OF IMMUNITY AND AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

By requesting an application and/or applying for appointment, reappointment, and/or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

1. Immunity:

   To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, such member's authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, or clinical privileges or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

2. Authorization to Obtain Information From Third Parties:

   (a) The individual specifically authorizes the Hospital, Medical Staff Leaders, and such individual's authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on such individual's qualifications for initial and continued appointment to the Medical Staff and

   (b) obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency or other third party to conduct a criminal background check on the individual and report the results to the Hospital.

3. Authorization to Release Information to Third Parties:

   The individual also authorizes Hospital representatives to release information to the individual's employer, other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and such individual's agents when information is requested in order to evaluate such individual's professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter. The specific process for release of information will be coordinated by Medical Staff Services.

4. Hearing and Appeal Procedures:

   The individual agrees that the hearing and appeal procedures set forth in this Manual are the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

5. Substantial Compliance:

   These Bylaws are intended, in part, to create a framework to ensure compliance with these statutory obligations. Provided that the Medical Staff and Board act in a manner consistent with these statutory obligations, and other than the timeframe for a provider to request a hearing or appellate review, strict compliance by the Medical Staff or Board with the procedures and timelines set forth in these Bylaws is not required. These Bylaws are not intended in any fashion to create legally binding rights to strict compliance with its provisions. Accordingly, these Bylaws shall not be interpreted as, nor construed to give rise to, any type of legal action, claim, or proceeding for breach of contract related to strict compliance.

6. Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, or peer review action and does not prevail, such individual will reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees and lost revenues.

7. Scope of Section:

   All of the provisions in this Article 13 are applicable in the following situations:

   (a) whether or not appointment or clinical privileges are

   (b) throughout the term of any appointment or reappointment and thereafter;

   (c) should appointment, reappointment, or clinical privileges be denied, revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

   (d) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about such individual's tenure as a member of the Medical Staff.

ARTICLE 14
HISTORY & PHYSICAL REQUIREMENTS

1. Providers granted clinical privileges to perform history and physical examinations (H&P) must complete and document the results of the history and physical examination no more than thirty (30) days before or twenty-four (24) hours after admission or registration of each patient, but prior to surgery or a procedure requiring anesthesia services.
2. When a history and physical examination is completed within thirty (30) days prior to admission or registration, a re-examination of the patient must be performed and any updates to the patient's conditions must be documented in the patient's medical record within twenty-four (24) hours after admission or hospitalization but prior to surgery or a procedure requiring anesthesia services.
3. The H&P must include at a minimum:

   (a) the history of the present illness which documents symptoms, duration and severity of illness;

   (b) review of systems;

   (c) family and social history;

   (d) review of medications and allergies;

   (e) the physical exam with positive and negative findings;

   (f) preliminary diagnoses; and

   (g) a thorough assessment and treatment plan which support the level of care services ordered.

   The complete H&P and any updates must be completed and documented by a qualified provider who has been granted privileges to complete an H&P.

4. Additional requirements for the completion of history and physical examinations may be set forth in the Medical Staff Rules and Regulations and/or applicable Hospital or Medical Staff polices.

ARTICLE 15

AMENDMENTS

The process for amendments set forth in Article 9 of the Medical Staff Governance and Organization Manual applies to all amendments and/or modifications to this Credentialing Manual.

ARTICLE 16

ADOPTION

This Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff, or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: 2/16/2022

Approved by MEC: 1/3/2022

Approved by the Board: 2/16/2022

APPENDIX A

The term “Professional Health Provider 1” shall include:

Optometrist

Psychologist

Clinical Lab Specialist

The term “Professional Health Provider 2” shall include:

Advanced Practice Registered Nurse

- Certified Clinical Nurse Specialist
- Certified Nurse Midwife
- Certified Nurse Practitioner
- Certified Nurse Anesthetist

Anesthesia Assistant

Physician Assistant

The term “Professional Health Provider 3” shall include:

Acupuncturist

Audiologist

Dental Assistant

Dietician

Massage Therapist

Occupational Therapist

Ophthalmologic Photographer

Physical Therapist

Psychometrist

Registered Nurse

Speech Therapist