

**AURORA  
BURLINGTON LAKELAND  
MEDICAL STAFF**

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**MEDICAL STAFF BYLAWS**

**Approved: September 19, 2016**



**AURORA BURLINGTON LAKELAND MEDICAL STAFF  
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## DEFINITIONS

“**Act**” means the Health Care Quality Improvement Act of 1986.

“**Administrator**” means the individual appointed by the Governing Body to act on its behalf in the overall management of the applicable Medical Center.

“**Advanced Practice Professional**” means an individual, other than a Practitioner, who is licensed and/or certified to render health care services independently or under the supervision of a Medical Staff Member, and who is authorized by the Medical Center(s) to provide direct health care services at the Medical Center(s). Clinical Assistants are not Advanced Practice Professionals and do not qualify for Clinical Privileges or Staff Membership.

“**Advanced Practice Professional Staff**” means all Advanced Practice Professionals who have been appointed to the Advanced Practice Professional Staff.

“**Adverse Action**” means an action or recommended action issued by the Medical Executive Committee or the Governing Body that entitles the affected Staff Member to hearing and appellate review rights as set forth in Section 5.2 of these Bylaws.

“**Adverse Action Notice**” means a Written Notice informing a Staff Member of an Adverse Action.

“**Appellate Review Request**” means a written request for an appellate review submitted in the manner set forth in these Bylaws by a Staff Member who is entitled to an appellate review under these Bylaws.

“**Applicant**” means a Practitioner or Advanced Practice Professional who completes and submits an Application for or has been granted the following at the Medical Centers:

1. Appointment
2. Reappointment
3. Clinical Privileges (including initial, renewed, modified, temporary, disaster or emergency Privileges)
4. Modification of Medical Staff Category

“**Application**” means a written request for appointment, reappointment, modification of Medical Staff category, and/or Clinical Privileges (including initial, renewed, modified, and/or temporary Clinical Privileges).

“**Associated Details**” means procedural details associated with the basic steps of the processes described in Section 10.1 of these Bylaws.<sup>1</sup>

“**Aurora**” or “**Aurora Health Care**” means Aurora Health Care, Inc.

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<sup>1</sup> JCS MS.01.01.01, EP 3 (October 2011).

**“Aurora Affiliate”** means any facility or entity owned, controlled, or managed by, or under common ownership, control or management with Aurora Health Care, Inc.

**“Certificate of Insurance”** means a current certificate of insurance evidencing professional malpractice insurance coverage with limits not less than those specified in Wis. Stat. ch. 655 or successor statutes thereto.

**“CFR”** means the United States Code of Federal Regulations.

**“Chief of Staff”** means the individual elected by the Medical Staff as its chief administrative officer.

**“Clinical Assistant”** means an individual qualified by academic education and clinical experience or training to provide patient care services in a clinical or supportive role. Clinical Assistants provide services only under the supervision of an employing or sponsoring member of the Medical Staff, or as otherwise permitted by law. Clinical Assistants are not members of the Medical Staff or the Advanced Practice Professional Staff and are not granted Clinical Privileges. A Clinical Assistant is an individual, other than a Practitioner and Advanced Practice Professional, who is: (i) licensed, certified and/or adequately trained to render health care services under the supervision of a Medical Staff Member; and (ii) authorized by the Medical Center(s) to provide direct health care services at the Medical Center(s). The disciplines included in the Clinical Assistant category include, but are not limited to: Registered Nurses (RNs); Surgical Assistants; Cardiovascular Perfusionists; Pathologist Assistants; Radiology/Ultrasound Technicians; Research Scientists; and Surgical Technicians.

**“Clinical Chairperson”** means the Chairperson of a Medical Staff Department.

**“Clinical Privileges”** or **“Privileges”** means permission granted by the Governing Body to appropriately licensed individuals to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, dental, or podiatry services at the Medical Centers.

**“Conditional Reappointment”** means a recommendation by the Medical Executive Committee and approval by the Governing Body of a term of reappointment for a Staff Member that may be subject to certain conditions that do not affect a Staff Member's Clinical Privileges. Recommendation or approval of Conditional Reappointment does not afford the Staff Member hearing and appeal rights.

**“Credentials Verification Organization”** or **“CVO”** means a qualified organization with which the Medical Center(s) have contracted to perform certain credentials verification services.

**“DEA”** means the United States Department of Justice Drug Enforcement Agency.

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**“Delivery Date”** means the date upon which any Written Notice is deemed to have been delivered to a Staff Member. The Delivery Date for Written Notices shall be as follows:

<b>Method of Delivery</b>	<b>Delivery Date</b>
Personal/Hand Delivery	Date of Delivery
Certified Mail, return receipt requested	Seventy-two (72) hours after deposit with the U. S. Postal Service, certified or registered with return receipt requested
Overnight Courier	Twenty-four (24) hours after deposit with a reputable overnight courier
Email	Date of Delivery

**“Dentist”** means an individual who has received a doctorate in dental surgery or doctorate in dental medicine degree and has a current, unrestricted license to practice dentistry in the State of Wisconsin.

**“Department”** means a clinical grouping of Staff Members in accordance with their specialty or major practice interest, as specified in these Bylaws.

**“Ex Officio”** means service as a member of a committee or other body by virtue of an office or a position held. Unless otherwise specified in these Bylaws, an Ex Officio member shall serve as a non-voting member.

**“Focused Professional Practice Evaluation” or “FPPE”** means a time-limited study, review, investigation, evaluation, or assessment of the training, experience, skill, professional conduct, qualifications, current competence, and/or clinical judgment or expertise of a particular Staff Member. Relevant information obtained from FPPE shall be integrated into performance improvement activities. The FPPE process is NOT part of the corrective action process. If corrective action is indicated, the corrective action procedures outlined in these Bylaws must be followed.

**“Good Standing”** means the Staff Member, at the time such standing is determined, has not, at a Medical Center or any Aurora Affiliate: (i) received a suspension or curtailment of his or her Staff Membership or Clinical Privileges for a period of greater than thirty (30) days within the previous twelve (12) months; (ii) been placed on Probation within the previous twelve (12) months; (iii) entered into a monitoring or some other agreement within the previous twelve (12) months that establishes the terms and conditions of the Staff Member’s continued appointment and exercise of Clinical Privileges or otherwise restricts the Staff Member’s Clinical Privileges or right to apply for Staff Membership; (iv) been the subject of a formal investigation that has not concluded or is the subject of current or pending corrective action; (v) been denied reappointment to the Medical Staff or Advanced Practice Professional Staff; (vi) withdrawn his or her application for reappointment to the Medical Staff or Advanced Practice Professional Staff while under formal investigation and/or subject to pending corrective action; or (vii) voluntarily resigned while under formal investigation and/or subject to pending corrective action.

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Notwithstanding the foregoing, a Staff Member is in Good Standing despite the fact that the Staff Member: (i) is subject to FPPE, including, but not limited to, routine proctoring agreements to demonstrate or improve clinical competence or (ii) is the subject of a Performance Improvement Plan, so long as the Staff Member is in compliance with its terms

**“Governing Body”** means the Board of Directors of Aurora Health Care Southern Lakes, Inc. or any group of individuals or committee that is delegated responsibility for acting on its behalf in matters regarding the Medical Staff and/or the Advanced Practice Professional Staff.

**“Hearing Request”** means a written request for a hearing submitted in the manner set forth in these Bylaws by a Staff Member who is entitled to a hearing under these Bylaws.

**“History and Physical” or “H&P”** means a medical history and physical examination that is performed to determine whether any aspect of the patient’s overall condition or medical history would affect the planned course of the patient’s treatment, such as a medication allergy or a new or existing condition that requires additional interventions to reduce risk to the patient. An H&P must be performed or approved by an individual who has been privileged to do so by the Medical Staff.<sup>2</sup>

**“Joint Commission Standard” or “JCS”** means a standard set forth by The Joint Commission.

**“Medical Center(s)”** means either or both of the following:

- (a) **Aurora Memorial Hospital of Burlington** (Aurora Health Care Southern Lakes, Inc., d/b/a Aurora Memorial Hospital of Burlington) located in Burlington, Wisconsin.
- (b) **Aurora Lakeland Medical Center** (Aurora Health Care Southern Lakes, Inc., d/b/a Aurora Lakeland Medical Center) located in Elkhorn, Wisconsin.

Each Medical Center is a “health care entity” as defined in 42 U.S.C. § 11151(4)(A) and a “hospital” as defined in 42 U.S.C. § 11151(5).

**“Medical Director”** means a physician under contract with a Medical Center to assume overall responsibility for a particular service.

**“Medical Executive Committee”** means the executive committee of the Medical Staff.

**“Medical Staff”** means all Practitioners who have been appointed to the Active, Courtesy, Consulting, Honorary, or Telemedicine Medical Staff by the Governing Body. The Medical Staff is a “professional review body” as that term is defined in 42 U.S.C. § 11151(11), and is an integral part of the Medical Centers (not a separate legal entity).<sup>3</sup>

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<sup>2</sup> 42 C.F.R. § 482.22(c)(5)(i) (Interpretive Guidelines, effective October 17, 2008).

<sup>3</sup> 42 C.F.R. § 482.12(a)(1) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.12(4)(a)1(2011).

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**“Medical Staff Services”** means the Medical Centers’ Medical Staff Office, the CVO or TSO, as applicable.

**“Medical Staff Year”** means the calendar year.

**“Modification Request”** means a written request for modification of an individual’s Medical Staff Category and/or Clinical Privileges.

**“National Practitioner Data Bank”** or **“NPDB”** means the data bank established under the Act.

**“Ongoing Professional Practice Evaluation”** or **“OPPE”** means a continuous process in which certain data is evaluated to identify professional practice trends that impact quality of care and patient safety. OPPE activities may be assigned to a particular Department or committee under the direction of the Peer Review Committee. Relevant information obtained from OPPE shall be integrated into performance improvement activities. The OPPE process is NOT part of the corrective action process. If corrective action is indicated, the corrective action procedures outlined in these Bylaws must be followed.

**“Oral Surgeon”** means a Dentist who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education who possess a current, unlimited license to practice dentistry in the State of Wisconsin.

**“Patient Encounter”** means, for the purpose of determining whether a Medical Staff Member “regularly treats” patients at the Medical Center(s), (a) an inpatient or outpatient admission of a patient during which the Medical Staff Member has direct, in-person contact with the patient; or (b) the performance of a procedure or diagnostic or therapeutic intervention for a Medical Center patient.

**“Physician”** means an appropriately licensed medical doctor (M.D.) or osteopathic physician (D.O.) who possesses a current, unlimited license to practice medicine in the State of Wisconsin.

**“Podiatrist”** means an individual who has received a Doctorate of Podiatric Medicine (DPM) and has a current, unrestricted license to practice podiatry in the State of Wisconsin.

**“Practitioner”** means a Physician, Podiatrist, Dentist, or Oral Surgeon.

**“Probation”** with respect to a Staff Member, that such Staff Member has received written notice that he or she will be subject to corrective action if specified conduct is repeated. The written notice of Probation may, but need not, be given as part of a formal investigation. Probation does not afford the affected Staff Member hearing or appeal rights.

**“Professional Review Action”** means any action or recommendation of a Professional Review Body which is taken or made in the conduct of Professional Review Activity, which is based on



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the competence or professional conduct of a health care provider and which affects, or may affect such individual's Staff Membership and/or Clinical Privileges.<sup>4</sup>

**“Professional Review Activity”** means any activity which is undertaken to determine whether (a) a health care provider is eligible for Staff Membership or Clinical Privileges; (b) the scope or conditions of such Staff Membership or Clinical Privileges; or (c) if such Staff Membership or Clinical Privileges should be modified or terminated.<sup>5</sup>

**“Professional Review Body”** means the Governing Body, Medical Executive Committee, Credentials Committee, Peer Review Committee, any Hearing or Appellate Review Committee, any subcommittee or member of the foregoing, and any other committee or entity which, or individual who, conducts or assists the Medical Center(s) in the performance of any Professional Review Activity and/or otherwise participates in a Professional Review Action.

**“Staff Member”** means a current appointee to the Active, Courtesy, Consulting, or Telemedicine Medical Staff, or the Advanced Practice Professional Staff.

**“Staff Membership”** means appointment to the Active, Courtesy, Consulting, or Telemedicine Medical Staff, or the Advanced Practice Professional Staff.

**“Telemedicine Service Organization”** or **“TSO”** means a Joint Commission-accredited hospital or ambulatory care organization that has contracted with a Medical Center to provide telemedicine services through a telemedicine link.<sup>6</sup>

**“Written Notice”** means a written notice that is delivered to the Staff Member via personal/hand delivery, or certified mail, return receipt requested to the Staff Member's last known residential or office address. Notwithstanding the above, for purposes of Medical Staff meetings, Department meetings, and Medical Staff committee meetings, the term “Written Notice” shall also include notice via email to the Staff Member's last known email address.

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<sup>4</sup> 42 U.S.C. § 11151(9).

<sup>5</sup> 42 U.S.C. § 11151(10).

<sup>6</sup> JCS MS.13.01.01, EP 1 (October 2011).

## ARTICLE 1. PURPOSE AND RESPONSIBILITIES

### 1.1 BYLAWS

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The purposes of these Bylaws are to: (1) create a system of rights and responsibilities between the organized Medical Staff and the Governing Body, and the organized Medical Staff and its members;<sup>7</sup> (2) describe the organization and structure of the Medical Staff; and (3) establish a mechanism for the organized Medical Staff to carry out its responsibilities and govern the professional activities of its members and other individuals with Clinical Privileges.<sup>8</sup>

### 1.2 ORGANIZED MEDICAL STAFF

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The purposes and responsibilities of the Organized Medical Staff are set forth in Section 7.2.

### 1.3 GOVERNING BODY

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The purposes and responsibilities of the Governing Body with regard to the Medical Staff are described in these Bylaws and the Policies Governing Medical Practices.<sup>9</sup>

#### 1.3.1 Bylaws and Policies.

The Governing Body approves and upholds these Bylaws, the Policies Governing Medical Practices, and other Medical Staff rules and regulations.<sup>10</sup>

#### 1.3.2 Staff Membership and Clinical Privileges.

The Governing Body determines, in accordance with applicable law, which categories of providers are eligible candidates for Staff Membership;<sup>11</sup> appoints Staff Members after considering the recommendations of the Medical Executive Committee;<sup>12</sup> ensures that the criteria for Staff Membership and/or Clinical Privileges are in writing and include individual character, competence, training, experience, and judgment;<sup>13</sup> and ensures that under no circumstances is the accordance of Staff Membership or Clinical Privileges dependent solely upon certification, fellowship, or membership in a specialty body or society.<sup>14</sup>

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<sup>7</sup> JCS MS.01.01.01, Introduction (October 2011).

<sup>8</sup> 42 C.F.R. § 482.12(a)(3) (Interpretive Guidelines, effective October 17, 2008); 42 C.F.R. § 482.22(c) (Interpretive Guidelines, effective October 17, 2008); JCS MS.01.01.01, Introduction (October 2011).

<sup>9</sup> 42 C.F.R. § 482.12(a).

<sup>10</sup> 42 C.F.R. § 482.12(a)(3-4); Wis. Admin. Code DHS § 124.12(5)(a) (2011); JCS MS.01.01.01, EP 2 (October 2011).

<sup>11</sup> 42 C.F.R. § 482.12(a)(1).

<sup>12</sup> 42 C.F.R. § 482.12(a)(2).

<sup>13</sup> 42 C.F.R. § 482.12(a)(6).

<sup>14</sup> 42 C.F.R. § 482.12(a)(7).

**1.3.3 Communication with the Medical Staff.**

The Governing Body: (a) works with Medical Staff leaders to evaluate each Medical Center's performance in relation to its mission, vision, and goals;<sup>15</sup> (b) ensures that the Medical Staff is accountable to the Governing Body for the quality of care provided to patients;<sup>16</sup> and (c) provides the organized Medical Staff with the opportunity to participate in Medical Center governance, and the opportunity to be represented at Governing Body meetings, by one or more of its members, as selected by the organized Medical Staff.<sup>17</sup>

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<sup>15</sup> JCS LD.01.03.01, EP 6 (October 2011).

<sup>16</sup> 42 C.F.R. § 481.12(a)(5); JCS MS.01.01.01, Introduction (October 2011); Wis. Admin. Code DHS § 124.12(2)(a) (2011).

<sup>17</sup> JCS LD.01.03.01, EPs 8 & 9 (October 2011).

## ARTICLE 2. STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

### 2.1 GENERALLY

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#### 2.1.1 No Entitlement.

No Applicant shall be entitled to Staff Membership or to the exercise of Clinical Privileges at a Medical Center merely by virtue of the fact that the Applicant: (a) is licensed to practice medicine, podiatry, or dentistry in this or in any other state; (b) is board certified or a member of any professional organization; or (c) had or currently has such privileges at another medical center.<sup>18</sup> Individuals in administrative positions who desire Staff Membership or Clinical Privileges are subject to the same procedures as all other Applicants for Staff Membership or Clinical Privileges.

#### 2.1.2 No Discrimination.

No Applicant who is otherwise qualified shall be denied Staff Membership and/or Clinical Privileges by reason of race, color, creed, age, sexual orientation, disability, gender, military status, or national origin, or other class protected by law, except as may be permitted by law.

#### 2.1.3 Exercise of Clinical Privileges; Certain Restrictions.

Each Staff Member providing direct clinical services at a Medical Center, by virtue of Staff Membership or otherwise, shall, in connection with such practice and except as provided in Section 2.7, be entitled to exercise only those Clinical Privileges that are within the scope of such Staff Member's licensure, certification, education, training and experience, and specifically granted to the Staff Member upon recommendation by the Medical Executive Committee and approval of the Governing Body. Certain Clinical Privileges may be subject to specific restrictions.

#### 2.1.4 Admitting and Prescribing Privileges.

The privilege to admit patients to a Medical Center shall be specifically delineated. Prescribing privileges shall be limited to the classes of drugs granted to the Applicant by the DEA and the Applicant's scope of practice and current competence.

#### 2.1.5 Exclusive Contracts.

The Governing Body may determine, in the interest of quality patient care and as a matter of policy, that certain Medical Center facilities, services, and coverages may be provided/used only on an exclusive basis in accordance with written contracts between the Medical Center(s) and certain qualified Practitioners/entities. The parties to any such contract may waive rights or privileges under these Bylaws. In the event of any conflict between any such contract and these Bylaws, the contract terms shall prevail.

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<sup>18</sup> 42 C.F.R. § 482.12(a)(7).

**2.1.6 Duration of Appointment, Reappointment and Clinical Privileges.**

Initial appointment and reappointment and Clinical Privileges shall be granted for a specific period not to exceed two (2) years upon final approval of the Governing Body.<sup>19</sup>

**2.1.7 Ongoing Evaluation of Qualifications and Competence.**

Each Applicant's competence to perform Clinical Privileges shall be assessed and evaluated on an ongoing basis through Medical Center OPPE and FPPE processes (as further described in the Policies Governing Medical Practices). In addition, each Applicant must report any changes in the Applicant's qualifications in accordance with Section 2.8.8 of these Bylaws. If at any time, such information indicates that the Applicant is no longer competent to perform any or all of the Applicant's previously granted Clinical Privileges, such Clinical Privileges may be modified or terminated by the Governing Body, upon the recommendation of the Medical Executive Committee.<sup>20</sup>

**2.2 PROVIDERS ELIGIBLE FOR STAFF MEMBERSHIP AND CLINICAL PRIVILEGES**

**2.2.1 Eligible Providers.**

The following categories of health care providers are eligible for Staff Membership and/or Clinical Privileges:<sup>21</sup>

**Medical Staff**

- Medical Doctors (MDs)
- Doctors of Osteopathic Medicine (DOs)
- Dentists
- Oral Surgeons
- Doctors of Podiatric Medicine

**Advanced Practice Professional Staff**

- Advance Practice Nurses
  - Certified Registered Nurse Anesthetists (CRNAs)
  - Certified Nurse Midwives (CNMs)
  - Nurse Practitioners (NPs)
  - Clinical Nurse Specialists (CNSs)
- Physician Assistants (PAs)
- Licensed Clinical Social Workers (LCSWs)
- Psychologists (Ph.D or Psy.D.)
- Chiropractors
- Anesthesiologist Assistants

<sup>19</sup> 42 C.F.R. § 482.22(a)(1); Wis. Admin. Code DHS §§ 124.12(4)(a)2. & 124.12(4)(c)3. (2011); JCS MS.06.01.07, EPs 8 & 9 (October 2011).

<sup>20</sup> JCS MS.08.01.03 (October 2011).

<sup>21</sup> 42 C.F.R. § 482.12(a)(1) (Interpretive Guidelines, effective October 17, 2008); 42 C.F.R. § 482.22(c)(2) (Interpretive Guidelines, effective October 17, 2008).

**2.2.2 Available Clinical Privileges.**

Each Medical Center, in consultation with the Medical Staff, shall determine which Clinical Privileges it has the space, equipment, personnel, and other necessary resources to support. No Applicant shall be granted Clinical Privileges if the Medical Center(s) do not have the necessary resources to support such Clinical Privileges.<sup>22</sup> Lists of the specific Clinical Privileges available to each category of provider listed above are maintained by Medical Staff Services.<sup>23</sup>

**2.3 QUALIFICATIONS FOR STAFF MEMBERSHIP AND/OR CLINICAL PRIVILEGES**

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Only those Applicants who continuously meet the qualifications, standards and requirements set forth in these Bylaws and associated Medical Staff and Medical Center policies (and provide documentation of the same) shall be eligible for Staff Membership and Clinical Privileges.<sup>24</sup>

Each Applicant shall have the burden of establishing that he or she is eligible for Staff Membership and Clinical Privileges and it is the sole responsibility of each Applicant to submit all of the information and supporting documentation requested by the Medical Staff on the forms and in the manner requested by the Medical Staff. Except as set forth in Section 2.7 (Temporary, Emergency and Disaster Privileges) and Section 3.7 (Honorary Medical Staff), such information and supporting documentation shall include the items listed below.

**2.3.1 Current Competence.**

Each Applicant must possess the individual character, current competence, training, skills, experience, judgment, background, and physical ability needed to perform requested Clinical Privileges and provide quality patient care.<sup>25</sup>

**2.3.2 Complete Application and Fee.**

Each Applicant must submit a complete, legible, signed Application and any applicable Application fee (such Application fee shall be established and modified by the Administrator in consultation with the Medical Executive Committee).

**2.3.3 License/Registration.<sup>26</sup>**

Each Applicant must: (a) possess a current, unrestricted license to practice his/her profession in the State of Wisconsin; (b) provide a list of all current and past licenses and certifications (in any state); and (c) provide a list of any current or previous challenges to licensure or certification, or voluntary relinquishment of licensure or certification (in any state). Medical Staff Services shall confirm the status of each Applicant's

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<sup>22</sup> JCS MS.06.01.01, EPs 1 & 2 (October 2011).

<sup>23</sup> 42 C.F.R. § 482.22(c)(2) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS §§ 124.12(4)(c)5. & 124.12(5)(b)2. (2011).

<sup>24</sup> 42 C.F.R. § 482.22(c)(4); Wis. Admin. Code DHS §§ 124.12(4)(c)1., 2. & 6. (2011); JCS MS.01.01.01, EPs 13 & 26 (October 2011); JCS MS.06.01.03, EP 6 (October 2011); JCS MS.06.01.05, EP 8 (October 2011); JCS MS.07.01.03, EPs 1-4 (October 2011).

<sup>25</sup> Wis. Admin. Code DHS §§ 124.12(4)(c)1., 2., & 6. (2011); JCS MS.06.01.07 (October 2011).

<sup>26</sup> 42 C.F.R. §§ 482.11(c), 482.22(c)(4); JCS MS.06.01.05, EPs 1, 9 (October 2011).

license/registration through primary source verification prior to appointment, reappointment, modification of Clinical Privileges, and at the time of license expiration.<sup>27</sup>

#### **2.3.4 Board Status and Residency/Training Program.**

Each Applicant must provide, as requested, (a) copies of certificates or letters confirming completion of an approved residency/training program or other educational curriculum, as applicable; (b) copies of certificates or letters from the appropriate specialty board confirming board status (i.e., board eligibility, or board certification), as applicable; and (c) information regarding the Applicant's previous voluntary or involuntary termination of board certification, if any. Medical Staff Services shall: (a) confirm each Applicant's residency and training through primary source verification prior to initial appointment and whenever the Applicant provides information regarding training programs completed after initial appointment; and (b) confirm each Applicant's board status through primary source verification prior to initial appointment and reappointment. Notwithstanding the foregoing, Medical Staff members who will not have clinical privileges need not be board certified or board eligible. In addition, board certification requirements may be waived in accordance with the Waiver of Board Certification Requirements Policy.

- (a) Physicians. A Physician must: (i) have successfully completed a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or the Medical Executive Committee; (ii) be board certified by a specialty board approved by the American Board of Medical Specialties, the Royal College of Physicians and Surgeons of Canada, or the American Osteopathic Association; or be board eligible and receive board certification in the specialty for which privileges are sought within five (5) years of Physician's completion of residency or fellowship, as applicable; and (iii) maintain board certification for the duration of the Physician's Staff Membership. In addition, physician who practice in subspecialties in which separate, additional board certification exists must also obtain and maintain their subspecialty board certification in the time frame outlined above and maintain their subspecialty board certification for the duration of the Physician's Medical Staff membership.
- (b) Podiatrists. A Podiatrist must: (i) have successfully completed a training program accredited by the Council on Podiatric Medical Education or approved by the Medical Executive Committee; (ii) be board certified by the American Board of Foot and Ankle Surgery; or be board eligible and receive board certification in the specialty for which privileges are sought within five (5) years of the Podiatrist's completion of residency or fellowship, as applicable; and (iii) maintain board certification for the duration of the Podiatrist's Staff Membership.
- (c) Dentists. A Dentist must: (i) have successfully completed a training program at a school of dentistry accredited by the American Dental Association or approved by the Medical Executive Committee; and (ii) have successfully completed at least one

<sup>27</sup> 42 C.F.R. §§ 482.11(c), 482.22(c)(4); Wis. Admin. Code DHS § 124.12(4)(c)3 (2011); JCS MS.06.01.03, EP 6 (October 2011); JCS MS.06.01.05, EPs 1, 9 (October 2011).



(1) year of a post-graduate program approved by the Commission on Dental Accreditation of the American Dental Association or the Medical Executive Committee.

- (d) Oral and Maxillofacial Surgeons. An Oral Surgeon must: (i) have successfully completed a post-graduate program residency program accredited by the Commission on Dental Accreditation of the American Dental Association or approved by the Medical Executive Committee; (ii) be board certified by the American Board of Oral and Maxillofacial Surgery; or be board eligible and receive board certification within five (5) years of the Oral Surgeon's completion of residency or fellowship, as applicable; and (iii) maintain board certification for the duration of the Oral Surgeon's Staff Membership.
- (e) Advanced Practice Professionals. Advanced Practice Professionals must have successfully obtained certification from the appropriate professional organization, as applicable.
- (f) Waiver. The Governing Body may waive the board certification requirements described above for an individual Practitioner if all of the following are met:
- i. the Practitioner has special competence or expertise;
  - ii. the Governing Body determines that a Medical Center has a demonstrated need for the Practitioner's services, and such need cannot be met without waiving the board certification requirement for the Practitioner;
  - iii. the waiver is recommended to the Governing Body by the Credentials Committee and the Medical Executive Committee; and
  - iv. the waiver is granted for the minimum length of time necessary for either: (1) the Practitioner to become board certified; or (2) a Medical Center to meet its patient care needs by securing the services of another Practitioner.

### 2.3.5 Peer Recommendations.

Peer recommendations are required for all Applicants seeking: (a) initial appointment and/or Clinical Privileges; (b) renewed Clinical Privileges if there is insufficient professional practice review data generated by the Medical Centers to evaluate the Applicant's competence; and (c) modified Clinical Privileges if there is insufficient professional practice review data generated by the Medical Centers to evaluate the Applicant's competence.<sup>28</sup> Such an Applicant must provide the names and addresses of peers (individuals in the same professional discipline practicing in the same or similar field as the Applicant) who (i) is not a spouse or first degree relative, (ii) recently worked with the Applicant, (iii) directly observed the Applicant's professional performance over a reasonable period of time, and (iv) can and will provide reliable information regarding the Applicant's proficiency in the following six areas of general competencies:<sup>29</sup>

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<sup>28</sup> JCS MS.07.01.03, EPs 1, 2 (October 2011).

<sup>29</sup> JCS MS.06.01.03, Introduction (October 2011); JCS MS.07.01.03, EP 4 (October 2011).



- (a) Patient Care. Each Applicant is expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
- (b) Medical/Clinical Knowledge. Each Applicant is expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of such knowledge to patient care and the education of others.
- (c) Practice-Based Learning and Improvement. Each Applicant is expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
- (d) Interpersonal and Communication Skills. Each Applicant is expected to demonstrate interpersonal and communication skills that enable the Applicant to (1) establish and maintain professional relationships with patients, families, and other members of health care teams, and (2) ensure that all patients treated by him or her shall receive quality care.
- (e) Professionalism. Each Applicant is expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward the Applicant's patients, profession, and society.
- (f) Systems-Based Practice. Each Applicant is expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

### **2.3.6 Professional Practice Evaluation Data.**

Each Applicant must provide or permit access to professional practice evaluation data generated by the Medical Centers and any other entity that currently privileges the Applicant, if available. The Applicant, in the previous twelve (12) months, must have (i) treated patients in a hospital or other appropriate setting in which the Applicant's care was subject to evaluation through peer review acceptable to the Medical Executive Committee, or (ii) successfully completed a graduate or post-graduate program, as applicable.

### **2.3.7 No Sanctions or Exclusion.**

Each Applicant must be eligible for participation in the Medicare and Medicaid programs and may not (1) be currently excluded, suspended, debarred, or ineligible to participate in any health care program funded in whole or in part by the federal or state government; or (2) have been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a health care program funded in whole or in part by the federal or state government after a period of exclusion, suspension, debarment, or ineligibility. Medical Staff Services shall confirm each Applicant's status through primary source verification prior to appointment and reappointment.

**2.3.8 DEA Registration.**

If the Applicant's practice will involve the prescription of controlled substances, the Applicant must possess a current, unrestricted DEA registration in each state in which the Applicant will prescribe medications.<sup>30</sup> The Applicant, upon request, must provide a copy of his/her current DEA registration certificate, as well as previously successful or currently pending challenges to registration or voluntary or involuntary relinquishment of registration, if any. Medical Staff Services shall confirm each Applicant's DEA registration through primary source verification prior to appointment and reappointment and at time of expiration.

**2.3.9 Specified Pre-Conditions.**

The Governing Body may precondition appointment, reappointment, and/or the granting or continued exercise of Clinical Privileges upon the Applicant's agreement to comply with certain conditions or restrictions, including but not limited to, the Applicant's agreement to undergo mental or physical examinations, tests and/or other evaluations the Governing Body deems appropriate to evaluate and/or ensure that there is no change in the Applicant's qualifications and ability to exercise Clinical Privileges and provide quality care and supervision to Applicant's patients.

**2.3.10 Signed Acknowledgement.**

Each Application must include the Applicant's specific, written acknowledgement that the Applicant:

- (a) Authorizes the release and exchange of all information necessary for the review and evaluation of services provided by or conduct of the Applicant;
- (b) Releases the Medical Centers and their affiliates from acts performed in good faith in connection with the Application;
- (c) Acknowledges the Applicant's responsibility to promptly notify and provide information to the Administrator regarding any changes to the Applicant's qualifications;
- (d) Acknowledges that the Applicant has received and read copies of the Medical Staff Bylaws, the Policies Governing Medical Practices, and associated Medical Center policies, and agrees to be bound by and comply with the same;
- (e) Authorizes the posting of the Applicant's affiliation with each Medical Center on each Medical Center's website; and
- (f) Acknowledges that if the Applicant participates in research activities, the Applicant must perform such activities in accordance with applicable regulations and Medical Center policies, and must provide prior written notification of any research activities to the Medical Centers' IRB.

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<sup>30</sup> 21 C.F.R. § 1301.12(b)(3). When an Applicant practices in more than one State, he or she must obtain a separate registration for each State. See Fed. Reg. December 1, 2006 (Vol. 71, No. 231) pages 69478–69480.

**2.3.11 Current and Past Employment, Staff Membership, and Privileges.**<sup>31</sup>

- (a) Employment, Staff Memberships, and Privileges. Each Applicant must provide contact names and addresses of institutions, organizations and entities with which: (1) the Applicant is currently employed, has staff membership, or holds privileges; and (2) the Applicant was employed, had staff membership, or held privileges during the five (5) years prior to the Application date<sup>32</sup>; and
- (b) Termination and Limitations. Any information regarding the voluntary or involuntary termination of the Applicant’s employment, staff membership, or limitation, reduction, denial or loss of clinical privileges at any other institution, organization, or entity.<sup>33</sup>

For initial Applicants, primary source verification will be performed for: (1) current staff memberships and privileges (and, if desired, current employment); and (2) previous staff memberships and privileges (and, if desired, previous employment) held by the Applicant during the five (5) years prior to the Application date. Staff membership, privileges and employment held by an initial Applicant prior to the five (5) years preceding the Application date may be verified through primary source verification at the discretion of the Medical Staff. For reappointment Applicants, primary source verification shall only be performed for the Applicant’s current staff memberships and privileges (and, if desired, employment).

**2.3.12 Absence of Criminal Background.**

Each initial Applicant (except Applicants to the Telemedicine Medical Staff), must complete a Background Disclosure Form and consent to and cooperate with the performance of a background check, the results of which do not prevent the Medical Staff from extending Staff Membership or Clinical Privileges to the Applicant.<sup>34</sup> Medical Staff Services will review the Background Information Disclosure form and complete the caregiver background check. Thereafter, Medical Staff Services will conduct an electronic background search for all reappointment Applicants (except reappointment Applicants to the Telemedicine Medical Staff) at least every four (4) years.<sup>35</sup> Beginning January 1, 2014, each new Applicant must have a record that is free of convictions and pleas of “guilty” or “no contest” or its equivalent to a felony in any jurisdiction.

**2.3.13 National Practitioner Data Bank Report.**<sup>36</sup>

Medical Staff Services will obtain an NPDB report for all initial and reappointment/renewal Applicants, and all current Staff Members seeking modified Clinical Privileges. Such NPDB report must not contain information which would prevent the Medical Staff from extending Staff Membership and Clinical Privileges to the Applicant.

<sup>31</sup> JCS MS.06.01.05, EP 9 (October 2011).

<sup>32</sup> Wis. Admin. Code DHS § 124.12(4)(a)3. (2011).

<sup>33</sup> JCS MS. 06.01.01, EP 9 (October 2011); MS. 06.01.13, EP 3 (October 2011).

<sup>34</sup> Wis. Stat. §§ 48.685 and 50.065 (2008) (Note: a caregiver background check is not required for Applicants who will not have direct contact with patients.).

<sup>35</sup> The background check may not be delegated to a TSO.

<sup>36</sup> JCS MS.06.01.05, EP 7 (October 2011).

**2.3.14 Telemedicine Services Agreement.**<sup>37</sup>

When telemedicine services are furnished at a Medical Center pursuant to a written agreement between a Telemedicine Service Organization (TSO) and a Medical Center or an entity affiliated with a Medical Center, the agreement shall comply with the applicable regulatory and accreditation requirements. If a Telemedicine Medical Staff Applicant is affiliated with and has been granted privileges by a TSO, the Applicant must be in good standing with such TSO and provide written documentation of his/her current privileges. Telemedicine Medical Staff Applicants whose telemedicine services at a Medical Center are not provided pursuant to a written agreement between a TSO and a Medical Center or an entity affiliated with a Medical Center shall be credentialed and privileged in accordance with the standard process set forth in these Bylaws.

**2.3.15 Collaboration or Supervisory Agreement.**

Advanced Practice Professionals must provide a copy of a written collaboration or supervisory agreement as requested by Medical Staff Services.

**2.3.16 TB, Rubella, Influenza and Immunization Status.**<sup>38</sup>

Each Applicant must provide (a) documentation related to the Applicant's TB and TB immunization status; (b) rubella immunization/titer status; and (c) proof of influenza immunization or a granted exemption in accordance with the Aurora Health Care System Influenza Immunization Policy. The requirements in this Section 2.3.16 are not required for Telemedicine Medical Staff Applicants.

**2.3.17 Certification of Fitness; Physical and Psychological Examination.**<sup>39</sup>

Each Applicant, upon request, must submit a statement that no health problems exist that would adversely affect the Applicant's ability to exercise requested Clinical Privileges and otherwise care for patients. Upon the request of any member of the Credentials Committee, Medical Executive Committee or Governing Body, each Applicant agrees to undergo mental or physical examinations, tests and/or other evaluations deemed appropriate to evaluate the Applicant's ability to exercise Clinical Privileges. If there is a known mental or physical impairment, the Applicant will provide evidence that the impairment does not adversely affect the Applicant's ability to exercise Clinical Privileges.

**2.3.18 Professional Liability Insurance.**

Each Applicant must submit a current Certificate of Insurance evidencing professional malpractice insurance coverage with limits not less than those specified in Wis. Stat. ch. 655 or successor statutes thereto and must maintain such insurance coverage.

**2.3.19 Claims, Lawsuits, Settlements and Judgments.**

Each Applicant must provide a listing and description of all claims, settlements, judgments and lawsuits pending or closed, which have ever been filed against the Applicant. Each Applicant shall provide the following information relating to any claims

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<sup>37</sup> 42 C.F.R. §§ 482.12(a)(8)–(9), 482.22(a)(3)–(4), (c)(6); JCS LD.04.03.09, EPs 4 & 23 (October 2011); JCS MS.13.01.01 (October 2011).

<sup>38</sup> JCS MS.06.01.05, EP 9 (October 2011).

<sup>39</sup> JCS MS.06.01.05, EP 6 (October 2011).

or actions for damages against the Applicant (pending or closed), regardless of whether there has been a final disposition: (a) the name of liability carrier at the time of the incident giving rise to the claim (and policy number, if available); (b) the docket number; (c) the name, address and age of claimant or plaintiff; (d) the nature and substance of the claim; (e) the date and place at which the claim arose; (f) amounts paid if any and the date and manner of disposition, judgment, settlement, or otherwise; (g) the date and reason for final disposition, if no judgment or settlement; and (h) any additional information requested by Medical Staff Services, the Credentials Committee, Medical Executive Committee, or Governing Body.<sup>40</sup>

### **2.3.20 Confirmation of Identity.**<sup>41</sup>

Each initial Applicant (not required at reappointment/renewal or for Telemedicine Medical Staff Applicants) must provide:

- (a) Current Photo. A head shot photo of the Applicant, minimum size of 2” x 2” taken within the past two (2) years, showing current appearance and full face with a light background, either in color or black and white. The photo must be on photo quality paper, not a copy. Note: The Applicant’s photo is exclusively used to confirm the Applicant’s identity and the Applicant’s appearance on the photo is not otherwise considered during the credentialing and privileging process.
- (b) Photo Identification.<sup>42</sup> The Applicant’s current picture hospital ID card or a valid picture ID of the Applicant issued by a state or federal agency (e.g. driver’s license or passport).

Medical Staff Services shall compare each initial Applicant to the Applicant’s current picture hospital ID card or valid picture ID issued by a state or federal agency (e.g. driver’s license or passport).

### **2.3.21 Continuing Education.**<sup>43</sup>

Each Applicant must attest in writing that the Applicant has completed the required number of acceptable continuing education hours required under the Applicant’s licenses and provide additional information about his/her participation in continuing education programs upon request.

### **2.3.22 Change in Qualifications.**

Each Applicant seeking reappointment and/or modification of current Clinical Privileges must describe in writing any changes to the Applicant’s qualifications for Staff Membership and/or Clinical Privileges.

### **2.3.23 Alternative Coverage.**

Each Applicant must have alternate coverage available as required by the Policies Governing Medical Practices and applicable Departmental policies, and shall promptly

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<sup>40</sup> Wis. Admin. Code DHS § 124.12(4)(a)4. (2011); JCS MS.06.01.05, EP 9 (October 2011).

<sup>41</sup> JCS MS.06.01.03, EP 5 (October 2011).

<sup>42</sup> JCS MS.06.01.03, EP 5 (October 2011)

<sup>43</sup> JCS MS.12.01.01, EP 5 (October 2011).

provide all documentation requested from time to time by Medical Staff Services regarding such coverage.

### **2.3.24 Other Information.**

Each Applicant must provide other information requested and deemed by the Clinical Chairperson, Medical Executive Committee, and/or Governing Body to be relevant to the evaluation of the Applicant's ability to exercise Clinical Privileges.

## **2.4 OBTAINING AND SUBMITTING AN APPLICATION**

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### **2.4.1 Obtaining an Application.**

Individuals seeking appointment, reappointment, and/or Clinical Privileges (including initial or modified Clinical Privileges) must submit a complete written Application.

- (a) Initial Appointment and Clinical Privileges. An individual seeking initial appointment and/or Clinical Privileges may request an Application by contacting Medical Staff Services. Unless the Applicant is seeking Honorary Medical Staff membership, Medical Staff Services personnel may contact the prospective Applicant to confirm that the prospective Applicant meets the following basic criteria:
- i. Possess a current, unrestricted license to practice his/her profession in Wisconsin;
  - ii. Can provide peer recommendations as provided in Section 2.3 of these Bylaws;
  - iii. Is eligible for participation in the state and federal reimbursement programs as provided in Section 2.3;
  - iv. Can provide a current certificate of insurance evidencing professional liability coverage with limits not less than those specified in Wisconsin Statutes Chapter 655 or successor statutes thereto; and
  - v. Practices in a specialty that is open to new Applicants (In accordance with Section 2.1.5 certain specialties, may be closed to new Applicants if a Medical Center enters into an exclusive agreement to secure such specialty services.).

If the prospective Applicant confirms he/she meets such criteria, Medical Staff Services shall send the appropriate Application to the potential Applicant, or make the Application accessible to the potential Applicant electronically. If a CVO or TSO will participate in the credentials verification process, the Application or a portion of the Application may be sent to the Applicant by the CVO or TSO. Applicants to the Honorary and Telemedicine Medical Staff may receive an abbreviated Application. If the prospective Applicant does not meet the basic qualifications above, Medical Staff Service personnel shall inform the Applicant



that Medical Staff Services will not provide or process an Application unless all such criteria are met. The failure to meet the criteria above and the denial of an Application on that basis shall not entitle a prospective Applicant to hearing or appeals rights under these Bylaws.

- (b) Reappointment and Renewal of Clinical Privileges. Medical Staff Services will send to each Applicant for reappointment/renewal the appropriate Application. Reappointment/renewal dates are defined as the Applicant's month of birth on the odd or even year of birth. If a CVO or a TSO will participate in the credentials verification process, the Application or a portion of the Application may be sent by the CVO or TSO. Honorary Medical Staff Members do not need to complete the reappointment application/review process. Reappointment, if granted, shall be for a period of not more than two (2) years. The Medical Executive Committee may, in its sole discretion, recommend that a Staff Member be granted Conditional Reappointment, upon approval of the Governing Board. Staff Members receiving Conditional Reappointment shall not be entitled to hearing and appellate review rights. Unless otherwise specified, appointment terms run through the last day of the Staff Member's birth month.
- (c) Modification of Medical Staff Category or Clinical Privileges. An individual seeking to modify his/her Medical Staff category or his/her current Clinical Privileges must request the appropriate Application from Medical Staff Services. Medical Staff Services shall send the appropriate Application to the potential Applicant, or make the Application accessible to the potential Applicant electronically, unless the particular Clinical Privileges sought are not available to the Applicant.
- (d) Honorary Medical Staff Members. Refer to Section 3.6.
- (e) Temporary, Emergency, and Disaster Privileges. Refer to Section 2.7
- (f) Previously Denied or Terminated Applicants. An individual who is subject to an Adverse Action regarding appointment, reappointment and/or Clinical Privileges, shall not be permitted to submit the same or a similar Application for at least two (2) years after notice of the Adverse Action, unless the Adverse Action provides otherwise. Applications submitted during this two (2) year period shall be returned to the Applicant, and no right of hearing or appellate review shall be available in connection with the return of such Application. An Application submitted subsequent to the two year period shall be processed as an initial Application.

#### **2.4.2 Application Submission.**

- (a) Initial Appointment. Initial Applicants must submit a complete Application (including required supporting documentation specified in the Application) to Medical Staff Services (or its designee) within ninety (90) days of the Applicant's receipt of the Application. If a complete Application is not submitted within ninety (90) days of the Applicant's receipt of the initial Application, the Application will

be considered withdrawn, no further processing will take place, and the Applicant shall not be entitled to hearing and appellate review rights.

- (b) Reappointment/Renewal. Reappointment/renewal Applicants must submit a complete Application (including required supporting documentation specified in the Application) to Medical Staff Services at least four (4) months prior to the expiration of the Staff Member's then current appointment period. In the event an Applicant fails to timely submit a reappointment/renewal Application, the Applicant's Staff Membership and Clinical Privileges shall be deemed to have expired at the end of the Applicant's then current term. Such expiration shall not entitle the Applicant to hearing or appellate review rights. Upon expiration, the Applicant must complete an initial Application, meet all of the requirements for initial appointment and Clinical Privileges, and pay any applicable Application fee.
- (c) Modification of Medical Staff Category or Clinical Privileges. A Medical Staff Member seeking modification of Medical Staff category or current Clinical Privileges must submit the request in writing to Medical Staff Services as set forth in Section 3.8. Requests may be submitted at any time. However, such requests will not be accepted or considered within the twelve (12) month period following an Adverse Action regarding a similar request, unless the Adverse Action provides otherwise.
- (d) Telemedicine Medical Staff Applicant. In lieu of a full application, a Telemedicine Medical Staff Applicant or the TSO with which the Applicant is affiliated may submit the Applicant's application for clinical privileges at the TSO and a list of the Applicant's current privileges at the TSO. The Applicant or TSO shall provide any additional information or materials that may be requested by Medical Staff Services, the Medical Staff, and/or the Governing Body, and the Applicant shall sign the acknowledgement required by Section 2.3.10 and any other statements that may be required by the Medical Centers and/or the Medical Staff.

### **2.4.3 Applicant's Burden.**

Each Applicant shall have the burden of producing complete, accurate and adequate information to allow a proper evaluation of and resolve any doubts related to his/her qualifications. This burden may include completion of a medical, psychiatric, or psychological examination, at the Applicant's expense, if deemed appropriate by the Medical Executive Committee, which may also select the examining physician. The Applicant's failure, as determined by the Medical Executive Committee in its sole discretion, to sustain this burden or the provision of information containing misrepresentations or omissions may be grounds for denial of an Application.



**2.5 REVIEW AND EVALUATION PROCESS<sup>44</sup>**

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**2.5.1 Generally.**

Prior to making a recommendation or decision regarding an Application, Medical Staff Services, the appropriate Clinical Chairperson, the Credentials Committee, the Medical Executive Committee, and the Governing Body will review all relevant information regarding the Applicant and verify that the Applicant meets the qualifications for Staff Membership and Clinical Privileges set forth in these Bylaws. The Clinical Chairperson, the Credentials Committee, the Medical Executive Committee, and/or the Governing Body may contact any of the Applicant’s peer references for additional information, and/or request an interview with the Applicant.

**2.5.2 Anticipated Time Periods for Application Processing.<sup>45</sup>**

All individuals and groups required to act on an Application shall do so in a timely and good faith manner<sup>46</sup> and, except for good cause (including without limitation a delay on the part of the Applicant), each Application should be processed within the time periods set forth below, measured from the receipt of a completed Application. These time periods are deemed guidelines and do not create any right to have an Application processed within these precise periods. If the provisions of the corrective action, or hearing and appellate review processes specified in these Medical Staff Bylaws are initiated, the time requirements provided therein shall govern the continued processing of the Application.

<b>Individual/Group</b>	<b>Time Period</b>
Medical Staff Services (and CVO or TSO)	60 days
Clinical Chairperson	Prior to next Credentials Committee Meeting
Credentials Committee	Next Scheduled Meeting
Medical Executive Committee	Next Scheduled Meeting
Governing Body	Next Scheduled Meeting

**2.5.3 Initial Review by Medical Staff Services.<sup>47</sup>**

(a) **Initial Review.** Medical Staff Services shall maintain a separate credentials file for each individual Applicant. However, if the Medical Executive Committee will rely on a TSO's credentialing and privileging decisions in accordance with Section 2.5.10, Medical Staff Services may maintain single credentials file for the TSO that contains credentialing information for all of the TSO's Telemedicine Medical Staff Applicants.<sup>48</sup> Medical Staff Services (and/or a designated CVO or TSO) will perform an initial review of each Applicant’s credentials file to ensure that it includes: (a) a complete Application; (b) verification of the Applicant’s credentials

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<sup>44</sup> JCS MS.01.01.01, EPs 14, 26, & 27 (October 2011).

<sup>45</sup> JCS MS.06.01.05, EP 11 (October 2011).

<sup>46</sup> JCS MS.06.01.07, EP 3 (October 2011).

<sup>47</sup> JCS MS.01.01.01, EP26; JCS MS.06.01.03, EPs 1-4, 6 (October 2011).

<sup>48</sup> 42 C.F.R. § 482.22(a)(1)-(2) (Interpretive Guidelines, effective October 17, 2008); 42 C.F.R. § 482.12(a)(8)–(9) (Interpretive Guidelines, effective July 15, 2011).

(including primary source verification of certain qualifications as set forth in Section 2.3); and (c) all other required documentation. If the Applicant's credentials file is deemed complete, it will be forwarded to the appropriate Clinical Chairperson for review.

- (b) Incomplete Credentials File. It is the sole responsibility of each Applicant to submit all the qualifying information and supporting documentation described in these Bylaws, or as otherwise requested by the Medical Staff, on the approved forms and in the manner requested. The Medical Centers are under no obligation to act on an Application until all such information and supporting documentation has been received (even if the missing information is to be provided by a third party). If the required information and documentation have not been submitted, the Applicant's file will be deemed incomplete. Medical Staff Services will notify the Applicant of the deficiencies and that the Applicant's failure to correct such deficiencies within thirty (30) days may be deemed a voluntary withdrawal of the Application. The Applicant shall not be entitled to hearing or appellate review rights in connection with such voluntary withdrawal.

#### **2.5.4 Clinical Chairperson Review and Recommendation.**

The Clinical Chairperson (or his/her designee) shall determine whether the Applicant's peer recommendations and professional practice review data is sufficient to assess the Applicant's competence to perform the requested Clinical Privileges. If not, the Clinical Chairperson (or his/her designee) shall refer the Applicant's credentials file back to Medical Staff Services and Medical Staff Services shall request that the Applicant provide additional information or peer recommendations. If the Applicant's peer recommendations and professional practice review data are sufficient, the Clinical Chairperson (or his/her designee) shall complete the evaluation described in Section 2.5.1 and submit a written recommendation to the Credentials Committee that includes the following:

- (a) Staff Membership. Whether the Applicant's request should be approved or disapproved, the appropriate Medical Staff category (as applicable), and the appropriate Department. If the recommendation regarding Staff Membership or Medical Staff category is adverse to the Applicant, the written recommendation shall clearly state the reason(s) for such Adverse Action.
- (b) Clinical Privileges. Whether the Applicant's request should be approved or disapproved, in whole or in part, and whether there are any recommended conditions or restrictions. If the Applicant seeks initial or modified Clinical Privileges, the written recommendation shall include a focused professional practice evaluation method to be instituted in accordance with the Medical Centers' peer review policy.<sup>49</sup> If the recommendation regarding Clinical Privileges is adverse to the Applicant, in whole or in part, the written recommendation shall clearly state the reason(s) for such Adverse Action.

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<sup>49</sup> JCS MS.08.01.01, EP 1 (October 2011).

**2.5.5 Credentials Committee Review and Recommendation.**

Upon completion of the evaluation described in Section 2.5.1 and review of the Clinical Chairperson’s written recommendation, the Credentials Committee will submit a written recommendation to the Medical Executive Committee that includes the information set forth in Sections 2.5.4(a) and (b). If the Credentials Committee disagrees with the recommendation of the Clinical Chairperson or the recommendation is adverse to the Applicant, in whole or in part, the Credentials Committee’s written recommendation shall include the reason(s) for the alternative recommendation.

**2.5.6 Medical Executive Committee Review and Recommendation.**

Upon completion of the evaluation described in Section 2.5.1, and review of the written recommendations of the Clinical Chairperson and the Credentials Committee, the Medical Executive Committee will draft a written recommendation that includes the information set forth in Sections 2.5.4(a) and (b). If the Medical Executive Committee disagrees with the recommendations of the Clinical Chairperson or the Credentials Committee, in whole or in part, or the recommendation is adverse to the Applicant, the Medical Executive Committee’s proposed recommendation shall include the reason(s) for the alternative recommendation. If the proposed recommendation is favorable to the Applicant, the Medical Executive Committee will submit its recommendation to the Governing Body. If the proposed recommendation is deemed an Adverse Action in accordance with the Medical Staff Bylaws, the Administrator (or his or her designee) will notify the Applicant of the proposed Adverse Action (including the reasons for such recommendation) and advise the Applicant of his/her hearing rights (if any) in accordance with these Medical Staff Bylaws. The Medical Executive Committee shall not submit the proposed Adverse Action to the Governing Body until the Applicant has had an opportunity to exercise or waive his/her hearing rights (if any) in accordance with these Medical Staff Bylaws.

**2.5.7 Governing Body Review and Decision.<sup>50</sup>**

Upon completion of the evaluation described in Section 2.5.1, and review of the written recommendations of the Clinical Chairperson, the Credentials Committee, and the Medical Executive Committee, the Governing Body will issue a written decision that includes the information set forth in Section 2.5.4. The written decision may precondition appointment or reappointment, and granting or continued exercise of Clinical Privileges, upon the Applicant undergoing mental or physical examinations and/or such other evaluations as it may deem appropriate at that time or at any intervening time, to evaluate the Applicant's ability to exercise Clinical Privileges.

**2.5.8 Expedited Governing Body Review and Decision.<sup>51</sup>**

- (a) To expedite appointment, reappointment, and granting of clinical privileges, and in lieu of the full Governing Body issuing a written decision in accordance with Section 2.5.7, the Governing Body may delegate to a committee of at least two

<sup>50</sup> Wis. Admin. Code DHS § 124.12(4)(a)1. (2011).

<sup>51</sup> JCS MS.06.01.11 (October 2011).

voting members of the Governing Body the authority to issue such decisions, provided that:

- i. The Applicant submitted a complete application; and
  - ii. The Medical Executive Committee's recommendation was not adverse and did not have limitations.
- (b) In the following situations, the committee of the Governing Body will evaluate on a case-by-case basis whether to utilize the expedited process; usually, the situations will result in ineligibility for the expedited process:
- i. There is a current challenge or a previously successful challenge to the Applicant's licensure or registration.
  - ii. The Applicant has received an involuntary suspension or termination of medical staff membership at any health care organization.
  - iii. The Applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges at any health care organization.
  - iv. The Medical Centers determine that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in settlement or a final judgment against the Applicant.
- (c) All appointments and grants of clinical privileges through the expedited process shall be reported to the full Governing Body at its next regularly scheduled meeting.

#### **2.5.9 Applicants to the Honorary Medical Staff<sup>52</sup>**

An Applicant to the Honorary Medical Staff need not meet the qualifications set forth in Section 2.3, nor complete the submission and review process set forth above. An Applicant to the Honorary Medical Staff must: (a) be recognized for his/her reputation and contributions to the health and medical sciences, as well as his/her contributions to the Medical Centers; (b) continue to exemplify high standards of professional and ethical conduct; (c) complete the appropriate Application; (d) be recommended for Honorary Medical Staff Membership by at least two (2) Active Medical Staff appointees; and (e) be approved for membership on the Honorary Medical Staff by the Medical Executive Committee and the Governing Body.

#### **2.5.10 Applicants to the Telemedicine Medical Staff.<sup>53</sup>**

Applications to the Telemedicine Medical Staff shall be processed in one of the following ways: (1) the application may be processed in accordance with the standard credentialing and privileging process set forth in these Bylaws; (2) the Medical Executive Committee may rely on credentialing information provided by the TSO in making its

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<sup>52</sup> JCS MS.01.01.01, EPs 14, 26, & 27 (October 2011).

<sup>53</sup> 42 C.F.R. §§ 482.12(a)(8)–(9), 482.22(a)(3)–(4); JCS MS.13.01.01.01 (October 2011).

recommendation regarding appointment and privileges; or (3) the Medical Executive Committee may rely on the credentialing and privileging decisions of the TSO in making its recommendation regarding appointment and privileges. The Medical Executive Committee may rely on the credentialing information provided by the TSO or the credentialing and privileging decisions of the TSO only if the TSO is subject to an agreement that complies with Section 2.3.14 and applicable regulatory and accreditation requirements. When the Medical Executive Committee is relying on the credentialing and privileging decisions of the TSO, an Applicant to the Telemedicine Medical Staff is not required to be evaluated by the Clinical Chairperson under Section 2.5.4 and the Credentials Committee under Section 2.5.5. However, the Medical Executive Committee and/or the Governing Body may, in its or their sole discretion, require any individual Telemedicine Medical Staff Applicant or all of a TSO's Applicants to be credentialed and privileged in accordance with the standard process set forth in these Bylaws. In addition, any Applicant for the Telemedicine Medical Staff who also wishes to apply for privileges to provide in-person services at the Medical Centers, shall be credentialed and privileged in accordance with the standard process.

## **2.6 NOTIFICATION OF STAFF MEMBERSHIP AND CLINICAL PRIVILEGING DECISIONS**

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### **2.6.1 Notification to Applicant.**

- (a) Favorable Decision. If the Governing Body's decision is favorable to the Applicant, the Administrator (or his or her designee) shall notify the Applicant in writing of the final decision of the Governing Body. The written notification will include, as applicable:
- i. that the Governing Body has approved the Applicant's request for appointment/reappointment or change in Medical Staff category;
  - ii. the Medical Staff Category to which the Applicant is appointed or reappointed;
  - iii. the Department assignment;
  - iv. the delineation of Clinical Privileges granted;
  - v. any special conditions or restrictions that apply; and
  - vi. for all Applicants seeking initial or additional Clinical Privileges, a description of the focused professional practice evaluation method that will be used to evaluate the Applicant's ability to perform the privileges.<sup>54</sup>
- (b) Unfavorable Decision. If Governing Body's decision is deemed an Adverse Action, the Administrator (or his or her designee) will provide the Applicant with Written Notice of the Adverse Action and advise the Applicant of his/her hearing rights in accordance with Section 5.3.1.

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<sup>54</sup> JCS MS.08.01.01, EP 1 (October 2011).

**2.6.2 Communication with Medical Center Departments.**

Medical Staff Services will ensure that the appropriate Departments and other Medical Center patient care areas are informed of the Clinical Privileges granted to an Applicant, as well as of any revisions or revocations of an Applicant's Clinical Privileges.<sup>55</sup>

**2.7 TEMPORARY, EMERGENCY, AND DISASTER PRIVILEGES**

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**2.7.1 Minimum Qualifications for Temporary Clinical Privileges.<sup>56</sup>**

All Applicants for temporary Clinical Privileges must meet the minimum qualifications set forth below:

- (a) License/Registration. As described in Section 2.3 of these Bylaws. An Applicant whose licensure or registration is or has been denied, limited, or challenged in any way is not eligible for temporary Clinical Privileges.<sup>57</sup>
- (b) Board Status and Residency/Training Program. As described in Section 2.3 of these Bylaws.
- (c) No Sanctions or Exclusion. As described in Section 2.3 of these Bylaws.
- (d) DEA Registration. As described in Section 2.3 of these Bylaws.
- (e) Signed Acknowledgement. As described in Section 2.3 of these Bylaws.
- (f) Current and Past Affiliations. As described in Section 2.3 of these Bylaws. An Applicant whose staff membership and/or clinical privileges have been involuntarily terminated, limited, reduced, or denied by either Medical Center or any other institution, organization, or entity is not eligible for temporary Clinical Privileges.<sup>58</sup>
- (g) National Practitioner Data Bank Report. As described in Section 2.3 of these Bylaws.
- (h) Professional Liability Insurance. As described in Section 2.3 of these Bylaws.
- (i) Completed Background Disclosure Form. As described in Section 2.3 of these Bylaws. Temporary privileges may be granted while Medical Staff Services awaits the results of the background check.
- (j) Telemedicine Services Agreement. As described in Section 2.3 of these Bylaws.

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<sup>55</sup> 42 C.F.R. § 482.22(a)(2) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.12(4)(c)5. (2011).

<sup>56</sup> Wis. Admin. Code DHS § 124.12(4)(c)4. (2011).

<sup>57</sup> JCS MS.06.01.13, EP 3 (October 2011).

<sup>58</sup> JCS MS.06.01.13, EP 3 (October 2011).



### 2.7.2 Request for Temporary Clinical Privileges.

The following Practitioners and Advanced Practice Professionals may request temporary Clinical Privileges by submitting a Clinical Privileges request to Medical Staff Services and providing the information necessary for verification of the minimum qualifications set forth in Section 2.7.1 of these Bylaws:

- (a) A Practitioner or Advanced Practice Professional (including a locum tenens Practitioner or Advanced Practice Professional) who has not submitted a complete Application for Staff Membership, but is seeking temporary Clinical Privileges in order to fulfill an important care, treatment or services need.
- (b) An Applicant (including a locum tenens Practitioner or Advanced Practice Professional) who has submitted a complete Application that raises no concerns and is awaiting review and approval of the Medical Executive Committee and the Governing Body.<sup>59</sup>

### 2.7.3 Granting of Temporary Clinical Privileges.<sup>60</sup>

- (a) Credentials Verification. Medical Staff Services (or a qualified CVS or TSO) will verify the Applicant's credentials and forward the Clinical Privileges request and the credentials file to the Chief of Staff.
- (b) Review by Chief of Staff. The Chief of Staff (or his/her designee) shall review the Clinical Privileges request and the credentials file. If the Chief of Staff (or his/her designee) approves the request, he/she shall submit a written recommendation to the Administrator (or his/her designee). If the Chief of Staff (or his/her designee) disapproves the request, Medical Staff Services shall notify the Applicant of the denial.
- (c) Review by Administrator. Upon receipt of a recommendation from the Chief of Staff, the Administrator (or his/her designee) shall review the Clinical Privileges request, the credentials file, and the Chief of Staff's recommendation.<sup>61</sup> The Administrator (or his/her designee) may grant temporary Clinical Privileges for a period of sixty (60) days, pending completion of the background check. Upon receipt of favorable background check results, the Applicant may continue to exercise such temporary Clinical Privileges for an additional specified period not to exceed (i) sixty (60) days (for a total of one hundred-twenty (120) days) for an Applicant granted temporary privileges during the pendency of the Applicant's application for Staff appointment and clinical privileges, or (ii) one hundred eighty (180) days (for a total of two hundred forty (240) days) for an Applicant granted temporary privileges to meet an important patient care need (including a locum tenens Applicant).<sup>62</sup> If the Administrator disapproves the request, Medical Staff Services shall notify the Applicant of the denial.

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<sup>59</sup> JCS MS.06.01.13, Rationale (October 2011).

<sup>60</sup> Wis. Admin. Code DHS § 124.12(5)(b)3. (2011).

<sup>61</sup> JCS MS.06.01.13, EP 4, 5 (October 2011).

<sup>62</sup> Wis. Admin. Code DHS § 124.12(4)(c)4. (2011); JCS.MS.06.01.13, EP 6 (October 2011).

**2.7.4 Emergency Privileges.**

In an emergency situation (defined as a circumstance in which immediate action is necessary to prevent serious harm or death), any Staff Member with Clinical Privileges may provide any type of patient care, treatment, or services necessary to prevent serious harm or death, regardless of his or her Medical Staff category or designated Clinical Privileges, as long as such care, treatment or services is within the scope of the Staff Member's license.<sup>63</sup> If time permits, such Staff Member, or other Medical Center personnel in attendance, shall attempt to locate an appropriately privileged Staff Member.

**2.7.5 Disaster Privileges.**

Disaster privileges may be granted to volunteer Practitioners or Advanced Practice Professionals only when the Medical Centers' Emergency Operations Plan has been activated in response to a disaster and the Medical Centers are unable to meet immediate patient needs.<sup>64</sup> Such disaster privileges may only be granted by the Administrator (or his/her designee) or the Chief of Staff (or his/her designee) in accordance with the Medical Centers' policy regarding disaster privileges.<sup>65</sup>

**2.7.6 Monitoring and Review.**

Individuals exercising temporary or disaster Clinical Privileges shall act under the supervision and observation of the Clinical Chairperson of the Department to which he/she is assigned.<sup>66</sup> The Chief of Staff or the Administrator may impose special requirements in order to monitor and assess the quality of care rendered by the Practitioner or Advanced Practice Professional exercising temporary or disaster Clinical Privileges.

**2.7.7 Termination of Temporary and Disaster Privileges.**

Temporary and disaster privileges shall automatically terminate at the end of the specific period for which they were granted. In addition, temporary and disaster privileges shall be immediately terminated by the Administrator (or his/her designee) upon notice of any failure by the Practitioner or Advanced Practice Professional to comply with any special requirements. The Administrator (or his/her designee) may at any time, upon the recommendation of the Chief of Staff (or his/her designee), terminate a Practitioner or Advanced Practice Professional's temporary or disaster privileges, effective upon the discharge of the Practitioner or Advanced Practice Professional's patient(s) from the applicable Medical Center. However, if the life or health of such patient(s) would be endangered by continued treatment by the Practitioner or Advanced Practice Professional, any person authorized to impose a summary suspension in accordance with Section 4.3 of these Bylaws may terminate the Practitioner or Advanced Practice Professional's temporary privileges, effective immediately. The Chief of Staff (or his/her designee) shall assign a Medical Staff appointee to assume responsibility for the care of such terminated Practitioner or Advanced Practice Professional's patient(s) until

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<sup>63</sup> JCS MS.06.01.13, Rationale (October 2011).

<sup>64</sup> JCS MS.01.01.01, 14 (October 2011); JCS EM.02.02.13, EP 1 (October 2011); JCS EM.02.02.15, EP 1 (October 2011).

<sup>65</sup> JCS EM.02.02.13, EP 2 (October 2011); JCS EM.02.02.15, EP 2 (October 2011).

<sup>66</sup> JCS EM.02.02.13, EPs 4, 6 (October 2011); EM.02.02.15, EPs 4, 6 (October 2011).



discharge from the applicable Medical Center. The wishes of the patient(s) shall be considered where feasible in selection of an alternative Staff Member.

### **2.7.8 Hearing and Appellate Review Rights.**

An individual who has been granted temporary or disaster Clinical Privileges shall not be entitled to the hearing and appellate review rights afforded by these Bylaws as the result of his/her inability to obtain temporary or disaster Clinical Privileges and/or the termination of such temporary or disaster Clinical Privileges.

## **2.8 ONGOING OBLIGATIONS**

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By signing and submitting an Application, or requesting temporary or disaster Clinical Privileges, each Applicant (or Staff Member, as applicable) signifies his/her agreement that acceptance of and continued compliance with the ongoing obligations, undertakings and requirements set forth below are express conditions of the Medical Staff's and Governing Body's consideration of Applicant's Application for appointment, reappointment and/or Clinical Privileges, continued Staff Membership and the ability to exercise Clinical Privileges.<sup>67</sup>

### **2.8.1 Maintain Qualifications.**

The Applicant agrees to maintain all necessary qualifications for Staff Membership and Clinical Privileges as set forth in Section 2.3 of these Bylaws.

### **2.8.2 FPPE or OPPE.**

The Applicant agrees to comply with all FPPE and OPPE processes and requirements imposed at any time by the Medical Executive Committee, including, without limitation, any performance improvement plan, proctoring requirement, monitoring requirement, or other condition imposed on the Applicant to demonstrate current clinical competence.

### **2.8.3 Agreement to Appear.**

The Applicant agrees to appear for any requested appearance regarding his/her Application/request, or subsequent to appointment or the granting of Clinical Privileges, to appear for any requested interviews related to questions regarding the Applicant's qualifications, conduct or competence.

### **2.8.4 Consultation and Review.**

The Applicant authorizes Medical Center representatives to consult with others who are or have been associated with the Applicant and who have information regarding the Applicant's competence and qualifications, and consents to the Medical Centers' representatives' inspection of all records and documents evaluating the Applicant's professional qualifications and competence to carry out the Clinical Privileges requested by Applicant, as well as the Applicant's moral and ethical qualifications. The Applicant also agrees the Medical Centers may obtain an evaluation of the Applicant's performance by a consultant selected by the Medical Centers if the Medical Centers consider it appropriate.

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<sup>67</sup> JCS MS.01.01.01, EP 15 (October 2011).

**2.8.5 Provide Continuous Care.**

Upon the granting of Staff Membership and Clinical Privileges, the Applicant agrees to: (a) provide or arrange for continuous care to his/her patients at the professional level of quality and efficiency established by the Medical Centers; (b) delegate in his/her absence the responsibility for diagnosis and care of his/her patients to a qualified Practitioner who possesses the Clinical Privileges necessary to assume care of such patients; and (c) seek consultation with another Practitioner who possesses appropriate Clinical Privileges in any case when the clinical needs of the patient exceed the Clinical Privileges of the Practitioner(s) currently attending the patient, or as otherwise required by the Medical Centers' policies regarding consultation.<sup>68</sup>

**2.8.6 Compliance with Ethical Guidelines.**

The Applicant agrees to strictly abide by the Principles of Medical Ethics of the American Medical Association, the American Podiatric Medical Association, Inc., the American Osteopathic Association, the Code of Ethics of the American Dental Association, or other applicable ethical principles or codes for the appropriate professional association of the Practitioner, as if the same were appended to and made a part of these Bylaws.

**2.8.7 Compliance With Bylaws, Policies, and Laws/Regulations.**

The Applicant agrees to strictly abide by: (a) these Bylaws, the Policies Governing Medical Practices, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Medical Centers, including but not limited to the Aurora Health Care System EMTALA policy;<sup>69</sup> and (b) all local, state and federal laws and regulations, Joint Commission Standards, and professional review regulations, standards and principles, as applicable to the Applicant's professional practice.

**2.8.8 Mandatory Self-Disclosure.<sup>70</sup>**

The Applicant agrees to notify the Administrator in writing immediately after he/she becomes aware (in no event later than three (3) business days) of any of the following:

- (a) Any circumstance or condition which would affect or result in a change in status of any of the Applicant's qualifications for Staff Membership and/or Clinical Privileges as set forth in these Bylaws;
- (b) Any disciplinary action, restriction, or change related to the Applicant's professional practice by any entity (including but not limited to the Applicant's employer, other hospitals, health plans, and agencies);
- (c) Applicant's receipt of notice that an adverse professional review action report or medical malpractice payment report has been filed with the NPDB;
- (d) Changes to the Applicant's participation in any health plan;

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<sup>68</sup> Wis. Admin. Code DHS § 124.12(5)(b)10. (2011); JCS MS.03.01.03, EPs 4, 5 (October 2011).

<sup>69</sup> JC MS.01.01.01, EP 5 (October 2011).

<sup>70</sup> See Wisconsin Department of Health Services, Division of Quality Assurance, DQA Memo 07-005, entitled *Anniversary of the Wisconsin Caregiver Law*, dated March 30, 2007.

- (e) Dishonorable discharge from any branch of the US Armed Forces, including any reserve component;
- (f) If the Applicant is admitted for, seeks, or is undergoing treatment for substance or alcohol abuse or a behavioral health problem. “Substance abuse” shall include but not be limited to, use or ingestion of illegal drugs, or use or ingestion of prescription medications not prescribed or not being taken as prescribed in the ordinary course of treatment of injury or disease. “Behavioral health problem” shall mean any condition or disease of a psychiatric or psychological nature which, in the opinion of a qualified psychiatrist, adversely affects the Practitioner’s ability to care for patients or practice his profession in accordance with the applicable prevailing standard of care;
- (g) Changes in residency;
- (h) Any pending charge (including arrest, charge, arraignment, or indictment) or conviction (including nolo contendere pleas and matters where sufficient facts of guilt were pled or found), whether for a felony, misdemeanor or ordinance, against the Applicant. Minor traffic offenses need not be reported under this Section. A charge of Driving Under the Influence is not a “minor traffic offense” and must also be reported;
- (i) The investigation of allegations, or a finding by any governmental or regulatory agency, that the Applicant committed any act, offense or omission related to the abuse or neglect of any person, or misappropriation or (improperly taking or using) the property of a patient or other person;
- (j) Requests by the Applicant to participate in a rehabilitation review with the Wisconsin Department of Health Services (DHS), a county department, private child placing agency, school board, or DHS designated tribe;<sup>71</sup> and
- (k) An occurrence or knowledge of any new or updated information that is pertinent to any question on Applicant’s Application form that is material to any professional qualification or credential.

### **2.8.9 Immunity from Liability.**

The Applicant agrees and acknowledges that the Medical Centers and all Medical Center representatives shall have absolute immunity from civil liability for actions performed in good faith in connection with providing, obtaining or reviewing information, and evaluating or making recommendations or decisions, concerning the following: (a) any Professional Review Activity; (b) any Professional Review Action; (c) any Adverse Action, corrective action, hearing or appellate review; (e) any FPPE, OPPE, or other evaluation of patient care services; (f) any utilization review; and (g) other Medical Center, departmental or committee activities related to patient care services and professional conduct.<sup>72</sup> For purposes of this Section 2.8.9, the term “Medical Center

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<sup>71</sup> See Wisconsin Department of Health Services, Division of Quality Assurance, DQA Memo 07-005, entitled Anniversary of the Wisconsin Caregiver Law, dated March 30, 2007.

<sup>72</sup> Wis. Admin. Code DHS § 124.12(4)(a)4. (2011).

representative” shall include, without limitation, the Medical Centers’ Staff Members, the Governing Body and its members, the Medical Executive Committee and its members, the Administrator, and Medical Center Officers, employees, agents, and any outside reviewers who provide or evaluate information concerning any Applicant’s qualifications, clinical competency, character, mental or emotional stability, health, ethics or any other matter that might have an effect on patient care. In furtherance of the foregoing, each Applicant shall, upon request of the Medical Centers, execute releases in favor of the Medical Centers, Medical Center representatives and third parties from whom information has been requested by the Medical Centers or an authorized Medical Center representative.

**2.8.10 Refrain From Fee Splitting.**

The Applicant agrees that he/she will not receive from or pay to another individual, either directly or indirectly, any part of a fee received for professional services, including but not limited to the division of fees between Medical Staff Members, except as may be permitted by law.<sup>73</sup>

**2.8.11 Perform Administrative and Medical Staff Duties.**

The Applicant agrees to perform such Medical Staff, Department, Committee, and Medical Center functions for which he/she is responsible based upon appointment, election, assignment, or otherwise, including as appropriate, participating in quality improvement and other monitoring activities, serving on Medical staff committees, and providing on-call coverage for emergency care services within his/her clinical specialty, as required by the Medical Staff.<sup>74</sup>

**2.8.12 Cooperate With Medical Centers.**

The Applicant agrees to cooperate with the Medical Centers in matters involving its fiscal responsibilities and policies, including matters relating to payment or reimbursement by governmental and third party payers.

**2.8.13 Participate in Quality Improvement and Other Initiatives.**

The Applicant agrees to participate in peer review (including OPPE and FPPE), quality assessment, performance improvement, risk management, case management/resource management, initiatives to promote the appropriate utilization of Medical Center resources, and other Medical Center review and improvement initiatives as requested. In addition, the Applicant agrees to maintain the confidentiality of all peer review information, quality assessment and performance improvement data, and other information related to professional review activities.

**2.8.14 Exhaustion of Remedies.**

The Applicant agrees that if an Adverse Action is taken or recommended, the Practitioner will exhaust the remedies afforded by these Bylaws before resorting to legal action.

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<sup>73</sup> Wis. Stat. § 448.08(1m) (2011); Wis. Admin. Code DHS § 124.12(5)(b)5. (2011).

<sup>74</sup> Wis. Admin. Code DHS § 124.12(3)(a) (2011).

**2.8.15 Submission of Medical Staff Dues.**

The Applicant agrees to pay Annual Medical Staff dues, if any, upon request. Dues shall be governed by the most recent action of the Medical Executive Committee. Honorary and Telemedicine Medical Staff Members will not be required to pay dues. Failure to pay dues shall be considered a voluntary resignation as specified in Section 2.9 of these Bylaws.

**2.8.16 Assessment of Competence.**

The Applicant agrees to sufficiently use the Medical Center(s) to allow the Governing Body, through assessment and appropriate Medical Staff committees, Clinical Chairpersons and others, as applicable, to evaluate the Applicant's current competence.

**2.8.17 Unanticipated Outcome Disclosure to Patients.**

The Applicant agrees to disclose unanticipated medical outcomes to the Medical Center(s), patients, and others in accordance with applicable policies.

**2.8.18 Staff Member Identification.**

The Applicant agrees to refrain from deceiving patients or staff as to the identity of an operating surgeon or any other individual providing treatment, care or services.

**2.8.19 Inappropriate Delegation of Responsibility for Diagnosis.**

The Applicant agrees to refrain from delegating responsibility for diagnoses or care of Medical Center patients to any Staff Member or other individual who is not adequately qualified, supervised, and/or credentialed by the Medical Staff with appropriate Clinical Privileges to undertake the responsibility.

**2.9 LEAVE OF ABSENCE; VOLUNTARY RESIGNATION**

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**2.9.1 Leave of Absence.**

(a) Request for Leave. A Staff Member may obtain a leave of absence from the Medical Staff or Advanced Practice Professional Staff, as applicable, for a period not to exceed one (1) year by submitting a written request to the Medical Executive Committee. A leave shall be granted if approved by the Medical Executive Committee and the Governing Body. The Medical Executive Committee and Governing Body may, in their discretion, extend a Staff Member's leave of absence for a period not to exceed one (1) additional year.

(b) Reinstatement.

i. *Request for Reinstatement.* At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Staff Member may request reinstatement of Staff Membership and Clinical Privileges by submitting a written request to the Chief of Staff. The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the Practitioner's qualifications for Staff Membership or Clinical Privileges, or if changes have occurred, a detailed description of the nature

of the changes and any additional information requested by the Chief of Staff, Administrator, Clinical Chairperson, Credentials Committee, Medical Executive Committee, and/or the Governing Body.

- ii. *Review Process.* The Chief of Staff will forward the request for reinstatement to the member's Clinical Chairperson for a recommendation. The Clinical Chairperson shall forward his/her recommendation to the Credentials Committee. The Credentials Committee shall make a recommendation and forward it to the Medical Executive Committee. The Medical Executive Committee shall make a recommendation and forward it to the Governing Body for approval. The refusal to reinstate a Practitioner following an approved leave of absence shall entitle the Practitioner to hearing and appellate review rights as provided in these Bylaws.
- (c) Failure to Return. Failure of a Staff Member to request reinstatement shall constitute a voluntary resignation from the Medical Staff or Advanced Practice Professional Staff, as applicable, and shall not entitle the Practitioner to hearing or appellate review rights. A Practitioner who seeks to regain his/her Staff Membership or Clinical Privileges following such voluntary resignation must complete an initial Application, meet all of the requirements for initial appointment and Clinical Privileges, and pay any applicable Application fee.

### **2.9.2 Voluntary Resignation.**

Resignations from the Medical Staff must be submitted in writing to Medical Staff Services and must state the date the resignation becomes effective; provided, however, voluntary relinquishments under Sections 2.8.15, 2.9.1, 2.11 and 4.5 of these Medical Staff Bylaws are automatic and, therefore, do not require a written submission in accordance with the requirements of this Section 2.9.2. The Practitioner's Clinical Chairperson, the Administrator, the Medical Executive Committee, and the Governing Body shall be informed of all resignations. A Practitioner who voluntarily resigns may not submit a new Application for Staff Membership for at least nine (9) months from the Practitioner's resignation date. In unusual circumstances, exceptions may be granted by the Medical Executive Committee.

## **2.10 MEDICO-ADMINISTRATIVE APPOINTMENTS**

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### **2.10.1 Appointment.**

A Staff Member who is appointed, employed, or under contract to perform administrative duties and who also renders clinical care must meet the qualifications for Staff Membership and necessary Clinical Privileges.

### **2.10.2 Termination.**

The Governing Body may terminate the administrative functions of any Practitioner serving in a medico-administrative capacity by giving prompt Written Notice to such Practitioner (or the entity with which a Medical Center contracts to provide such



administrative services) and the Medical Executive Committee. Such termination shall not affect such Practitioner's Staff Membership or Clinical Privileges except as provided in these Bylaws and/or in any contract with the Practitioner (or the entity with which a Medical Center contracts to provide such administrative services). If the termination is deemed an Adverse Action, the Administrator (or his or her designee) will provide Practitioner with Written Notice of the Adverse Action in accordance with these Medical Staff Bylaws (except as otherwise provided in any contract between a Medical Center and such Practitioner, or a Medical Center and the entity with which a Medical Center contracts to obtain such administrative services).

## **2.11 CONTRACT TERMINATION**

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A Staff Member whose Staff Membership and Clinical Privileges are covered fully by means of a contract with a Medical Center shall be deemed to have automatically and voluntarily relinquished his or her Staff Membership and Clinical Privileges in any of the following events (a) the termination of such contract; (b) the termination of the Staff Member's employment or association with the entity with which a Medical Center has the contract; or (c) the Staff Member is no longer assigned to a Medical Center by the entity with which a Medical Center has the contract. Unless specifically provided to the contrary in the contract, the Staff Member's relinquishment of Staff Membership and Clinical Privileges in accordance with this Section shall not give rise to a hearing or appeal or review in accord with these Medical Staff Bylaws.

A Staff Member who has only a portion of his or her Clinical Privileges exercisable pursuant to a contract with a Medical Center shall be deemed to have automatically and voluntarily relinquished the specific privileges covered by the contract in the event of (a) through (c), above. Unless specifically provided to the contrary in the contract, the Staff Member's relinquishment of Clinical Privileges in accordance with this section shall not give rise to a hearing or appeal or review in accord with these Medical Staff Bylaws.

## ARTICLE 3. STAFF CATEGORIES

### 3.1 GENERALLY

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#### 3.1.1 Designation; Modification.

Each Staff Member shall be designated as a member of one of the staff categories set forth below. At the time of appointment and each reappointment, each Staff Member's staff category shall be recommended by the Medical Executive Committee and approved by the Governing Body.<sup>75</sup> Requests for modification of staff category shall be submitted and reviewed as set forth in Article 2 of these Bylaws.

#### 3.1.2 Medical Staff.

Each Practitioner shall be designated as a member of one of the following Medical Staff categories:<sup>76</sup>

- Active
- Courtesy
- Consulting
- Telemedicine
- Honorary

#### 3.1.3 Advanced Practice Professional Staff.

Each Advanced Practice Professional shall be designated as a member of the Advanced Practice Professional Staff.

### 3.2 ACTIVE MEDICAL STAFF

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#### 3.2.1 Composition.

The Active Medical Staff shall consist of Medical Staff Members who:

- (a) are located closely enough to the applicable Medical Center(s) to provide continuous care to their patients;
- (b) assume all the functions and responsibilities of appointment to the Active Medical Staff<sup>77</sup>; and
- (c) regularly treat patients at the Medical Center(s). "Regularly treat" means the Active Medical Staff Member has more than twenty-five (25) Patient Encounters during the most recent two (2) year reappointment period. In the event an Active Medical Staff Member does not regularly treat patients at the Medical Center(s), the Administrator (or his/her designee) shall notify the Practitioner, and the

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<sup>75</sup> 42 C.F.R. § 482.22(c)(3).

<sup>76</sup> Wis. Admin. Code DHS § 124.12(3)(b). (2011).

<sup>77</sup> Wis. Admin. Code DHS § 124.12(3)(a). (2011).



Practitioner shall be deemed to have voluntarily requested reassignment to the Courtesy Medical Staff.

### **3.2.2 Rights and Obligations.**

- (a) Active Medical Staff appointees shall be:
  - i. eligible to apply for Clinical Privileges; (including the privilege to admit, perform procedures, and/or write orders<sup>78</sup>);
  - ii. encouraged to attend Medical Staff-and Department meetings;
  - iii. eligible to vote at Medical Staff and Department meetings;
  - iv. eligible to serve in a voting capacity on and as chairperson of one or more Medical Staff committees;
  - v. eligible to hold Medical Staff office; and
  - vi. eligible to serve as a Clinical Chairperson.
- (b) As may be required by the Medical Executive Committee or the Governing Body, Active Medical Staff appointees must actively participate in recognized functions of Medical Staff appointment, including but not limited to, participating in quality improvement and other monitoring activities, serving on Medical Staff committees, and discharging other functions as may be required from time to time.
- (c) Active Medical Staff appointees must participate in emergency department back-up call and other specialty coverage programs in accordance with the Policies Governing Medical Practices and/or as requested by the Medical Executive Committee. At the discretion of the Clinical Chairperson of the applicable Department, Active Medical Staff Members who have attained the age of sixty-five (65) years may be released from the obligation and responsibility of providing emergency department back-up call service.

## **3.3 COURTESY MEDICAL STAFF**

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### **3.3.1 Composition.**

The Courtesy Medical Staff shall consist of Medical Staff Members who:

- (a) are members of the active or associate staff of another medical center where they actively participate in a patient care evaluation program and other quality management activities similar to those required of the Active Medical Staff of this Medical Staff. In the event a Practitioner does not have active staff or associate staff privileges at another medical center, the Medical Executive Committee may waive this requirement if additional quality assurance measures are established;

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<sup>78</sup> Wis. Admin. Code DHS § 124.12(5)(b)11. (2011).

- (b) are located closely enough to the applicable Medical Center(s) to provide continuous care to their patients;
- (c) assume all the functions and responsibilities of appointment to the Courtesy Medical Staff; and
- (d) occasionally treat patients at the Medical Centers. A Medical Staff Member occasionally treats patients if he/she has no more than twenty-five (25) Patient Encounters at the Medical Center(s) during the most recent two (2) year reappointment period. In the event a Courtesy Medical Staff Member has more than twenty-five (25) Patient Encounters in the most recent two (2) year reappointment period, the Administrator (or his/her designee) shall notify the Practitioner and the Practitioner shall be deemed to have voluntarily requested reassignment to the Active Medical Staff.

### 3.3.2 Rights and Obligations.

- (a) Courtesy Medical Staff appointees shall be eligible to:
  - i. apply for Clinical Privileges (including the privilege to admit, perform procedures, and/or write orders<sup>80</sup>);
  - ii. attend Medical Staff meetings in a non-voting capacity;
  - iii. serve on one or more Medical Staff committees in a non-voting capacity; and
  - iv. serve on one or more Medical Staff committees in a voting capacity, if the Medical Executive Committee determines that such appointee has expertise that is not otherwise available.
- (b) Courtesy Medical Staff appointees shall **not** be eligible to:
  - i. serve as a Clinical Chairperson; or
  - ii. hold Medical Staff office.
- (c) At the request of the Medical Executive Committee, Courtesy Medical Staff Members shall participate in emergency department back-up call under exigent circumstances including, but not limited to, gaps in coverage caused by the lack of a particular specialty on the Active Medical Staff.

## 3.4 CONSULTING MEDICAL STAFF

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### 3.4.1 Composition.

The Consulting Medical Staff shall consist of Medical Staff Members who:

- (a) have been granted consulting privileges as their only Clinical Privileges at the Medical Center(s) and shall not have admitting privileges;

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<sup>80</sup> Wis. Admin. Code DHS § 124.12(5)(b)11. (2011).

- (b) come to the Medical Center(s) solely to provide consultation services to Staff Members regarding subject matter that is within the Practitioner’s area of expertise; and
- (c) assume all the functions and responsibilities of appointment to the Consulting Medical Staff.

**3.4.2 Rights and Obligations.**

- (a) Consulting Medical Staff appointees shall be eligible for consulting Clinical Privileges only.
- (b) Consulting Medical Staff appointees are eligible to attend Medical Staff, Department, or Medical Staff committee meetings in a non-voting capacity.
- (c) Consulting Medical Staff appointees shall **not** be eligible to:
  - i. serve on Medical Staff committees;
  - ii. hold Medical Staff office;
  - iii. serve as a Clinical Chairperson; or
  - iv. participate in emergency department back-up call.

**3.5 TELEMEDICINE MEDICAL STAFF**

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**3.5.1 Composition.**

The Telemedicine Medical Staff shall consist of Medical Staff Members who:

- (a) have been granted telemedicine privileges as their only Clinical Privileges at the Medical Center(s);
- (b) provide medical services within the Practitioner’s area of expertise through a telemedicine link from a remote location; and
- (c) assume all the functions and responsibilities of appointment to the Telemedicine Medical Staff.

**3.5.2 Rights and Obligations.**

- (a) Telemedicine Medical Staff appointees shall be eligible to:
  - i. apply for telemedicine Clinical Privileges only;
  - ii. attend Medical Staff and Department meetings in a non-voting capacity; and
  - iii. serve on one or more Medical Staff committees in a voting or non-voting capacity and/or serve as a Medical Staff committee chairperson if the Medical Executive Committee determines that such appointee has expertise that is not otherwise available.
- (b) Telemedicine Medical Staff appointees shall **not** be eligible to:
  - i. serve as a Clinical Chairperson; or
  - ii. hold Medical Staff office.

### **3.6 HONORARY MEDICAL STAFF**

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#### **3.6.1 Composition.**

The Honorary Medical Staff shall consist of Practitioners who are recognized for their reputations and their contributions to the health and medical sciences, as well as their contributions to the Medical Center(s). Honorary Medical Staff Members must complete the appropriate Application as requested and:

- (a) be recommended for Honorary Medical Staff Membership by at least one Active Medical Staff appointee; and
- (b) be approved for membership on the Honorary Medical Staff by the Medical Executive Committee and the Governing Body.

#### **Rights and Obligations.**

- (a) Honorary Medical Staff appointees shall **not** be eligible for Clinical Privileges.
- (b) Honorary Medical Staff appointees shall be eligible to:
  - i. attend Medical Staff, Department, and Medical Staff committee meetings in a non-voting capacity with the approval of the Chief of Staff; and
  - ii. serve on one or more Medical Staff committees in a voting or non-voting capacity and/or serve as a Medical Staff committee chairperson if the Medical Executive Committee determines that such appointee has expertise that is not otherwise available.

### **3.7 ADVANCED PRACTICE PROFESSIONAL STAFF**

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#### **3.7.1 Composition.**

The Advanced Practice Professional Staff shall consist of Advanced Practice Professionals who:

- (a) are located closely enough to the applicable Medical Center(s) to provide continuous care to their patients; and
- (b) assume all the functions and responsibilities of appointment to the Advanced Practice Professional Staff.

#### **3.7.2 Rights and Obligations.**

- (a) Advanced Practice Professional Staff appointees shall be eligible to:
  - i. apply for Clinical Privileges;<sup>77</sup>
  - ii. attend Medical Staff, Department and Medical Staff committee meetings in a non-voting capacity;

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<sup>77</sup> Wis. Admin. Code DHS § 124.12(5)(b)11. (2011).

## ARTICLE 3 – STAFF CATEGORIES

- iii. serve on one or more Medical Staff committees in a non-voting capacity; and
  - iv. serve on one or more Medical Staff committees in a voting capacity, if the Medical Executive Committee determines that such appointee has expertise that is not otherwise available.
- (b) Advanced Practice Professional Staff appointees shall **not** be eligible to:
- i. apply for admitting privileges;
  - ii. serve as a Medical Staff Officer;
  - iii. serve as a Clinical Chairperson; or
  - iv. vote in elections for Medical Staff Officers and Clinical Chairpersons.
- (c) As may be required by the Medical Executive Committee or the Governing Body, Advanced Practice Professional appointees must actively participate in recognized functions of Staff appointment, including but not limited to, participating in quality improvement and other monitoring activities, serving on Medical Staff committees, and discharging other functions as may be required from time to time.
- (d) At the request of the Medical Executive Committee, Advanced Practice Professional Staff Members shall participate in emergency department back-up call under exigent circumstances including, but not limited to, gaps in coverage caused by the lack of a particular specialty on the Active Medical Staff.

### **3.8 CHANGE IN MEDICAL STAFF CATEGORY**

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Except for automatic reassignment processes specified in Sections 3.2 and 3.3, a Medical Staff Member seeking to change his/her current Medical Staff category must submit the request in writing to Medical Staff Services. Such requests shall be reviewed and approved or denied using the same process set forth for Medical Staff appointment/reappointment. Requests may be submitted at any time.

## ARTICLE 4. CORRECTIVE ACTIONS

### 4.1 FORMAL CORRECTIVE ACTION PROCESS<sup>78</sup>

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#### 4.1.1 Request for and Notice of Informal Inquiry or Investigation.

- (a) Request for Informal Inquiry or Investigation. The Administrator, the appropriate Clinical Chairperson, the Chief of Staff, three (3) or more Medical Staff Members, and/or the Governing Body, may submit a written request for an informal inquiry or investigation (“Request for Informal Inquiry or Investigation”) to the Medical Executive Committee whenever information indicates that a Medical Staff Member’s acts, omissions, demeanor, conduct or professional performance may be:
- i. Below the standards or aims of the Medical Staff, including applicable professional standards;
  - ii. Detrimental to patient safety or to the delivery of quality care;
  - iii. Unethical, disruptive or harassing; and/or
  - iv. Contrary to these Bylaws, the Policies Governing Medical Practices, the policies of the Medical Centers, or applicable laws, regulations, or accreditation standards.<sup>79</sup>
- (b) Basis for Request. A Request for Informal Inquiry or Investigation must be based on a reasonable belief that the action is in furtherance of quality health care<sup>80</sup> and supported by reference to the specific acts or omissions which constitute the grounds for the request.
- (c) Notice to Administrator. The Chief of Staff (or his/her designee) shall notify the Administrator in writing within seven (7) days of the Medical Executive Committee’s receipt of a Request for Informal Inquiry or Investigation, and will continue to keep the Administrator fully informed of all action taken in connection therewith.
- (d) Written Notice to Medical Staff Member. The Administrator (or his/her designee) shall provide the affected Medical Staff Member with Written Notice of the Request for Informal Inquiry or Investigation. The Written Notice shall:
- i. Advise the Medical Staff Member of the Request for Informal Inquiry or Investigation and the basis therefore; and
  - ii. Advise the Medical Staff Member that he/she may request a preliminary interview with the Medical Executive Committee.

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<sup>78</sup> JCS MS.01.01.01, EPs 30 & 33 (October 2011).

<sup>79</sup> JCS MS.01.01.01, EP 30 (October 2011).

<sup>80</sup> 42 U.S.C. § 11112(a)(1).

#### **4.1.2 Preliminary Interview with Medical Staff Member.**

The Medical Staff Member may request a preliminary interview with the Medical Executive Committee prior to its taking action on a Request for Informal Inquiry or Investigation. At such preliminary interview, the Medical Staff Member shall again be apprised of the general nature of the Request for Informal Inquiry or Investigation and be afforded the opportunity to discuss, explain or refute the allegations. This preliminary interview shall not constitute a hearing and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A record of such preliminary interview shall be made by the Medical Executive Committee.

#### **4.1.3 Initial Meeting to Determine Course of Action.**

Following the receipt of a Request for Informal Inquiry or Investigation and a preliminary interview (if requested by the Medical Staff Member), the Medical Executive Committee shall meet as soon as practicable to determine whether (a) the matter can be handled informally without conducting a formal investigation using the procedure described in Section 4.2, or (b) the matter should proceed to a formal investigation and/or corrective action using the procedure described in Section 4.1.4.

#### **4.1.4 Formal Investigation and Corrective Action.**

If the Medical Executive Committee determines that a matter cannot be resolved informally, the Medical Executive Committee (or its designee) shall formally investigate the concerns described in the Request for Informal Inquiry or Investigation (and any other concerns or issues that arise during the course of its review) and make a reasonable attempt to obtain the facts related to such concerns.<sup>81</sup> As part of its investigation, the Medical Executive Committee shall offer the Medical Staff Member the opportunity to meet with the Medical Executive Committee to discuss, explain and refute the allegations. This meeting shall not constitute a hearing and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A record of such meeting shall be made by the Medical Executive Committee. Following such formal investigation, the Medical Executive Committee's action may include, but is not limited to, one or more of the following:

- (a) Rejection or modification of the Request for Informal Inquiry or Investigation;
- (b) Issuance of a warning;
- (c) Issuance of a letter of reprimand;
- (d) Requirement to complete specific education;
- (e) Imposition of a term of Probation or monitoring;
- (f) Requirement to seek consultations;
- (g) Recommendation for reduction, suspension or revocation of Clinical Privileges;
- (h) Recommendation that an existing summary suspension of Clinical Privileges be terminated, modified or sustained;

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<sup>81</sup> 42 U.S.C. § 11112(a)(2).



- (i) Recommendation that the Medical Staff Member's Staff Membership be revoked; and/or
- (j) Any other action which may be appropriate under the circumstances.

**4.1.5 Administrative Suspension.**

At any time during an informal inquiry or formal investigation, the affected Medical Staff Member's Clinical Privileges may be suspended by the Chief of Staff or the Administrator for a period not to exceed fourteen (14) days. The suspension shall be deemed precautionary and preliminary in nature. In the event of an administrative suspension pursuant to this Section 4.1.5, another Medical Staff Member with appropriate Clinical Privileges shall be assigned responsibility for the care of the suspended Medical Staff Member's patients until the administrative suspension has expired. The suspended Medical Staff Member shall confer with the Medical Staff Member(s) so assigned to the extent necessary to ensure continuous quality care.

**4.1.6 Written Notice of Adverse Action.**

Before any action of the Medical Executive Committee that may be deemed an Adverse Action is forwarded to the Governing Body, the Administrator shall notify the affected Medical Staff Member of the Adverse Action and the Medical Staff Member shall be provided an opportunity to exercise his or her hearing rights (if any), as set forth in Article 5 of these Medical Staff Bylaws.

**4.1.7 Communication with Medical Center Departments.**

Medical Staff Services will ensure that the appropriate Departments and other Medical Center patient care areas are informed of any Adverse Actions that affect a Medical Staff Member's Clinical Privileges, including but not limited to summary suspension, automatic suspension, and automatic termination.<sup>82</sup>

**4.1.8 Enforcement and Alternative Coverage.**

The Chief of Staff shall enforce all corrective actions with the assistance of the Administrator and the applicable Clinical Chairperson(s). Immediately upon the imposition of a summary suspension, automatic suspension, or automatic termination, the Chief of Staff (or his/her designee) shall have authority to appoint an alternative Medical Staff Member to provide medical coverage for the suspended/terminated Medical Staff Member's patients who remain at a Medical Center at the time of such suspension or termination. Unless otherwise decided by the Chief of Staff, such alternative coverage shall be the responsibility of the Medical Staff Member who agreed, by signing the applicable form, to serve as the suspended/terminated Medical Staff Member's alternate for coverage. The wishes of the patients shall be considered in the selection of such alternative Medical Staff Member. The suspended/terminated Medical Staff Member shall confer with the alternative Medical Staff Member to the extent necessary to ensure continuous quality care.

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<sup>82</sup> 42 C.F.R. § 482.22(a)(2) (Interpretive Guidelines, effective October 17, 2008).

**4.1.9 Notice to Affiliates.**

When a Medical Staff Member receives notice of a corrective action taken or recommended, the Chief of Staff or his or her designee shall notify, as appropriate, the other Aurora Affiliates where the Medical Staff Member is on staff, employed, or applies for Medical Staff membership or employment of the same.

**4.2 INFORMAL CORRECTIVE ACTION PROCESS**

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Notwithstanding any other provision in these Medical Staff Bylaws, the Medical Executive Committee may, without the initiation of a Request for Informal Inquiry or Investigation, take any of the actions set forth below with respect to a Medical Staff Member to address conduct and/or professional performance (e.g., clinical competence) issues. Such action shall take effect immediately, shall not require Governing Body approval, and shall not entitle the affected Medical Staff Member to hearing and appeal rights. Such informal resolution may include a personal interview with the Medical Staff Member. A written record of any and all actions taken pursuant to this Section 4.2 shall be kept in the Medical Staff Member’s credentials file, together with any written response from the Medical Staff Member. In addition, the MEC may, with or without the initiation of a Request for Informal Inquiry or Investigation, recommend to the Governing Body that a Medical Staff Member be granted Conditional Reappointment.

- (a) Remedial actions to be voluntarily undertaken;
- (b) Issuance of a warning;
- (c) Issuance of a letter of reprimand;
- (d) A monitoring agreement;
- (e) Requirement to complete specific education; and/or
- (f) Administrative suspension for a period no longer than fourteen (14) days.

**4.3 SUMMARY SUSPENSION<sup>83</sup>**

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**4.3.1 Authority and Indications.**

The Chief of Staff, the Chief of Staff Elect, the Administrator, a majority of the Medical Executive Committee, or a majority of the Governing Body, shall each have the authority to summarily suspend all or any portion of a Medical Staff Member’s Clinical Privileges if the failure to take such action may result in imminent danger to the health, safety or welfare of any individual.<sup>84</sup>

**4.3.2 Written Notice of Summary Suspension.**

The Administrator (or his/her designee) shall provide the affected Medical Staff Member with Written Notice of the summary suspension (“Summary Suspension Notice”). Such summary suspension shall become effective on the Delivery Date of the Summary

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<sup>83</sup> JCS MS.01.01.01, EPs 29 & 32 (October 2011).

<sup>84</sup> 42 U.S.C. § 11112(c)(2).

Suspension Notice. A written report stating the reasons for the summary suspension shall be submitted to the Medical Executive Committee by the suspending agent within 24 hours of the Delivery Date of the Summary Suspension Notice.

**4.3.3 Informal Interview.**

A Medical Staff Member whose Clinical Privileges have been summarily suspended shall be entitled to request (in writing and received by the Administrator within ten (10) days of the Delivery Date of the Summary Suspension Notice) an informal interview with the Medical Executive Committee within such reasonable time period thereafter as the Medical Executive Committee shall determine. The informal interview shall include at least: (a) a review of the written report stating the reasons for the summary suspension, and (b) an opportunity for the Medical Staff Member to discuss the matter with the Medical Executive Committee. During such interview, the Medical Staff Member shall be invited to discuss, explain or refute the allegations against the Medical Staff Member. The Medical Executive Committee may request further information as required to make a recommendation regarding the summary action. This informal interview shall be preliminary in nature and none of the procedural rules provided in Article 5 with respect to hearings shall apply, except that a record of the interview shall be made by the Medical Executive Committee.

**4.3.4 Medical Executive Committee Recommendation.**

The Medical Executive Committee may recommend modification, continuance or termination of the terms of the summary suspension. Before any action of the Medical Executive Committee that may be deemed an Adverse Action is forwarded to the Governing Body, the Administrator shall notify the affected Medical Staff Member of the Adverse Action and the Medical Staff Member shall be provided an opportunity to exercise his or her hearing rights (if any), as set forth in Article 5. The terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending completion of the hearing and appellate review process, if any.

**4.3.5 Notice to Aurora Affiliates.**

When a Medical Staff Member is summarily suspended, the Chief of Staff (or his/her designee) shall notify, as appropriate, the other Aurora Affiliates where the Medical Staff Member is on staff, employed, or applies for Medical Staff membership or employment of the same.

**4.4 ADVANCED PRACTICE PROFESSIONALS**

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**4.4.1 Applicability.**

Advanced Practice Professionals are not entitled to the procedures and rights set forth in Sections 4.1 through 4.3 of this Article 4 or the hearing and appeal rights set forth in Article 5 of these Medical Staff Bylaws.<sup>85</sup>

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<sup>85</sup> Wis. Admin. Code DHS § 124.12(4)(c)6. (2011).

**4.4.2 Corrective or Other Action Against an Advanced Practice Professional.**

Notwithstanding any other provision set forth in these Medical Staff Bylaws, the Medical Executive Committee retains the right to take any action, up to and including suspension or termination of Advanced Practice Professional Staff Membership and Clinical Privileges, against an Advanced Practice Professional, with or without cause. Such actions taken do not entitle the Advanced Practice Professional to any process, hearing or appeal rights other than the limited rights specified in Section 4.4.3 below.

**4.4.3 Limited Right to Review Adverse Action.**

In the event an action taken against an Advanced Practice Professional would be deemed an Adverse Action giving rise to procedures and/or rights if taken against a Medical Staff Member, the Advanced Practice Professional shall have the right to personally appear before the Medical Executive Committee to discuss the matter and have the action reviewed by the Medical Executive Committee. To exercise such right, the Advanced Practice Professional must file a written request for review with the Medical Executive Committee within fifteen (15) days of the Adverse Action. This limited right of review and the interview shall not constitute a “hearing” or “appeal” and are not subject to the procedural rules applicable to hearings and appeals. A decision on the action shall be made by the Medical Executive Committee and the decision of the Medical Executive Committee in reviewing the action shall be final.

**4.4.4 Notice to Affiliates.**

When corrective action is taken against an Advanced Practice Professional, the Chief of Staff or his or her designee shall notify, as appropriate, the other Aurora Affiliates where the Advanced Practice Professional is on staff, employed, or applies for Staff Membership or employment of the same.

**4.5 AUTOMATIC SUSPENSION AND VOLUNTARY RELINQUISHMENT<sup>86</sup>**

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**4.5.1 Failure to Complete Medical Records.**

- (a) Any Staff Member who has any delinquent records will have his or her Clinical Privileges suspended. A record is considered delinquent twenty-one (21) days after the patient’s inpatient or outpatient visit or the deficiency has been allocated, whichever comes first and is applied toward all medical record types – H&P’s, operative reports, discharge summaries, procedure notes (inpatient and outpatient) and outpatient progress notes/hospital-based clinical visits of any kind. Deficiencies may include missing documentation, missing signatures on orders and/or missing signatures on entries. This means:
- i. Staff Members will not be allowed to admit elective inpatients or outpatients.
  - ii. Staff Members will not be allowed to advance schedule inpatient or outpatient procedures

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<sup>86</sup> JCS MS.01.01.01, EPs 28 & 31 (October 2011).

## ARTICLE 4 – CORRECTIVE ACTIONS

- iii. Since procedures currently advance scheduled will not be cancelled, Staff Members are expected to have their suspension removed prior to the date of admission/procedure.
- (b) Emergency admissions through the Emergency Department are not affected; therefore, Emergency Department call is not affected. An increase in emergency admissions from Staff Members with suspended Clinical Privileges will be reviewed by the Staff Member's Department Chief.
- (c) The attending physician, not resident, has the responsibility for the documentation of medical care. Failure of a resident to complete the record during the thirty (30) day period does not absolve the attending from suspension, although it is the requirement of the Medical Education programs that residents and fellows schedule medical records completion weekly. It is anticipated that the attending Staff Member will include accountability for completion of the medical record as a part of resident training.
- (d) In determining the appropriateness of suspension, the Medical Records Department will factor in circumstances beyond the Staff Member's control. These include: prior notification of vacations or other absences and the unavailability of a medical record.
- (e) To be removed from suspension the Staff Member must complete all available delinquent deficiencies from the Staff Member's in-basket.
- (f) Once the Staff Member has completed his or her records, the Medical Records Department will be notified automatically, the following day, via SmartChart Report. Any Staff Member needing scheduling privileges reinstated more quickly should contact their respective Medical Record Department. The Medical Record Department will verify delinquencies are complete and will remove the Staff Member from the suspension status and will notify the appropriate departments.
- (g) Staff Members on suspension may consult as requested on inpatients.
- (h) Staff Members on suspension for Medical Records will be allowed to refer patients to the Medical Center(s) for diagnostic testing that does not require that the Staff Member be in attendance.
- (i) Staff Members whom are on suspension for more than thirty (30) days OR have three (3) episodes of suspension in a twelve (12) month period will result in an automatic voluntary relinquishment of the Staff Member's Clinical Privileges.. The thirty (30) days will commence on the day the Staff Member is notified.
- (j) Any requests for exceptions to this section shall be directed by the Staff Member to the Administrator.

### **4.5.2 Adverse Change in Licensure or Certification.**

- (a) Revocation and Suspension. A revocation or suspension of a Staff Member's license, certification or other credential authorizing practice in this State shall be

deemed to be a voluntary relinquishment of such Staff Member’s Staff Membership and Clinical Privileges as of the date such revocation or suspension becomes effective.

- (b) **Restriction.** If a Staff Member’s license, certification or other credential authorizing practice in this State is limited, restricted or made subject to certain conditions (including without limitation, Probation) by the applicable licensing or certifying authority, any of the Staff Member’s Clinical Privileges which are within the scope of the state’s limitation, restriction, or condition, shall be automatically suspended, limited, restricted or conditioned by the Medical Center(s) in a similar manner, as of the date such state action becomes effective and throughout its term.
- (c) **Expiration.** If a Staff Member’s license, certification or other credential authorizing practice in this State expires, the Staff Member’s Membership and Clinical Privileges shall be immediately and automatically suspended as of the effective date of such expiration. The failure of the Staff Member to submit proof of a current, unrestricted license, certification or other credential authorizing practice in this State within thirty (30) days after the expiration of such license, certification or other credential shall be deemed a voluntary relinquishment of the Staff Member’s Staff Membership and Clinical Privileges. If the Staff Member submits a current, unrestricted license, certification or other credential authorizing practice in this State prior to the voluntary relinquishment of Staff Membership and Clinical Privileges, the Staff Member’s Staff Membership and Clinical Privileges shall be automatically reinstated without further action on the part of the Staff Member or any Medical Staff committee. Medical Staff Services shall notify the Administrator when the license, certification or other credential is received.

**4.5.3 Exclusion from Health Care Program.**

A Staff Member’s exclusion from participation in Medicare, Medicaid or any health care program funded in whole or in part by the federal or state government, shall be deemed to be a voluntary relinquishment of such Staff Member’s Staff Membership and Clinical Privileges as of the date such exclusion becomes effective.

**4.5.4 Adverse Change in DEA Certification.**

If a Staff Member’s Drug Enforcement Administration (DEA) certification is revoked, suspended or voluntarily relinquished, or whenever such certification is subject to Probation, the Staff Member shall immediately and automatically be divested of the right to prescribe medications covered by such number. As soon as reasonably possible after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the DEA number was revoked, suspended or relinquished. The Medical Executive Committee may then take such further corrective action as may be appropriate under the circumstances.

**4.5.5 Failure to Maintain Professional Liability Insurance.**

- (a) If a Staff Member fails to maintain the amount of professional liability insurance required and/or fails to submit a Certificate of Insurance as required under these



Bylaws or as otherwise requested, the Staff Member's Staff Membership and Clinical Privileges shall be immediately and automatically suspended.

- (b) The failure of the Staff Member to submit a Certificate of Insurance within thirty (30) days after the automatic suspension shall be deemed to be a voluntary relinquishment of the Staff Member's Staff Membership and Clinical Privileges.
- (c) If the Staff Member submits a Certificate of Insurance prior to the voluntary relinquishment of Staff Membership and Clinical Privileges, the Staff Member's Staff Membership and Clinical Privileges shall be automatically reinstated without further action on the part of the Staff Member or any Medical Staff committee. Medical Staff Services shall notify the Administrator when the Certificate of Insurance has been received.

#### **4.5.6 Failure to Pay Dues.**

If a Staff Member fails to pay required dues, after a written warning of delinquency and a specified time frame not to exceed thirty (30) days, the Staff Member's Staff Membership and Clinical Privileges, shall be automatically suspended and shall remain so suspended until the Staff Member pays the delinquent dues. A failure to pay such dues within six (6) months after the date the automatic suspension became effective shall be deemed to be a voluntary relinquishment of the Staff Member's Staff Membership and Clinical Privileges.

#### **4.5.7 Conviction of Serious Crime.**

If a Staff Member is (a) convicted of a "Serious Crime" as such term is defined in Section 50.065 of the Wisconsin Statutes, or any successor statute thereto, and the Staff Member has not received rehabilitation approval pursuant to Section DHS 12.12 of the Wisconsin Administrative Code, or any successor regulation thereto; or (b) is convicted of, or pleads "guilty" or "no contest" or its equivalent to a felony in any jurisdiction, the Staff Member shall be deemed to have voluntarily relinquished his or her Staff Membership and Clinical Privileges as of the date of such conviction or plea.

#### **4.5.8 Failure to Maintain Collaborative or Supervisory Relationship**

If an Advanced Practice Professional: (i) fails to maintain a required collaborative or supervisory relationship and written agreement with one or more Medical Staff Members (e.g., the Advanced Practice Professional's sole supervising physician's Medical Staff membership is terminated, or the sole supervision physician terminates the supervisory relationship with the Advanced Practice Professional); or (ii) fails to comply with the terms of his/her collaborative or supervisory agreement, the Advanced Practice Professional's Clinical Privileges shall be automatically suspended and shall remain so suspended until the Advanced Practice Professional provides Medical Staff Services with adequate evidence that an appropriate collaborative or supervisory relationship and agreement exists and that the Advanced Practice Professional is in compliance with the terms of such collaborative or supervisory agreement. A failure to provide Medical Staff Services with adequate evidence that an appropriate collaborative or supervisory relationship and agreement exists and that the Advanced Practice Professional is in compliance with the terms of such collaborative or supervisory agreement, within one (1)



month after the date the automatic suspension became effective, shall be deemed to be a voluntary relinquishment of the Advanced Practice Professional's Staff Membership and Clinical Privileges.

**4.5.9 Failure to Provide Proof of Influenza Immunization.**

A Staff Member's failure to provide proof of influenza immunization or a granted exception in accordance with the Aurora Health Care System Influenza Immunization Policy after a written warning of delinquency and a specified time frame not to exceed thirty (30) days shall be deemed a voluntary relinquishment of the Staff Member's Staff Membership and Clinical Privileges.

**4.5.10 Failure to Complete Required Electronic Medical Record Training.**

If a Staff Member fails to complete required electronic medical record training within thirty (30) days of appointment or prior to first patient contact, whichever is sooner, the Staff Member's Staff Membership and Clinical Privileges shall be automatically suspended and shall remain so suspended until the Staff Member completes the required training. The failure of the Staff Member to complete the training within thirty (30) days after the date the automatic suspension became effective shall be deemed to be a voluntary relinquishment of the Staff Member's Staff Membership and Clinical Privileges.

**4.5.11 Failure to Complete ICD Training**

If a Staff Member fails to complete required International Statistical Classification of Diseases and Related Health Problems (ICD) training within thirty (30) days of appointment or prior to first patient contact, whichever is sooner, the Staff Member's Staff Membership and Clinical Privileges shall be automatically suspended and shall remain so suspended until the Staff Member completes the required training. The failure of the Staff Member to complete the training within thirty (30) days after the date the automatic suspension became effective shall be deemed to be a voluntary relinquishment of the Staff Member's Staff Membership and Clinical Privileges.

**4.5.12 Failure to Complete Required Training**

If a Staff Member fails to complete any training required by the Medical Executive Committee within the timeframe required by the Medical Executive Committee, the Staff Member's Staff Membership and Clinical Privileges shall be automatically suspended and shall remain so suspended until the Staff Member completes the required training. The failure of the Staff Member to complete the training within thirty (30) days after the date the automatic suspension became effective shall be deemed to be a voluntary relinquishment of the Staff Member's Staff Membership and Clinical Privileges.

**4.5.13 Failure to Satisfy an Appearance Requirement.**

If a Staff Member fails to satisfy an appearance required under Section 2.8.3, the Staff Member shall be deemed to have voluntarily relinquished his or her Staff Membership and Clinical Privileges as of the date the Medical Executive Committee determines the Staff Member missed such appearance without good cause.

**4.5.14 Failure to Complete FPPE or OPPE.** If a Staff Member fails to comply with any FPPE and OPPE processes and requirements imposed at any time by the Medical Executive Committee, including, without limitation, any performance improvement plan, proctoring requirement, or monitoring requirement, the Staff Member shall be deemed to have voluntarily relinquished his or her Staff Membership and Clinical Privileges as of the date the Medical Executive Committee determines the Staff Member has failed to comply with such processes or requirements.

**4.5.15 Failure to Make Mandatory Self-Disclosure.**

If the Medical Executive Committee determines that (1) the Staff Member failed to make any report required to be made under Section 2.8.8 and (2) the Staff Member knowingly intended to withhold such information, the Staff Member shall be deemed to have voluntarily relinquished his or her Staff Membership and Clinical Privileges as of the date the Medical Executive Committee makes such determinations.

**4.5.16 Written Submission Not Required.**

Voluntary relinquishments under this Section 4.4 are automatic and, therefore, do not require a written submission in accordance with the requirements of Section 2.9.2 of these Medical Staff Bylaws

**4.5.17 Written Confirmation and Procedural Rights.**

Written confirmation of voluntary relinquishment shall be given to the affected Staff Member by Medical Staff Services, with notice to the Governing Body, the Medical Executive Committee, the Administrator, the Chief Medical Officer, and any Aurora Affiliate where the Staff Member is on staff or employed. Voluntary relinquishment does not entitle the affected Staff Member to hearing and appellate review rights.

# ARTICLE 5. HEARING AND APPELLATE REVIEW PROCEDURE

## 5.1 GENERAL PROVISIONS

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### 5.1.1 Purpose.

The hearing and appellate review processes described herein are designed to ensure that: (1) Adverse Actions are issued or imposed in the furtherance of quality health care after full consideration and reconsideration of all quality and safety issues; and (2) any Medical Staff Member who is subject to an Adverse Action has a fair opportunity to appeal such action.<sup>87</sup>

### 5.1.2 Applicability.

For purposes of this Article 5, the term “Medical Staff Member” may include “Applicant,” as may be applicable under the circumstances. The procedures and rights set forth in this Article 5 are not applicable to Advanced Practice Professionals.<sup>88</sup>

### 5.1.3 Exhaustion of Remedies; Right to One Hearing / Appellate Review

If an Adverse Action is taken or recommended, the Medical Staff Member must exhaust the remedies afforded by these Bylaws before resorting to legal action. No Medical Staff Member shall be entitled to more than one hearing and one appellate review on any matter which shall have been the subject of an Adverse Action.

### 5.1.4 Construction of Time Periods; Waiver.

Failure by any Hearing Committee or Appellate Review Committee, the Medical Executive Committee, or the Governing Body, to comply with a time limit specified in this Article 5 shall not be deemed to invalidate their actions. Notwithstanding the above, where these Bylaws specifically provide that any right shall be waived as a result of the failure to act within a specified time period, such provisions shall be strictly applied.

## 5.2 GROUNDS FOR A HEARING OR APPELLATE REVIEW

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### 5.2.1 Adverse Actions.

Except as otherwise specified in these Bylaws, any one or more of the following, if recommended or issued by the Medical Executive Committee or the Governing Body, shall be deemed an Adverse Action and shall constitute grounds for a hearing and/or appellate review:

- (a) Denial of initial Medical Staff appointment;
- (b) Denial of Medical Staff reappointment;
- (c) Revocation of Staff Membership;

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<sup>87</sup> 42 U.S.C. § 11112(a)(1)–(2); Wis. Admin. Code DHS § 124.12(5)(b)4 (2011); JCS MS.10.01.01, Rationale (October 2011).

<sup>88</sup> Wis. Admin. Code DHS § 124.12(4)(c)6 (2011)

- (d) Refusal to reinstate a Medical Staff Member following an approved leave of absence;
- (e) Involuntary change or denial of a requested change in Medical Staff category, if such involuntary change or denial results in the denial, reduction, or termination of Clinical Privileges;
- (f) Denial of requested Clinical Privileges;
- (g) Involuntary reduction or suspension of Clinical Privileges for a period of fifteen (15) days or more;
- (h) Termination of current Clinical Privileges; and/or
- (i) Imposition of a mandatory monitoring, supervision, proctoring, review or consultation requirement, but only if: (i) the monitor/supervisor/proctor/reviewer/consultant must provide prior approval of the provision of medical care by the Medical Staff Member, and (ii) the monitoring, supervision, proctoring, review or consultation is not imposed as part of the FPPE process for newly granted privileges.

**5.2.2 Actions Which Do Not Entitle the Medical Staff Member to Hearing/Appellate Review Rights.**

The following shall not be deemed Adverse Actions and shall not constitute grounds for a hearing and/or appellate review rights (unless the action is reportable to the NPDB):

- (a) Any summary suspension of Clinical Privileges imposed in accordance with Section 4.3 of these Bylaws for a period of fourteen (14) days or less.<sup>89</sup>
- (b) Any automatic suspension or voluntary relinquishment in accordance with Section 4.5 of these Bylaws.
- (c) The revocation of Staff Membership and/or Clinical Privileges in accordance with Section 2.11 of these Bylaws, unless specifically provided to the contrary in the contract.
- (d) Involuntary change or denial of a requested change in Medical Staff category, if such involuntary change or denial does not result in the denial, reduction or termination of Clinical Privileges.
- (e) The denial, suspension or revocation of temporary, emergency or disaster privileges.
- (f) The denial or refusal to accept an incomplete Application.
- (g) Monitoring, supervision, proctoring, review or consultation conducted as part of the FPPE process for newly granted privileges, including, without limitation, routine assignment of a proctor to a recently appointed Medical Staff Member, or to a Medical Staff Member with newly granted privileges.

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<sup>89</sup> 42 U.S.C. § 11112(c)(1)(B) (providing that a health care entity need not meet notice and hearing requirements in the case of a suspension or restriction of clinical privileges for a period not longer than 14 days); See also 45 C.F.R. § 60.11(a)(i); Wis. Stat. § 50.36(3)(c) (2011).

- (h) The imposition of monitoring, supervision, proctoring, review or consultation requirements, where prior approval of the monitor/supervisor/proctor/reviewer/consultant is not required prior to the provision of medical care by the Medical Staff Member.
- (i) A recommendation that a Medical Staff Member be directed to obtain retraining, additional training or continuing education.
- (j) Letters of warning, reprimand, censure or admonition.
- (k) Appointment, reappointment or Clinical Privileges which are granted for a period of less than two (2) years.
- (l) Failure to place a Medical Staff Member on any on-call or interpretation roster, or removal of any Medical Staff Member from any such roster.
- (m) Denial or revocation of membership on the Honorary Medical Staff.
- (n) The removal of a Medical Staff Member from any medico-administrative position, including removal from a Medical Staff Member’s position as a Medical Staff Officer or Clinical Chairperson.
- (o) The refusal to review or approve the granting of additional time to submit an Application for reappointment/renewal.
- (p) The refusal to recommend or approve a waiver of board certification requirements.
- (q) The reclassification of a Staff Member as not in Good Standing, provided that the reason for such reclassification is not itself an Adverse Action under Section 5.2.1.

### **5.3 PRE-HEARING PROCESS<sup>90</sup>**

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#### **5.3.1 Written Notice of Adverse Action.<sup>91</sup>**

The Administrator shall be responsible for giving prompt Written Notice of any Adverse Action (“Adverse Action Notice”) to any affected Medical Staff Member who is entitled to a hearing. The Adverse Action Notice shall:

- (a) Advise the Medical Staff Member of the Adverse Action;
- (b) Contain a brief statement identifying the acts and/or omissions upon which the Adverse Action is based;
- (c) Advise the Medical Staff Member that he/she may request a hearing to review the Adverse Action by submitting a written hearing request (“Hearing Request”) to the Administrator via personal/hand delivery or certified mail, return receipt requested within thirty (30) days of the Medical Staff Member’s receipt of the Adverse Action Notice;

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<sup>90</sup> JCS MS.01.01.01, EP 34 (October 2011).

<sup>91</sup> 42 U.S.C. § 11112(b)(1)(A)–(B).

- (d) State that the Medical Staff Member’s failure to submit a Hearing Request within the specified time, or to personally appear at the scheduled hearing, shall constitute a waiver of the Medical Staff Member’s right to the hearing and subsequent appellate review;
- (e) Advise the Medical Staff Member that: (i) the Medical Staff Member has the right to be represented at the hearing by a Medical Staff Member, legal counsel, or any other individual chosen by the Medical Staff Member; (ii) if the Medical Staff Member intends to be represented by legal counsel, the Medical Staff Member’s Hearing Request must indicate that the Medical Staff Member will be so represented; and (iii) if the Medical Staff Member’s Hearing Request does not indicate that the Medical Staff Member will be represented by legal counsel, the Medical Staff Member shall be deemed to have waived the right to be so represented;
- (f) Advise the Medical Staff Member that the Medical Staff Member may: (i) call, examine and cross-examine witnesses, to present evidence deemed relevant by the Hearing Committee Chairperson or the Chairperson’s designee (regardless of its admissibility in a court of law); and (ii) submit a written statement at the close of the hearing;
- (g) Advise the Medical Staff Member that a record of the hearing, shall be made, and that the Medical Staff Member has a right to receive a copy of such hearing record upon payment of reasonable charges for the preparation thereof; and
- (h) State that upon completion of the hearing procedure, the Medical Staff Member will receive a copy of the Hearing Committee Report, which shall include its recommendations and the basis therefor.

### **5.3.2 Hearing Request; Failure to Request Hearing.**

A Medical Staff Member who is entitled to a hearing under these Bylaws shall have thirty (30) days following the Delivery Date of the Adverse Action Notice to submit a Hearing Request to the Administrator via personal/hand delivery or by certified mail, return receipt requested.<sup>92</sup> The Medical Staff Member’s failure to timely submit a Hearing Request shall be deemed a waiver of the Medical Staff Member’s right to such hearing, and to any appellate review to which the Medical Staff Member might otherwise have been entitled on the matter. If the Adverse Action was *issued* by the Medical Executive Committee, it shall remain effective pending the Governing Body’s action. If the Adverse Action was *recommended* by the Medical Executive Committee, it shall not become effective until the Governing Body takes action on the matter.

### **5.3.3 Appointment of Hearing Committee.**<sup>93</sup>

- (a) Medical Executive Committee Review. When a hearing relates to an Adverse Action of the Medical Executive Committee, the Chief of Staff, in consultation with the Medical Executive Committee and the Administrator, shall provide the affected Medical Staff Member with a list of seven (7) Active Medical Staff

<sup>92</sup> 42 U.S.C. § 11112(b)(1)(B)(i)–(ii).

<sup>93</sup> JCS MS.01.01.01, EP 35 (October 2011); JCS MS.10.01.01, EP 4 (October 2011).

Members who would be able to serve on the Hearing Committee, none of whom may have participated in the underlying Adverse Action or be in direct economic competition with the Medical Staff Member.<sup>94</sup> The Medical Staff Member shall then have for three (3) business days, the option to strike two (2) of the potential committee members resulting in a Hearing Committee composed of five (5) members. The Chief of Staff shall designate one of the Hearing Committee members to serve as the Hearing Committee Chairperson.

- (b) Governing Body Review. When a hearing relates to an Adverse Action of the Governing Body that is not based on a prior Adverse Action of the Medical Executive Committee, the Governing Body shall appoint a Hearing Committee of no fewer than three (3) Active Medical Staff Member Practitioners, none of whom may be in direct economic competition with the affected Medical Staff Member.<sup>95</sup> The Governing Body shall designate one of the Hearing Committee members to serve as the Hearing Committee Chairperson.

#### **5.3.4 Scheduling of Hearing; Postponement<sup>96</sup>**

Within ten (10) days after receipt of a Hearing Request, the Medical Executive Committee or the Governing Body, as applicable, shall schedule and arrange for such hearing. The hearing date shall be not less than thirty (30) days, nor more than sixty (60) days, from the date of the Administrator’s receipt of the Hearing Request, unless otherwise agreed by the Medical Staff Member and the Hearing Committee Chairperson. The approval or disapproval of rescheduling requests made by the Medical Staff Member is within sole discretion of the Hearing Committee Chairperson.

#### **5.3.5 Written Notice of Hearing.<sup>97</sup>**

The Administrator (or his/her designee) shall be responsible for giving prompt Written Notice of the hearing (“Hearing Notice”) to the affected Medical Staff Member. The Hearing Notice shall:

- (a) State the time, place and date of the hearing;
- (b) Provide a list of witnesses (if any) who may testify on behalf of the Medical Executive Committee or the Governing Body (depending on which body’s action prompted the Hearing Request);
- (c) Inform the Medical Staff Member that the Medical Staff Member must provide the Hearing Committee with the following:
  - i. a list of witnesses the Medical Staff Member intends to call at the hearing (at least three (3) days prior to the hearing or as otherwise agreed by the parties);
  - ii. access to written materials that the Medical Staff Member intends to present at the hearing (at least three (3) days prior to the hearing or as otherwise agreed by the parties); and

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<sup>94</sup> 42 U.S.C. § 11112(b)(3)(A)(iii).

<sup>95</sup> 42 U.S.C. § 11112(b)(3)(A)(iii).

<sup>96</sup> 42 U.S.C. § 11112(b)(2)(A); JCS MS.01.01.01, EP 34 (October 2011); JCS MS.10.01.01, EP 2 (October 2011).

<sup>97</sup> 42 U.S.C. § 11112(b)(2)(A)–(B).



- iii. the name and address of the Medical Staff Member’s legal counsel (if the Medical Staff Member intends to be represented by legal counsel at the hearing).

**5.3.6 Representation.**

The Medical Staff Member may appoint a Medical Staff Member, legal counsel, or any other individual chosen by the Medical Staff Member to represent the Medical Staff Member at the hearing, present facts in opposition to the Adverse Action, and cross-examine witnesses. The Medical Executive Committee, when its action has prompted the hearing, shall appoint one or more of its members, an Active Medical Staff appointee, and/or legal counsel, to represent it at the hearing, present facts in support of the Adverse Action, and examine witnesses. The Governing Body, when its action has prompted the hearing, shall appoint one or more of its members, and/or legal counsel to represent it at the hearing, present the facts in support of the Adverse Action, and examine witnesses. The Medical Executive Committee or Governing Body representative shall not simultaneously serve as the Presiding Officer of the hearing. If the Medical Staff Member or the party that imposed the Adverse Action will be represented by legal counsel, that party shall inform the other party of the name and address of such counsel.

**5.3.7 Access to Information.**

The parties shall cooperate in good faith to (within a reasonable period prior to the hearing date): (a) exchange lists of expected witnesses and written materials to be presented at the hearing; and (b) inform the other party of any changes to the lists of expected witnesses, and/or the written materials to be presented at the hearing. The affected Medical Staff Member shall have access to the written materials, favorable or unfavorable, that: (i) were considered by the Medical Executive Committee or the Governing Body in undertaking the Adverse Action; or (ii) will be considered by the Hearing Committee during the hearing. The Medical Executive Committee or Governing Body, as applicable, shall provide Written Notice of any subsequent modifications to the grounds for the Adverse Action.

**5.4 HEARING PROCEDURE<sup>98</sup>**

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**5.4.1 Presiding Officer.**

The Hearing Committee Chairperson (or the Chairperson’s designee), shall preside over the hearing to: (a) determine the order of procedure during the hearing, (b) assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and (c) maintain decorum.

**5.4.2 Robert’s Rules of Order.**

The latest edition of ROBERT’S RULES OF ORDER shall prevail at the hearing, except that the Hearing Committee Chairperson may vote.

**5.4.3 Personal Presence Required.**

The Medical Staff Member for whom the hearing has been scheduled must be personally present. An affected Medical Staff Member who fails without good cause to appear and

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<sup>98</sup> JCS MS.01.01.01, EP 34 (October 2011); JCS MS.10.01.01, EP 3 (October 2011).

participate at such hearing shall be deemed to have waived such Medical Staff Member's hearing and appellate review rights and to have accepted the Adverse Action, and the same shall thereupon become and remain in effect as provided.<sup>99</sup>

**5.4.4 Submission of Written Statements.**

Prior to or during the hearing, the Medical Staff Member and the Medical Executive Committee or the Governing Body (as applicable) may submit written statements concerning any issue of procedure or of fact, and such written statements shall become a part of the hearing record. The Medical Staff Member's written statement may be submitted to the Hearing Committee through the Administrator by personal/hand delivery or by certified mail, return receipt requested, or brought to the hearing.

**5.4.5 Hearing Record.**

An accurate record of the hearing must be kept. Participants in the hearing shall be informed of all matters noticed and those matters shall be noted in the hearing record. The mechanism by which the hearing is recorded shall be established by the Hearing Committee and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription, or by the taking of adequate minutes. A Medical Staff Member desiring an alternate method of recording the hearing shall bear the primary cost thereof.

**5.4.6 Evidence; Witnesses.**

The affected Medical Staff Member and the Medical Executive Committee and/or Governing Body shall each have the right to: (a) call and examine witnesses, (b) introduce written evidence, (c) cross-examine any witness on any matter relevant to the issue of the hearing, (d) challenge any witness, and (e) rebut any evidence. If the Medical Staff Member does not testify on such Medical Staff Member's own behalf, the Medical Staff Member may be called and examined as if under cross-examination. The Hearing Committee may order that oral evidence be taken only upon oath or affirmation administered by any person entitled to notarize documents in the State of Wisconsin. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence may be considered, regardless of the existence of any common law or statutory rule which might make such evidence inadmissible in a civil or criminal action.

**5.4.7 Standard of Proof.**

It shall be the obligation of the Medical Executive Committee/Governing Body representative to present appropriate evidence in support of the Adverse Action, but the affected Medical Staff Member shall thereafter be responsible for supporting such Medical Staff Member's challenge to the Adverse Action by an appropriate showing that the charges or grounds involved lack any factual basis, or that such basis or any action based thereon is either arbitrary or capricious. The Medical Staff Member for whom the hearing is being held shall be given the opportunity, on request, to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee.

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<sup>99</sup> 42 U.S.C.S § 11112(b)(3)(B).

**5.4.8 Recess; Conclusion; Deliberations.**

The Hearing Committee may, in its sole discretion and without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. Within ten (10) days after the hearing is closed, the Hearing Committee shall conduct its deliberations. The Hearing Committee may: (a) conduct its deliberations outside the presence of the Medical Staff Member for whom the hearing was convened at a time convenient to itself; and (b) consider any pertinent information that was made available to the Medical Staff Member prior to or during the hearing. A Hearing Committee member who failed to attend the hearing may not participate in deliberations or voting on the matter.

**5.4.9 Hearing Committee Report.**

Upon the conclusion of its deliberations, the Hearing Committee shall issue a written Hearing Committee Report, which (a) shall include the Hearing Committee’s recommendations, including confirmation, modification, or rejection of the original Adverse Action and the basis therefore, and (b) may include the Hearing Committee’s official notice of any generally accepted technical or scientific matter relating to the issues under consideration at the hearing and of any facts which may be judicially noticed by the courts of this state. Within fifteen (15) days after the hearing, the Hearing Committee shall: (a) submit the Hearing Committee Report, the hearing record, and all other documentation, to the Medical Executive Committee or the Governing Body, whichever appointed it, and (b) deliver a copy of the Hearing Committee Report to the Medical Staff Member through the Administrator by personal/hand delivery or certified mail, return receipt requested.

**5.5 MEDICAL EXECUTIVE COMMITTEE/GOVERNING BODY REVIEW AND RECOMMENDATION**

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**5.5.1 Review.**

The entity that appointed the Hearing Committee (the Medical Executive Committee or the Governing Body) shall review the Hearing Committee Report, the hearing record and all other documentation considered by the Hearing Committee, and shall make a recommendation.

**5.5.2 Favorable Recommendation.**

If the Medical Executive Committee’s reconsidered recommendation is favorable to the Medical Staff Member, the recommendation shall be forwarded to the Governing Body for action at its next regularly scheduled meeting. If the Governing Body’s reconsidered recommendation is favorable to the Medical Staff Member, it shall be the final decision in the matter and the Administrator shall provide the affected Medical Staff Member with Written Notice of the Governing Body’s decision.

**5.5.3 Unfavorable Recommendation.**

If the Medical Executive Committee’s or Governing Body’s reconsidered recommendation is an Adverse Action which would entitle the Medical Staff Member to

appellate review, the Administrator shall promptly provide Written Notice of the Adverse Action, as provided in Section 5.6.1 of these Bylaws.

## **5.6 PRE-APPEAL PROCESS<sup>100</sup>**

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### **5.6.1 Written Notice of Adverse Action.<sup>101</sup>**

The Administrator shall be responsible for giving prompt Written Notice of an Adverse Action to any affected Medical Staff Member who is entitled to appellate review. The Written Notice shall:

- (a) Advise the Medical Staff Member of the Adverse Action;
- (b) Contain a brief statement identifying the acts and/or omissions upon which the Adverse Action is based;
- (c) Advise the Medical Staff Member of the Medical Staff Member's right to request an appellate review of the Adverse Action in accordance with this Article 5, and specify that the Medical Staff Member shall have ten (10) days within which to submit a written Appellate Review Request to the Administrator via personal/hand delivery or certified mail, return receipt requested;
- (d) Inform the Medical Staff Member that unless the Medical Staff Member's Appellate Review Request specifically requests the opportunity for oral argument, the appellate review shall be held only on the record on which the Adverse Action is based, supplemented by a written statement by the Medical Staff Member if the Medical Staff Member so desires;
- (e) State that the Medical Staff Member's failure to submit an Appellate Review Request within the specified time and/or to include a request for the opportunity to present an oral argument in such Appellate Review Request, shall constitute a waiver of the Medical Staff Member's right to appellate review and/or the Medical Staff Member's right to present an oral argument (as applicable);
- (f) Advise the Medical Staff Member that: (i) the Medical Staff Member has the right to be represented at the appellate review by a Medical Staff Member, legal counsel, or any other individual chosen by the Medical Staff Member; (ii) if the Medical Staff Member intends to be represented by legal counsel, the Medical Staff Member's Appellate Review Request must indicate that the Medical Staff Member will be so represented; and (iii) if the Medical Staff Member's Appellate Review Request does not indicate that the Medical Staff Member will be represented by legal counsel, the Medical Staff Member shall be deemed to have waived the right to be so represented;
- (g) Advise the Medical Staff Member of the Medical Staff Member's right to submit a written statement at the close of the appellate review;

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<sup>100</sup> JCS MS.10.01.01, EP 5 (October 2011).

<sup>101</sup> 42 U.S.C. § 11112(b)(1)(A)–(B).

- (h) Advise the Medical Staff Member that a record of the appellate review shall be made, and of the Medical Staff Member’s right to receive a copy upon payment of reasonable charges for the preparation thereof; and
- (i) State that upon completion of the appellate review the Medical Staff Member shall receive a copy of the written recommendation of the Appellate Review Committee, including a statement of the basis of the recommendation.

**5.6.2 Appellate Review Request; Failure to Request Appellate Review.**

A Medical Staff Member who is entitled to an appellate review under these Bylaws shall have ten (10) days following the Delivery Date of the Adverse Action Notice to submit an Appellate Review Request to the Administrator via personal/hand delivery or by certified mail, return receipt requested. The Medical Staff Member’s failure to timely submit an Appellate Review Request shall be deemed a waiver of the Medical Staff Member’s right to such appellate review and the Adverse Action shall thereupon become and/or remain effective pending the Governing Body’s final decision on the matter. The Medical Staff Member shall be notified of the Governing Body’s final decision as set forth in Section 5.8.1 of these Bylaws.

**5.6.3 Appointment of Appellate Review Committee and Chairperson.**

The Governing Body shall appoint (a) an Appellate Review Committee, which shall consist of not less than three (3) Governing Body members, none of whom have been members of any committee which previously made a recommendation on the matter; and (b) one Governing Body member to act as the Appellate Review Committee Chairperson.

**5.6.4 Scheduling / Rescheduling of Appellate Review.**<sup>102</sup>

Within ten (10) days after receipt of a Medical Staff Member’s written Appellate Review Request, the Appellate Review Committee shall schedule a date for such appellate review, including a time and place for oral argument (if requested). The date of the appellate review shall not be less than fifteen (15) days, nor more than thirty (30) days, from the date of receipt of the affected Medical Staff Member’s Appellate Review Request, unless otherwise agreed by the affected Medical Staff Member and the Appellate Review Committee Chairperson. The approval or disapproval of rescheduling requests made by the Medical Staff Member is within sole discretion of the Appellate Review Committee Chairperson.

**5.6.5 Written Notice of Appellate Review.**

The Appellate Review Committee Chairperson shall, through the Administrator, be responsible for giving prompt Written Notice of the appellate review to the Medical Staff Member. The Written Notice shall:

- (a) State the time, place and date of the appellate review;
- (b) Contain a concise statement which identifies the acts, omissions or transactions upon which the Adverse Action is based;

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<sup>102</sup> JCS MS.01.01.01, EP 34 (October 2011).

- (c) Advise the Medical Staff Member of the Medical Staff Member’s right to submit a written statement at the close of the appellate review;
- (d) If the Medical Staff Member requested the opportunity for oral argument, the Written Notice shall inform the Medical Staff Member that the Medical Staff Member’s failure to personally appear to present such oral argument shall constitute a waiver of the Medical Staff Member’s right to present an oral argument;
- (e) If the Medical Staff Member has not requested the opportunity for oral argument, the Written Notice shall inform the Medical Staff Member that the appellate review shall be held only on the record on which the Adverse Action is based, supplemented by a written statement by the Medical Staff Member, if the Medical Staff Member so desires. Such a written statement must be submitted by the Medical Staff Member to the Administrator by personal/hand delivery or certified mail, return receipt requested at least five (5) days prior to the appellate review;
- (f) Advise the Medical Staff Member that a record of the appellate review shall be made, and of the Medical Staff Member’s right to receive a copy upon payment of reasonable charges for the preparation thereof; and
- (g) State that upon completion of the appellate review the Medical Staff Member shall receive a copy of the written recommendation of the Appellate Review Committee, including a statement of the basis of the recommendation.

**5.6.6 Representation.**

The Medical Staff Member may appoint a Medical Staff Member, legal counsel, or any other individual chosen by the Medical Staff Member to represent the Medical Staff Member at the appellate review, present facts in opposition to the Adverse Action, and cross-examine witnesses. The Medical Executive Committee, when its action has prompted the appellate review, shall appoint one or more of its members, an Active Medical Staff appointee, and/or legal counsel, to represent it at the appellate review, present facts in support of the Adverse Action, and examine witnesses. The Governing Body, when its action has prompted the hearing, shall appoint one or more of its members, and/or legal counsel to represent it at the appellate review, present the facts in support of the Adverse Action, and examine witnesses. The Medical Executive Committee or Governing Body representative shall not simultaneously serve as the Presiding Officer of the appellate review. If the Medical Staff Member or the party that imposed the Adverse Action will be represented by legal counsel, that party shall inform the other party of the name and address of such counsel.

**5.6.7 Access to Information.**

The parties shall cooperate in good faith (within a reasonable period prior to the appellate review) to exchange information and written materials that will be presented at the appellate review and any changes to the same. The Medical Staff Member shall have access to:

- (a) the Hearing Committee Report;
- (b) the hearing record (and transcript, if any); and



- (c) all other written material, favorable or unfavorable, that: (i) was considered by the Hearing Committee in the development of the Hearing Committee Report; (ii) was considered by the Medical Executive Committee or the Governing Body in undertaking the Adverse Action; and (iii) will be considered by the Appellate Review Committee during the appellate review.

## **5.7 APPELLATE REVIEW PROCEDURE<sup>103</sup>**

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### **5.7.1 Presiding Officer.**

The Appellate Review Committee Chairperson (or his/her designee) shall preside over the appellate review to: (a) determine the order of procedure during the appellate review, (b) assure that all participants in the appellate review have a reasonable opportunity to present relevant oral and documentary evidence, and (c) maintain decorum.

### **5.7.2 Robert’s Rules of Order.**

The latest edition of ROBERT’S RULES OF ORDER shall prevail at the hearing, except that the Appellate Review Committee Chairperson may vote.

### **5.7.3 Quorum; Personal Presence of Staff Member Not Required.**

All Appellate Review Committee members must be present when the appellate review takes place and no member may vote by proxy. The personal presence of the Medical Staff Member for whom the appellate review has been scheduled is not required, unless the Medical Staff Member has requested the opportunity to present an oral argument. A Medical Staff Member who requested the opportunity for an oral argument but fails without good cause to appear and participate, shall be deemed to have waived such Medical Staff Member’s right to present an oral argument.

### **5.7.4 Submission of Written Statements.**

Prior to or during the appellate review, the Medical Staff Member and the Medical Executive Committee or the Governing Body (as applicable) may submit written statements concerning any issue of procedure or of fact, and such written statements shall become a part of the appellate review record. The Medical Staff Member’s written statement may be submitted to the Appellate Review Committee through the Administrator by personal/hand delivery or by certified mail, return receipt requested, or brought to the appellate review.

### **5.7.5 Review of Records; Standard of Proof.**

The Appellate Review Committee shall act as the appellate body for the purpose of determining whether the Adverse Action against the affected Medical Staff Member was justified and was not arbitrary or capricious. It shall review and consider:

- (a) the Hearing Committee Report;
- (b) the hearing record (and transcript, if any);

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<sup>103</sup> JCS MS.01.01.01, EP 34 (October 2011).



- (c) all other material, favorable or unfavorable, that was considered by the Hearing Committee in the development of its report, or considered by the Medical Executive Committee or the Governing Body in undertaking the Adverse Action;
- (d) any written statements submitted pursuant to Section 5.7.4 of these Bylaws; and
- (e) any oral argument.

New or additional matters not raised during the original hearing or in the Hearing Committee Report and not otherwise reflected in the hearing record may only be introduced at the appellate review with the approval of the Appellate Review Committee.

**5.7.6 Oral Argument.**

The Medical Staff Member (or his/her representative) may present an oral argument against the Adverse Action and any member of the Appellate Review Committee may direct questions to the Staff Member. The representative of the entity that imposed the Adverse Action (the Medical Executive Committee or the Governing Body) shall be permitted to speak in favor of the Adverse Action recommendation and any member of the Appellate Review Committee may direct questions to such representative.

**5.7.7 Record of Oral Argument.**

An accurate record of the appellate review oral argument (if any) must be kept. Participants in the oral argument shall be informed of all matters noticed and those matters shall be noted in the record. The mechanism by which an oral argument is recorded shall be established by the Appellate Review Committee and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes. A Medical Staff Member desiring an alternate method of recording the appellate review shall bear the primary cost thereof.

**5.7.8 Recess; Deliberations.**

The Appellate Review Committee may, in its sole discretion and without special notice, recess the appellate review and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the appellate review shall be adjourned (the “Adjournment Date”). Within ten (10) days after the Adjournment Date, the Appellate Review Committee shall complete its deliberations. The Appellate Review Committee may: (a) conduct its deliberations outside the presence of the Medical Staff Member for whom the hearing was convened at a time convenient to itself; and (b) consider any pertinent information that was made available to the Medical Staff Member prior to or during the hearing and appellate review process.

**5.7.9 Appellate Review Committee Report.**

Within fifteen (15) days after the Adjournment Date, the Appellate Review Committee shall issue a written Appellate Review Committee Report, which (a) shall include the Appellate Review Committee’s recommendations, including confirmation, modification, or rejection of the original Adverse Action and the basis therefore, and (b) may include the Appellate Review Committee’s official notice of any generally accepted technical or scientific matter relating to the issues under consideration at the appellate review and of any facts which may be judicially noticed by the courts of this state. The Appellate

Review Committee shall: (a) submit such Appellate Review Committee Report, the appellate review and hearing record, and all other documentation, to the Governing Body; and (b) deliver a copy of the Appellate Review Committee Report to the Medical Staff Member through the Administrator by personal/hand delivery or certified mail, return receipt requested.

## **5.8 FINAL DECISION BY GOVERNING BODY**

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### **5.8.1 Final Decision.**

Within five (5) days of its receipt of the Appellate Review Committee Report and the other documentation described in Section 5.7.4 of these Bylaws, the Governing Body shall make a final decision in the matter and shall send notice thereof to the Medical Executive Committee and the Administrator. The Administrator shall send Written Notice of the Governing Body's final decision to the affected Medical Staff Member and such decision shall become effective upon the Delivery Date of such Written Notice.

### **5.8.2 Communication with Medical Center Departments.**

The Administrator will ensure that the appropriate Departments and other Medical Center patient care areas are informed of any revisions or revocations of a Medical Staff Member's Clinical Privileges.<sup>104</sup>

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<sup>104</sup> 42 C.F.R. § 482.22(a)(2) (Interpretive Guidelines, effective October 17, 2008).

## ARTICLE 6. MEDICAL EXECUTIVE COMMITTEE

### 6.1 COMPOSITION

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#### 6.1.1 Voting Members.

The Medical Executive Committee shall include the voting members listed below.<sup>105</sup> A majority of Medical Executive Committee members must be Physicians.<sup>106</sup> Medical Executive Committee members serve ex officio with vote.<sup>107</sup> A Medical Executive Committee member may be removed from the Medical Executive Committee by removing him/her from the office/service identified below.<sup>108</sup>

- (a) Chief of Staff (The Chief of Staff shall serve as the Medical Executive Committee Chairperson);
- (b) Chief of Staff Elect;
- (c) Past Chief of Staff for 1 year;
- (d) Clinical Chairperson, Department of Medicine;
- (e) Clinical Chairperson, Department of Surgery;
- (f) Clinical Chairperson, Department of Obstetrics/Pediatrics;
- (g) Medical Director of Imaging;
- (h) Medical Director of Emergency;
- (i) Medical Director of Pathology and Clinical Laboratory;
- (j) Medical Director of Anesthesia;
- (k) Medical Director of the Intensive Care Unit (ICU);
- (l) Medical Director of Hospitalist Services; and

#### 6.1.2 Nonvoting Members.

The following individuals shall be invited to attend Medical Executive Committee meetings, but are not eligible to vote at such meetings.

- (a) President, Chief Administrative Officer
- (b) Chief Nursing Officer
- (c) Chief Medical Officer
- (d) Co-Chairs of the Practice Evaluation Committee
- (e) Director of Risk Management and Medical Staff Services

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<sup>105</sup>JCS MS.01.01.01, EPs 20 & 22 (October 2011).

<sup>106</sup> 42 C.F.R. § 482.22(b)(2) (Interpretive Guidelines, effective October 17, 2008).

<sup>107</sup>JCS MS.01.01.01, EPs 20 & 21 (October 2011).

<sup>108</sup>JCS MS.01.01.01, EPs 20 & 21 (October 2011).

**6.1.3 Invited Guests and Observers**

The Chief of Staff may at his or her discretion invite other people to attend the Medical Executive Committee meetings

**6.1.4 Appointment of Secretary/Treasurer.**

The Medical Executive Committee shall select, from among its voting members, an individual to serve as the Secretary/Treasurer of the Medical Executive Committee. The Secretary/Treasurer shall:

- (a) ensure that attendance is taken and accurate and complete minutes of all Medical Executive Committee meetings are kept;
- (b) be responsible for all fiscal affairs of the Medical Staff; and
- (c) attend to all correspondence and perform such other duties as ordinarily pertain to such office.

**6.2 DUTIES AND RESPONSIBILITIES**

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The Medical Executive Committee is authorized to represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.<sup>109</sup> The authority delegated to the Medical Executive Committee may be limited or removed by the Medical Staff by amending these Medical Staff Bylaws in accordance with Section 10.1.<sup>110</sup> The duties and responsibilities of the Medical Executive Committee shall be to:<sup>111</sup>

- (a) Coordinate the activities and general policies of the Departments;
- (b) Receive, review and act upon Department and Medical Staff committee reports;
- (c) Develop, implement, approve and monitor Medical Staff policies not otherwise the responsibility of the Departments;
- (d) Provide liaison between the Medical Staff, the Administrator and the Governing Body;
- (e) Make recommendations to the Administrator on matters of a medico-administrative nature;
- (f) Make recommendations to the Governing Body or the Administrator on matters concerning the management of the Medical Centers;
- (g) Fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to patients in the Medical Centers and participation in quality improvement activities;

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<sup>109</sup> JCS MS.01.01.01, EP 23 (October 2011).

<sup>110</sup> JCS MS.01.01.01, EP 20 (October 2011).

<sup>111</sup> JCS MS.01.01.01, EP 20 (October 2011).

- (h) Ensure that the Medical Staff actively participates in the Medical Centers' accreditation programs and assists the Medical Centers in maintaining their accreditation status;
- (i) Review and act on the credentials of all Applicants and make recommendations to the Governing Body for staff appointment, assignments to Departments and delineation of Clinical Privileges;
- (j) Review periodically all information available regarding the performance and clinical competence of Staff Members and other individuals with Clinical Privileges, and as a result of such reviews, make recommendations to the Governing Body for reappointments and renewal of or changes in Clinical Privileges;
- (k) Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all appointees to the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;
- (l) Report at each general Medical Staff meeting;
- (m) Supervise and make recommendations regarding infection control practices in all phases of the Medical Centers' activities;
- (n) Make recommendations relating to changes to the Medical Staff structure; and revisions to and updating of the Medical Staff Bylaws, policies, rules and regulations; and
- (o) Review, recommend, and support Medical Center sponsored educational activities that are relevant to the Medical Staff and to the nature and type of care offered by the Medical Centers. When applicable, these educational activities shall relate to performance improvement activities.

## **6.3 MEDICAL EXECUTIVE COMMITTEE MEETINGS**

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### **6.3.1 Scheduling and Notice.**

- (a) Regular Meetings. The Medical Executive Committee shall meet as often as necessary, but in no event less than quarterly, to fulfill its duties and responsibilities.
- (b) Special Meetings. The Chief of Staff may call a special meeting of the Medical Executive Committee at any time.
- (c) Telecommunication. Medical Executive Committee members may participate in regular or special Medical Executive Committee meetings by, or through the use of, any means of communication by which all participants may simultaneously hear each other, such as by teleconference. Any participant in a meeting by such means shall be deemed present in-person at such meeting.

- (d) Notice. Medical Staff Services shall send Written Notice of each regular and special Medical Executive Committee meeting to all Medical Executive Committee members.

**6.3.2 Quorum and Voting Requirements.**

A quorum shall consist of at least fifty percent (50%) of the Medical Executive Committee’s voting members. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action, unless these Bylaws or any law, ordinance, or governmental rule or regulation requires a greater number of affirmative votes.

**6.3.3 Attendance Requirements.**

Medical Executive Committee members are expected to attend at least seventy percent (70%) of the meetings held.

**6.3.4 Minutes.**

Minutes of each regular and special Medical Executive Committee meeting shall be prepared and shall include a record of the attendance of Medical Executive Committee members and the vote taken on each matter. Minutes of each Medical Executive Committee meeting shall be maintained in a permanent file.

**6.3.5 Robert's Rules of Order.**

Medical Executive Committee meetings shall be run in a manner determined by the Chief of Staff. When parliamentary procedure is needed, as determined by the Chief of Staff or evidenced by a majority vote of those attending the meeting, the latest edition of ROBERT’S RULES OF ORDER shall prevail, except that the Chief of Staff may vote.

## ARTICLE 7. ORGANIZED MEDICAL STAFF

### 7.1 COMPOSITION

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The Medical Centers have a single, self-governing organized Medical Staff, composed of current Medical Staff Members.<sup>112</sup>

### 7.2 DUTIES AND RESPONSIBILITIES

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The purposes and responsibilities of the organized Medical Staff are as described below. Provision shall be made in these Bylaws or by resolution of the Medical Executive Committee, approved by the Governing Body, either through assignment to Departments, to Medical Staff committees, to Medical Staff Officers or officials, or to interdisciplinary Medical Center committees, for the effective performance of the Medical Staff functions specified in this Section and described in the Policies Governing Medical Practices, and such other Medical Staff functions as the Medical Executive Committee or the Governing Body shall reasonably require.

#### 7.2.1 Administration and Enforcement of Bylaws and Policies.

The organized Medical Staff develops, adopts, reviews, amends, monitors and enforces compliance with these Bylaws, the Policies Governing Medical Practices, and other Medical Staff policies necessary for the proper functioning of the Medical Staff and the integration and coordination of Staff Members with the functions of the Medical Center(s).<sup>113</sup>

#### 7.2.2 Communication With and Accountability to the Governing Body.

The organized Medical Staff is accountable to the Governing Body for the quality of medical care provided to the Medical Centers' patients,<sup>114</sup> assists the Governing Body by serving as a professional review body,<sup>115</sup> and cooperates with the Governing Body, Administration, and Medical Center staff to resolve conflicts with regard to issues of mutual concern.

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<sup>112</sup> 42 C.F.R. § 482.22; JCS MS.01.01.01, EP 12 (October 2011); JCS LD.01.05.01, EPs 2 & 8 (October 2011).

<sup>113</sup> 42 C.F.R. § 482.22(c) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.12(2)(b) (2011); JCS MS.01.01.01, EPs 1-2, 4 (October 2011); JCS LD.01.05.01, EP 6 (October 2011).

<sup>114</sup> 42 C.F.R. § 482.22(b) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.12(2)(a) (2011).

<sup>115</sup> 42 C.F.R. § 482.12(a)(5).



**7.2.3 Recommendations for Staff Membership and Clinical Privileges.<sup>116</sup>**

The organized Medical Staff: (i) develops criteria for Staff Membership and Clinical Privileges that are designed to assure the Medical Staff and the Governing Body that patients will receive quality care, treatment, and services;<sup>117</sup> (ii) utilizes the criteria to evaluate and recommend individuals for Staff Membership and Clinical Privileges;<sup>118</sup> and monitors and evaluates the ethical and professional practice of individuals with Clinical Privileges<sup>119</sup> in order to make recommendations regarding such individuals' continued Staff Membership and Clinical Privileges.

**7.2.4 Quality Assurance and Performance Improvement.**

The organized Medical Staff provides leadership in, participates in, conducts, oversees, and/or coordinates Medical Center activities related to quality assurance, performance improvement, patient safety, patient satisfaction, risk management, case management, utilization review and resource management, including the following:<sup>120</sup>

- (a) Establishes and maintains patient care standards and ensures that all the Medical Centers' patients receive care that is commensurate with applicable standards of care and available community resources;
- (b) Monitors the quality of care, treatment and services provided by individuals with Clinical Privileges, including the performance and appropriateness of medical record documentation, the performance of invasive procedures, blood usage, and drug usage;<sup>121</sup>
- (c) Measures, assesses, and improves processes that primarily depend on the activities of individuals credentialed and privileged through the Medical Staff process;<sup>122</sup>
- (d) Pursues corrective actions with respect to Staff Member's with Clinical Privileges when warranted;
- (e) Communicates findings, conclusions, recommendations, and actions to improve performance to the Medical Executive Committee and the Governing Body;
- (f) Assists each Medical Center in identifying community health needs and establishing services or programs to meet such needs and other institutional goals; and
- (g) Coordinates the care, treatment and services provided by individuals with Clinical Privileges with those provided by the Medical Centers' nursing, technical, and administrative staff.

<sup>116</sup> Wis. Admin. Code DHS § 124.12(5)(b)3. (2011); JCS MS.07.01.01 (October 2011).

<sup>117</sup> JCS LD.01.05.01, EP 5 (October 2011); JCS MS.03.01.01 (October 2011).

<sup>118</sup> JCS MS.03.01.01 (October 2011); JCS MS.06.01.05 (October 2011).

<sup>119</sup> Wis. Admin. Code DHS § 124.12(2)(a) (2011).

<sup>120</sup> 42 C.F.R. § 482.22(b)(1); 42 C.F.R. § 482.22(c)(3); JCS MS.03.01.01, Rationale, EPs 4 & 5 (October 2011); JCS MS.05.01.01, Rationale (October 2011); JCS MS.05.01.03 (October 2011).

<sup>121</sup> JCS MS.03.01.01, Rationale (October 2011); JCS MS.05.01.01 (October 2011).

<sup>122</sup> JCS MS.05.01.01, EP 1 (October 2011); see also PI.03.01.01, EPs 1-4 (October 2011).

**7.2.5 Continuing Education.**

The organized Medical Staff: (a) provides continuing education opportunities to promote current best practices, encourage continuous advancement in professional knowledge, and complement quality assessment/improvement activities; and (b) supervises the Medical Centers’ professional library services if present on site.

**7.2.6 Compliance with Laws, Regulations, and Accreditation Standards.**

The organized Medical Staff assists each Medical Center in reviewing and maintaining Medical Center accreditation and ensuring compliance with applicable accreditation standards and federal, state, and local laws and regulations.<sup>123</sup>

**7.2.7 Other.**

The organized Medical Staff:

- (a) Monitors the Medical Centers’ infection control program and investigates and controls nosocomial infections;
- (b) Participates in the development of a response plan for fire and other disasters;<sup>124</sup>
- (c) Engages in other functions reasonably requested by the Medical Executive Committee or the Governing Body; and
- (d) Implements a process to manage any conflicts that arise between the Medical Staff and the Medical Executive Committee.<sup>125</sup>

**7.3 MEDICAL STAFF OFFICERS**

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**7.3.1 Medical Staff Officers.**<sup>126</sup>

The officers of the Medical Staff shall be:

Chief of Staff

Chief of Staff Elect

**7.3.2 Duties and Responsibilities.**

- (a) Chief of Staff. The Chief of Staff shall serve as the organized Medical Staff’s chief administrative officer and will fulfill those duties specified in the Policies Governing Medical Practices, and shall:
  - i. act in coordination and cooperation with the Administrator in all matters of mutual concern within the Medical Centers;
  - ii. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff and Medical Executive Committee meetings;

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<sup>123</sup> 42 C.F.R. § 482.11(a).

<sup>124</sup> JCS EM.02.01.01, EP 1 (October 2011).

<sup>125</sup> JCS MS.01.01.01, EP 10 (October 2011).

<sup>126</sup> Wis. Admin. Code DHS § 124.12(6)(a) (2011); JCS MS.01.01.01, EP 19 (October 2011).

## ARTICLE 7 – ORGANIZED MEDICAL STAFF

- iii. serve as a voting member on the Medical Executive Committee;
  - iv. serve as ex officio member of all other Medical Staff committees without vote;
  - v. be responsible for the enforcement of these Bylaws, the Policies Governing Medical Practices, and associated policies; for implementation of sanctions where these Bylaws are indicated; and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against an appointee to the Medical Staff;
  - vi. appoint clinical service committee chairpersons and committee members to all standing, special, and multi-disciplinary Medical Staff committees except the Medical Executive Committee;
  - vii. present the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the Administrator;
  - viii. receive, and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on quality improvement review with respect to the Medical Staff's delegated responsibility to provide medical care;
  - ix. be responsible for the educational activities of the Medical Staff;
  - x. be the spokesperson for the Medical Staff in its external professional and public relations;
  - xi. ensure that attendance is taken at and accurate and complete minutes are kept of all Medical Executive Committee meetings; and
  - xii. attend to all correspondence and perform such other duties as ordinarily pertain to such office.
- (b) Chief of Staff Elect. The Chief of Staff Elect shall:
- i. be a voting member of the Medical Executive Committee;
  - ii. in the absence of the Chief of Staff, assume all the duties and have the authority of the Chief of Staff;
  - iii. automatically succeed the Chief of Staff upon the expiration of the Chief of Staff's term or when the Chief of Staff fails to serve for any reason; and
  - iv. attend to and perform such other duties as ordinarily pertain to such office.

### 7.3.3 Qualifications; Nomination; Election, Term.

(a) Qualifications.

- i. At the time of nomination and election, and throughout his or her term of office, a Medical Staff Officer must:
  - Be an Active Medical Staff Member<sup>127</sup> in Good Standing,<sup>128</sup> for at least one year (unless the Medical Executive Committee determines that such Active Medical Staff Member has expertise that is not otherwise available);
  - Demonstrate an interest in maintaining quality patient care at the Medical Centers; and
  - Constructively participate in Medical Staff affairs, including active participation in peer review activities and on Medical Staff committees.
- ii. Medical Staff Officers may not:
  - Serve as a medical staff officer, department chairperson (except as an endowed department chairperson as part of a graduate medical education program), medical executive committee member, or member of a governing body or board, of any non-Aurora hospital or ambulatory surgery center that provides health care services in competition with the Medical Centers; and/or
  - Have an ownership interest in any non-Aurora hospital or ambulatory surgery center that provides health care services in competition with the Medical Centers.

(b) Nomination. Medical Staff Officer nominees shall be set forth by a Nominating Committee. The Nominating Committee shall consist of the Chief of Staff, the Chief of Staff Elect, the Administrator and, on a rotating basis in the order set forth in Section 8.1.2 of these Bylaws, the Clinical Chairperson of the applicable Department. The Nominating Committee shall contact each nominee and advise him or her of the responsibilities of the office and shall eliminate from consideration any nominee who does not indicate a willingness to fulfill the responsibilities of the office.

(c) Election. Medical Staff Officers shall be elected every other year at the annual meeting of the Medical Staff (or via electronic voting if applicable) and shall be confirmed by the Governing Body. Only appointees of the Active Medical Staff shall be eligible to vote. Election by the Medical Staff for each office shall require a majority vote. If, in voting, a candidate does not receive a majority vote, successive voting shall ensue with the name of the candidate receiving the fewest votes being omitted from each successive slate until a majority is obtained by one

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<sup>127</sup> Wis. Admin. Code DHS § 124.12(6)(b) (2011).

<sup>128</sup> Wis. Admin. Code DHS § 124.12(6)(b) (2011).

candidate.<sup>129</sup> The election mechanisms that may be considered for utilization include paper ballots and electronic voting via computer, fax, or other technology.

- (d) **Term.** All Medical Staff Officers shall serve for a two (2) year term unless removed from office or a successor is elected. A Medical Staff Officer may be elected to a second term. A Medical Staff Officer may not serve a third consecutive term in the same office unless two-thirds (2/3) of the Active Medical Staff present at a regular or special meeting of the Medical Staff at which the question is considered vote to approve such a third consecutive term, and such third consecutive term is approved by the Governing Body. Such third consecutive term shall become effective when approved by the Medical Executive Committee. Medical Staff Officers shall take office on the first day of the Medical Staff year.

#### **7.3.4 Vacancies in Office.**

Vacancies in office during a Medical Staff Officer's two (2) year term, except for the Chief of Staff, shall be filled by the Medical Executive Committee, after consultation with the Administrator. The individual filling the vacancy shall serve out the remaining term. If there is a vacancy in the office of the Chief of Staff, the Chief of Staff Elect shall serve out the remaining term.

#### **7.3.5 Resignation.**

Any Medical Staff Officer may resign at any time by giving written notice to the Medical Executive Committee.

#### **7.3.6 Removal from Office.<sup>130</sup>**

- (a) **Automatic Removal.** The Medical Executive Committee shall automatically remove from office any Medical Staff Officer upon verification of such Medical Staff Officer's: (i) revocation or suspension of license to practice medicine, podiatry or dentistry in the State of Wisconsin; or (ii) revocation or denial of Active or Associate Medical Staff Membership. There shall be no right of appellate review or hearing in connection with removal from a Medical Staff Officer position.
- (b) **Discretionary Removal.**
- i. **Suspension of Appointment.** Upon the suspension of any Medical Staff Officer's Medical Staff appointment, the Medical Executive Committee shall consider the removal of such Medical Staff Officer pending the results of the hearing and appellate review procedures provided in these Bylaws.
  - ii. **Request for Removal.** The Medical Executive Committee shall consider the removal of a Medical Staff Officer from office in the event:
    - the Medical Executive Committee receives a written request to consider such removal signed by at least one-quarter (1/4) of the Active Medical

<sup>129</sup> JCS MS.01.01.01, EP 18 (October 2011).

<sup>130</sup> JCS MS.01.01.01, EP 18 (October 2011).

Staff or signed by the Administrator (any such request shall include a list of the allegations or concerns precipitating the request of removal);

- the Medical Executive Committee receives written certification by two (2) physicians with special qualification in the appropriate medical field(s) that the Medical Staff Officer, to a reasonable medical certainty, cannot be expected to perform the duties of the office because of illness for a minimum of three (3) months;
- By a vote of two-thirds (2/3) of the Active Medical Staff present at a regular or special meeting of the Medical Staff at which the question is considered.

(c) Removal Procedure.

- Medical Executive Committee Meeting.* A meeting of the Medical Executive Committee shall be called within seven (7) days to consider the removal of the Medical Staff Officer. A quorum of the Medical Executive Committee must be present to act on the removal. The Medical Staff Officer in question shall have no vote on his or her removal, and may be excluded from the meeting except as provided in (ii) below.
- Appearance of Officer.* The Medical Staff Officer in question shall be permitted to make an appearance before the Medical Executive Committee prior to the Medical Executive Committee taking a final vote on the Medical Staff Officer's removal.
- Vote.* A Medical Staff Officer may be removed by an affirmative vote by two-thirds (2/3) of the Medical Executive Committee members present at a meeting of the Medical Executive Committee at which there is a quorum present. The Medical Staff Officer who is subject to the removal process may not participate or be present during the vote.
- Notification.* The Administrator shall provide the Medical Staff Officer with written notification of the Medical Executive Committee's final decision.
- Hearing and Appeal Rights.* There shall be no right of appellate review or hearing in connection with removal from a Medical Staff Officer position.

## **7.4 MEDICAL STAFF MEETINGS**

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### **7.4.1 Purpose.**

The primary objective of Medical Staff meetings shall be to report on the activities of the Medical Staff and to conduct other business as may be on the agenda.<sup>131</sup>

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<sup>131</sup> Wis. Admin. Code DHS § 124.12(7)(c) (2011).  
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#### **7.4.2 Scheduling and Notice.**

- (a) Regular Meetings. The Medical Staff shall meet as determined by the Medical Executive Committee, but no less than once every year.<sup>132</sup> Written Notice stating the time, place and purposes of each regular Medical Staff meeting shall be conspicuously posted and shall be sent to each member of the Medical Staff at least five (5) days before the date of such meeting. The attendance of a Medical Staff Member at a meeting shall constitute a waiver of notice of such meeting.
- (b) Special Meetings. The Chief of Staff may call a special meeting of the Medical Staff at any time. Written Notice stating the time, place and purposes of each special Medical Staff meeting shall be conspicuously posted and shall be sent to each member of the Medical Staff at least forty-eight (48) hours before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the Written Notice of such special meeting. The attendance of a Medical Staff Member at a meeting shall constitute a waiver of notice of such meeting.

The Chief of Staff shall be required to call a special meeting within twenty (20) days after receipt of:

- i. a written request signed by not less than one-fourth (¼) of the members of the Active Medical Staff which states the purpose of such special meeting; or
- ii. a written Medical Executive Committee resolution which states the purpose of such special meeting.

The Chief of Staff shall designate the time and place of any special meeting.

#### **7.4.3 Minutes.**

Written minutes of each Medical Staff meeting shall be prepared, recorded and maintained in a permanent file.<sup>136</sup> Copies thereof shall be submitted to the Medical Executive Committee.

#### **7.4.4 Attendance Requirements.**

Medical Staff Members are encouraged to attend Medical Staff meetings. Meeting attendance will not be used in evaluating members at the time of reappointment, however, it is expected that members of the Medical Staff will make every effort to attend Medical Staff meetings.<sup>133</sup>

#### **7.4.5 Quorum and Voting Requirements.**

For Medical Staff meetings, a quorum shall consist of those present and voting. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action.

#### **7.4.6 Robert's Rules of Order.**

Medical Staff meetings shall be run in a manner determined by the Chief of Staff. When parliamentary procedure is needed, as determined by the Chief of Staff or evidenced by a

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<sup>132</sup> Wis. Admin. Code DHS §§ 124.12(5)(b)6. & 124.12(7)(a) (2011).

<sup>136</sup> Wis. Admin. Code DHS § 124.12(7)(d) (2011).

<sup>133</sup> Wis. Admin. Code DHS § 124.12(7)(b) (2011).



ARTICLE 7 – ORGANIZED MEDICAL STAFF

majority vote of those attending the meeting, the latest edition of ROBERT’S RULES OF ORDER shall prevail, except that the Chief of Staff may vote.

## ARTICLE 8. CLINICAL DEPARTMENTS

### 8.1 ORGANIZATION OF DEPARTMENTS AND SECTIONS

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#### 8.1.1 Organization.

Each Department shall be organized as a separate part of the Medical Staff and shall have a Clinical Chairperson who is: (a) elected by the Active Medical Staff Members of the applicable Department; and (b) has the authority, duties and responsibilities as specified in Section 8.3 of these Bylaws. A Clinical Chairperson may establish Sections within his/her Department, and appoint Section Chairpersons, subject to approval by the Medical Executive Committee and the Governing Body.

#### 8.1.2 Designation.

The current Departments are:

- (a) Medicine
- (b) Surgery
- (c) Obstetrics/Pediatrics

### 8.2 ASSIGNMENT TO DEPARTMENTS

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#### 8.2.1 Assignment.

The Medical Executive Committee will, after consideration of the recommendations of the Clinical Chairperson of the appropriate Department(s), recommend Department assignments for each Staff Member in accordance with the Staff Member's qualifications. Each Staff Member shall be assigned to at least one Department, but may also be assigned to and/or granted Clinical Privileges or specified services in one or more other Departments. The exercise of Clinical Privileges or the performance of specified services within any Department shall be subject to the policies of that Department and the authority of that Department's Clinical Chairperson.

#### 8.2.2 Multiple Departments.

A Staff Member who wishes to be assigned to more than one Department must declare which Department shall be designated as his/her major affiliation. A Medical Staff Member who meets the qualifications in Section 8.3.1 of these Bylaws shall be eligible for nomination as Clinical Chairperson only in that Department which he/she has declared as his/her major Department affiliation. Membership in Departments other than the declared major Department does not confer the privilege to be nominated for the position of Clinical Chairperson, but does confer all other privileges of discussion, voting and appointment to committees which may be established by the Department.

### 8.3 CLINICAL CHAIRPERSONS

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#### 8.3.1 Qualifications, Nomination; Election; Term.<sup>134</sup>

(a) Qualifications.

- i. At the time of nomination and election, and throughout his or her term of office, a Clinical Chairperson must:
  - Be an Active Medical Staff Member in Good Standing for a period of at least one year (unless the Medical Executive Committee determines that such Staff Member has expertise that is not otherwise available);
  - Be and remain board certified in his/her specialty;<sup>135</sup>
  - Demonstrate an interest in maintaining quality patient care at the Medical Centers; and
  - Constructively participate in Medical Staff affairs, including active participation in peer review activities and on Medical Staff committees.
- ii. A Clinical Chairperson may not:
  - Serve as a medical staff officer, department chairperson (except as an endowed department chairperson as part of a graduate medical education program), medical executive committee member, or member of a governing body or board, of any non-Aurora hospital or ambulatory surgery center that provides health care services in competition with the Medical Centers; and/or
  - Have an ownership interest in any non-Aurora hospital or ambulatory surgery center that provides health care services in competition with the Medical Centers.

(b) Nomination. The Active Medical Staff Members of each Department shall nominate candidates for the position of Clinical Chairperson of such Department at the Departmental meeting held within each election year. The Manager of Medical Staff Services shall contact each nominee and advise the nominee of the Clinical Chairperson's responsibilities and eliminate from consideration any nominee who does not indicate a willingness to fulfill such responsibilities. Each Department shall offer the Governing Body a slate of nominees. The Governing Body shall then approve or reject each nominee; provided, however, that in the event none of the Department's Clinical Chairperson nominees are acceptable to the Governing Body, the Department shall submit a new slate of nominee(s) to the Governing Body for approval, and such process shall be repeated until the Governing Body has approved at least one candidate for Clinical Chairperson.

(c) Election. The Clinical Chairperson of each Department shall be elected, in each odd-numbered year, by a majority vote of all Active Medical Staff Members present at the final department meeting of the year. In the event no nominee

<sup>134</sup> JCS MS.01.01.01, EP 36 (October 2011).

<sup>135</sup> JCS MS.01.01.01, EP 36 (October 2011).

receives a majority vote, the nominee receiving the fewest votes shall be eliminated and successive run-off elections shall be held until one (1) nominee receives a majority of the votes cast. The results of the election shall be announced at the next Medical Staff meeting. The election mechanisms that may be considered for utilization include paper ballots and electronic voting via computer, fax, or other technology.

- (d) Term. Each Clinical Chairperson shall serve a two (2) year term unless removed from office or a successor is appointed by the applicable Department. Unless otherwise approved by the Medical Executive Committee, a Clinical Chairperson may not serve more than two (2) consecutive terms.

**8.3.2 Duties and Responsibilities.**<sup>136</sup>

The primary responsibility delegated to each Clinical Chairperson is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Department. To carry out this responsibility, each Clinical Chairperson shall:

- (a) Serve as Chairperson of the Department meetings while providing leadership and guidance to the Medical Staff.
- (b) Be a voting member of the Medical Executive Committee.
- (c) Establish, when appropriate, sections within the Department, and appoint chairpersons thereof, subject to approval by the Medical Executive Committee and the Governing Body.
- (d) Be responsible for the enforcement within the Department of actions taken by the Medical Executive Committee and the Governing Body.
- (e) Be responsible for the enforcement within the Department of Medical Center(s) policies, these Medical Staff Bylaws, and the Policies Governing Medical Practices.
- (f) Establish guidelines for the granting of Clinical Privileges and the performance of specified services within the Department.
- (g) Conduct or participate in, and make recommendations regarding the need for, continuing education programs based upon current best practices and the findings of review, evaluation and monitoring activities.
- (h) Be responsible for all clinical and administrative activities of the Department (including maintaining the quality of the medical records), unless otherwise provided for by the Medical Centers.
- (i) Maintain continuing surveillance of the professional performance of all individuals in the Department who have delineated Clinical Privileges, and report thereon to the Medical Executive Committee as part of the reappointment process and at other such times as may be indicated.

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<sup>136</sup> Wis. Admin. Code DHS § 124.12(9)(b) (2011); JCS MS.01.01.01, EP 36 (October 2011).

ARTICLE 8 – CLINICAL DEPARTMENTS

- (j) Recommend to the Medical Executive Committee the criteria for Clinical Privileges that are relevant to the care provided by the Department.
- (k) Make recommendations to the Medical Executive Committee regarding Staff Membership (e.g. appointment and reappointment) and Clinical Privileges for Department members.
- (l) Assess and recommend to the relevant Medical Center authority off-site sources for necessary patient care services not provided by the Department or the Medical Center(s).
- (m) Be responsible for the integration of the Department into the primary functions of the Medical Center(s) and for the coordination and integration of interdepartmental and intradepartmental services.
- (n) Develop and implement policies and procedures to guide and support the provision of care, treatment and services within the Department.
- (o) Make recommendations for a sufficient number of qualified and competent Practitioners to provide care, treatment and services within the Department.
- (p) Make recommendation regarding the qualifications and competence of Department or service personnel who are not Practitioners and who provide care, treatment, and services.
- (q) Be responsible for the continuous assessment and improvement of the quality of care, treatment, and services provided within the Department.
- (r) Be responsible for the maintenance of quality control programs, as appropriate.
- (s) Be responsible for the orientation and continuing education of Department members, including but not limited to education on fire and other regulations designed to promote safety.
- (t) Make recommendations for space and other resources needed by the Department.
- (u) Report and recommend to management of the Medical Center(s) when necessary with respect to matters affecting patient care in the Department such as personnel, budget planning, supplies, special regulations, standing orders and techniques.
- (v) Be responsible for arranging and securing appropriate Departmental emergency service on-call coverage in accordance with the needs of the Medical Centers.
- (w) Monitor, on a continuing and concurrent basis, adherence to:
  - i. Medical Center(s), Medical Staff and Department policies and procedures;
  - ii. requirements for alternative coverage and for consultations;
  - iii. sound principles of clinical practice; and
  - iv. fire and other regulations designed to promote patient safety.
- (x) Coordinate the patient care provided by the Department's appointees with nursing and ancillary patient care services and with administrative support services.

- (y) Submit written reports to the Medical Executive Committee on a regularly scheduled basis concerning:
  - i. findings of the Department's evaluation and monitoring of tissue review, medical records review, blood utilization review and utilization review, actions taken thereon, and the results of such action;
  - ii. recommendations for maintaining and improving the quality of care provided in the Department and the Medical Centers; and
  - iii. such other matters as may be requested from time to time by the Medical Executive Committee.
- (z) Promulgate Department policies addressing administrative and clinical procedures specific to the Department to be effective upon approval by the Medical Executive Committee. The Chief of Staff of the Medical Staff delegates authority to Clinical Chairpersons to sign appropriate policies as required.
- (aa) Conduct quarterly meetings of the Department for the purpose of performing the functions described herein.
- (bb) Establish Departmental committees or other mechanisms as are necessary and desirable to properly perform Department functions.

### **8.3.3 Vacancies in Department Chairperson.**

Vacancies in a Clinical Chairperson position shall be filled by the Chief of Staff, in consultation with the Administrator. The individual filling the vacancy shall serve out the remaining term.

### **8.3.4 Resignation of Clinical Chairperson.**

Any Clinical Chairperson may resign at any time by giving written notice to the Medical Executive Committee.

### **8.3.5 Removal of Clinical Chairperson.**

Removal of a Clinical Chairperson may be initiated at any time upon a two-thirds (2/3) majority vote of all Active Medical Staff Members of the applicable Department, but such removal shall not be effective unless and until it has been ratified by the Medical Executive Committee and approved by the Governing Body. A Clinical Chairperson may also be removed at any time during his/her term of office by the Governing Body. There shall be no right of appellate review or hearing in connection with removal from a Clinical Chairperson position.

## **8.4 DEPARTMENTAL MEETINGS**

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### **8.4.1 Scheduling and Notice.**

- (a) Regular Meetings. Each Department may set the time for holding the Department's regular meetings by resolution. Departmental meetings shall be held at least quarterly. Written Notice stating the time, place and purposes of each regular

Department meeting shall be conspicuously posted and shall be sent to each member of the Department at least five (5) days before the date of such meeting. The attendance of a Department member at a meeting shall constitute a waiver of notice of such meeting.

- (b) Special Meetings. A special meeting of a Department may be called at any time by or at the request of the Clinical Chairperson thereof, or by the Chief of Staff. Written Notice stating the time, place and purposes of each special Department meeting shall be conspicuously posted and shall be sent to each member of the Department at least forty-eight (48) hours before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the Written Notice of such special meeting. The attendance of a Department member at a meeting shall constitute a waiver of notice of such meeting.
- (c) Telecommunication. Department members may participate in regular or special Departmental meetings by, or through the use of, any means of communication by which all participants may simultaneously hear each other, such as by teleconference. Any participant in a meeting by such means shall be deemed present in person at such meeting.

**8.4.2 Attendance Requirements.**

All Department members are encouraged to attend Departmental meetings.

**8.4.3 Participation by Administrator.**

The Administrator (or his/her designee) may attend any Medical Staff Department or section meeting.

**8.4.4 Minutes.**

Minutes of each regular and special Departmental meeting shall be prepared and shall include a record of the Department members in attendance and the vote taken on each matter. The minutes shall be signed by the Clinical Chairperson (or his/her designee) and copies thereof shall be submitted to the Medical Executive Committee. Minutes of Departmental meetings shall be maintained in a permanent file.

**8.4.5 Quorum and Voting Requirements.**

For Departmental meetings, a quorum shall consist of those present and voting. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action.

**8.4.6 Robert's Rules of Order.**

Departmental meetings shall be run in a manner determined by the Clinical Chairperson. When parliamentary procedure is needed, as determined by the Clinical Chairperson or evidenced by a majority vote of those attending the meeting, the latest edition of ROBERT'S RULES OF ORDER shall prevail, except that the Clinical Chairperson may vote.



## ARTICLE 9. MEDICAL STAFF COMMITTEES

### 9.1 FORMATION, COMPOSITION, AND DISSOLUTION

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The Medical Executive Committee may, without amendment of these Bylaws: (a) establish Medical Staff committees to perform one or more Medical Staff functions,<sup>137</sup> (b) appoint Medical Staff committee members and chairpersons; and (c) dissolve or rearrange Medical Staff committee structure or composition, provided no such action taken with respect to items (a)-(c) is inconsistent with these Bylaws. The actions taken by the Medical Executive Committee with respect to items (a)-(c) are subject to Governing Body approval.

### 9.2 DUTIES AND RESPONSIBILITIES

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The Medical Executive Committee shall, without amendment of these Bylaws, describe the duties and responsibilities of each Medical Staff committee (except the Medical Executive Committee). Such duties and responsibilities shall be set forth in the Policies Governing Medical Practices. Medical Staff committees (other than the Medical Executive Committee) shall confine their activities to the purposes for which they are appointed, and shall report to the Medical Executive Committee.

### 9.3 MEDICAL STAFF COMMITTEE MEETINGS

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#### 9.3.1 Scheduling and Notice.

- (a) Regular Meetings. Each Medical Staff committee may set the time for holding the committee's regular meetings by resolution.
- (b) Special Meetings. A special meeting of a Medical Staff committee may be called at any time by or at the request of the chairperson thereof, or by the Chief of Staff.
- (c) Notice. Written Notice stating the place, day, and hour of any special meeting or of any regular meeting of a Medical Staff committee not held pursuant to resolution shall be delivered or sent to each committee member not less than two (2) business days before the time of such meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

#### 9.3.2 Participation by Administrator.

The Administrator (or his/her designee) may attend any Medical Staff committee meetings.

#### 9.3.3 Minutes.

Minutes of each regular and special Medical Staff committee meeting shall be prepared and shall include a record of the committee members in attendance and the vote taken on

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<sup>137</sup> Wis. Admin. Code DHS § 124.12(8)(a) (2011).

each matter. The minutes shall be signed by the Medical Staff committee chairperson (or his/her designee) and copies thereof shall be submitted to the Medical Executive Committee. Minutes of Medical Staff committee meetings shall be maintained in a permanent file.

**9.3.4 Quorum and Voting Requirements.**

The quorum and voting requirements for each Medical Staff committee shall be set forth in the Policies Governing Medical Practices.

**9.3.5 Robert's Rules of Order**

Medical Staff committee meetings shall be run in a manner determined by the Medical Staff committee chairperson. When parliamentary procedure is needed, as determined by the Medical Staff committee chairperson or evidenced by a majority vote of those attending the meeting, the latest edition of ROBERT’S RULES OF ORDER shall prevail, except that the Medical Staff committee chairperson may vote.

**9.4 CURRENT MEDICAL STAFF COMMITTEES**

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**9.4.1 Credentials Committee**

(a) Composition. The Credentials Committee shall consist of:

- i. Chief of Staff
- ii. Chief of Staff Elect
- iii. Each Department Chair
- iv. Chief Medical Officer

(b) Duties and Responsibilities. The purpose and responsibilities of the Credentials Committee shall include, but are not limited to:

- i. Reviewing the credentials of all Applicants and making recommendations to the Medical Executive Committee for Medical Staff and Advanced Practice Professional Staff appointment, assignments to departments, and delineation of Clinical Privileges;
- ii. Periodically reviewing all information available regarding the performance and clinical competence of Staff Members and other Practitioners and Advanced Practice Professionals with Clinical Privileges at the Medical Centers and, as a result of such reviews, making recommendations to the Medical Executive Committee for reappointments and renewal or changes in Clinical Privileges;

- iii. Consulting with, and obtaining any information from, any sources which the Credentials Committee deems necessary, desirable or relevant to the matter in question;
- iv. Reporting at each general Medical Executive Committee meeting and at other meetings as requested by the Medical Executive Committee; and
- v. Performing such other duties as requested from time to time by the Medical Executive Committee.

**9.4.2 Practice Evaluation Committee.**

The Practice Evaluation Committee (PEC) shall be composed of the individuals identified in its charter. The powers and duties of PEC and the requirements for PEC meetings, reports and recommendations are set forth in the PEC charter, which charter shall be approved by the Medical Executive Committee and the Governing Body. PEC shall generally report and make recommendations to the Medical Executive Committee. However, PEC shall also be responsible for approving performance improvement plans, monitoring compliance of individual Staff Members with performance improvement plans and making all necessary reports to the Credentials Committee of a Staff Member's failure to comply in any material respect with a performance improvement plan.

# ARTICLE 10. MEDICAL STAFF BYLAWS AND POLICIES

## 10.1 MEDICAL STAFF BYLAWS

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### 10.1.1 Adoption of Medical Staff Bylaws.<sup>138</sup>

These Medical Staff Bylaws have been developed by the organized Medical Staff, shall be adopted at any regular or special meeting of the Active Medical Staff, and shall become effective when approved by the Governing Body.

### 10.1.2 Required Processes: Basic Steps and Associated Details

These Medical Staff Bylaws contain the basic steps of the processes listed below.<sup>139</sup> Associated details may be placed in these Medical Staff Bylaws, a Policy Governing Medical Practice, or a Medical Center Policy approved by the Medical Executive Committee.<sup>140</sup>

(a) Privileging/Credentialing/Appointment

- i. Medical Staff appointment and reappointment.
- ii. Credentialing and re-credentialing of Staff Members.
- iii. Privileging and re-privileging of Staff Members.

(b) Adverse Actions

- i. Automatic suspension of Staff Membership and/or Clinical Privileges.
- ii. Summary suspension of Staff Membership or Clinical Privileges.
- iii. Recommending termination or suspension of Staff Membership and/or termination, suspension, or reduction of Clinical Privileges.
- iv. Fair hearing and appeal process, including the process for scheduling and conducting hearings and appeals.

(c) Medical Staff / Medical Executive Committee

- i. Selection and removal of Medical Staff officers.
- ii. How the Medical Executive Committee's authority is delegated or removed.
- iii. Selection and removal of Medical Executive Committee members.

(d) Adoption and Amendment of Certain Documents

- i. Adopting and amending these Medical Staff Bylaws.
- ii. Adopting and amending Medical Staff Policies.

### 10.1.3 Periodic Review of Medical Staff Bylaws.<sup>141</sup>

These Bylaws shall be reviewed no less frequently than biennially by the Medical Executive Committee or other committee appointed by the Chief of Staff for such purpose ("Bylaws Committee").

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<sup>138</sup> JCS MS.01.01.01, EPs 1, 2, 3 & 24 (October 2011).

<sup>139</sup> JCS MS.01.01.01, EP 3 (October 2011).

<sup>140</sup> JCS MS.01.01.01, EP 3 (October 2011).

<sup>141</sup> JCS MS.01.01.01, EP 24 (October 2011).

**10.1.4 Amendment of Medical Staff Bylaws.**

Neither the Medical Staff nor the Governing Body may unilaterally amend these Medical Staff Bylaws. All amendments to these Bylaws must be approved by both the Medical Staff and the Governing Body.<sup>142</sup> The Medical Executive Committee will ensure that approved amendments are communicated to the Medical Staff.

- (a) Amendments Proposed by a Medical Staff Member, Committee or Department. Any Medical Staff Member, Medical Staff committee (including the Medical Executive Committee), or Department, may submit a proposed amendment to these Medical Staff Bylaws to the Chief of Staff. The Chief of Staff shall determine whether to forward the proposed amendment to the Medical Executive Committee and/or the Bylaws Committee (if one has been appointed) for its review and comment; and (ii) shall submit the proposed amendment to the Medical Staff at the next regular Medical Staff meeting, at a special Medical Staff meeting called for such purpose, or using electronic voting via computer, fax, or other technology. For a vote taken at a Medical Staff meeting, an amendment so presented shall require a two-thirds (2/3) vote of the Active Medical Staff Members present for Medical Staff approval. For a vote taken via electronic voting, an amendment so presented shall require a two-thirds (2/3) vote of the Active Medical Staff Members voting. An amendment approved by the Medical Staff shall be forwarded to the Governing Body for its approval and shall become effective if and when it is approved by the Governing Body.<sup>143</sup>
- (b) Amendments Proposed by the Governing Body. Amendments proposed by the Governing Body shall be submitted to the Chief of Staff. The Chief of Staff shall submit the proposed amendment to the Medical Staff at the next regular Medical Staff meeting, at a special Medical Staff meeting called for such purpose, or using electronic voting via computer, fax, or other technology. For a vote taken at a Medical Staff meeting, an amendment proposed by the Governing Body shall require a majority (51%) vote of the Active Medical Staff Members present. For a vote taken via electronic voting, an amendment so presented shall require a majority (51%) vote of the Active Medical Staff Members voting. An amendment approved by the Medical Staff shall be returned to the Governing Body for its final approval and shall become effective if and when it is approved by the Governing Body.
- (c) Amendment to Comply with Law or Regulations. The professional conduct of Staff Members shall at all times be governed by applicable state and federal statutes and regulations. In the event the provisions of these Medical Staff Bylaws are not consistent with any applicable state or federal statute or regulation, the Medical Executive Committee may provisionally adopt an amendment to such documents without prior notification to the Medical Staff or the Governing Body. In such a circumstance, the Medical Executive Committee will immediately notify the Medical Staff and the Governing Body, and the provisional amendment shall be

<sup>142</sup>JCS MS.01.01.03, EP 1 (October 2011); JCS MS.01.03.03, EP 1 (October 2011).

<sup>143</sup> JCS MS.01.01.01, EP 8 (October 2011).

submitted to the Medical Staff at the next regular Medical Staff meeting, at a special Medical Staff meeting called for such purpose, or using electronic voting via computer, fax, or other technology. For a vote taken at a Medical Staff meeting, an amendment so presented shall require a majority (51%) vote of the Active Medical Staff Members present for Medical Staff approval. For a vote taken via electronic voting, an amendment so presented shall require a majority (51%) vote of the Active Medical Staff Members voting. An amendment approved by the Medical Staff shall be forwarded to the Governing Body for its approval and shall become effective if and when it is approved by the Governing Body.

#### **10.1.5 Technical Modifications of Medical Staff Bylaws.**

Modifications that do not materially change any Bylaw provision, such as reorganization, reformatting, renumbering, correction of grammatical, spelling, or punctuation errors, or correction of statutory, regulatory, or accreditation standard citations contained in a footnote reference, shall not be considered an amendment of the Medical Staff Bylaws and shall not require approval as described above.

## **10.2 POLICIES GOVERNING MEDICAL PRACTICES**

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### **10.2.1 Adoption of Policies Governing Medical Practices.**

- (a) Generally. The Medical Executive Committee may adopt Policies Governing Medical Practices as may be necessary to implement more specifically the general principles found within these Medical Staff Bylaws and guide and support the provision of care, treatment and services at the Medical Centers, subject to the approval of the Governing Body.<sup>144</sup> The Policies Governing Medical Practices must be consistent with these Medical Staff Bylaws, Medical Center policies, and applicable statutes and regulations.<sup>145</sup> The Medical Executive Committee will ensure that all approved Policies are communicated to the Medical Staff.<sup>146</sup>
- (b) Adoption Process. Any Medical Staff Member, Medical Staff committee (including the Medical Executive Committee), or Department, may submit a proposal to adopt a Policy Governing Medical Practices to the Chief of Staff. The Chief of Staff shall submit the proposed Policy to the Medical Executive Committee for approval at the next regular Medical Executive Committee meeting, or at a special Medical Executive Committee meeting called for such purpose. To be approved by the Medical Executive Committee, a proposed Policy must be approved by a majority (51%) vote of the Medical Executive Committee. A Policy approved by the Medical Executive Committee shall be forwarded to the Governing Body for its approval and shall become effective if and when it is approved by the Governing Body. If a proposed Policy is not approved by the Medical Executive Committee, the Medical Staff may submit the proposed Policy directly to the Governing Body if (2/3) of the Active Medical Staff Members vote to submit such proposed Policy directly to the

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<sup>144</sup> JCS LD.04.01.07, EP 1 (October 2011); MS.01.01.01, EP 25 (October 2011).

<sup>145</sup> JCS MS.01.01.01, EP 4 (October 2011).

<sup>146</sup> JCS MS.01.01.01, EP 9 (October 2011).

Governing Body. Such a proposed Policy shall become effective if and when it is approved by the Governing Body.<sup>147</sup>

**10.2.2 Amendment of Policies Governing Medical Practices.**

The Policies Governing Medical Practices may be amended or repealed upon recommendation of the Medical Executive Committee, subject to the approval of the Governing Body. The Medical Executive Committee will ensure that all approved amendments are communicated to the Medical Staff.

- (a) Amendments Proposed by the Medical Executive Committee. An amendment to the Policies Governing Medical Practices proposed and approved by the Medical Executive Committee shall be forwarded to the Governing Body for its approval and shall become effective if and when it is approved by the Governing Body.
- (b) Amendments Proposed by a Medical Staff Member, Committee, or Department. Any Medical Staff Member, Medical Staff committee, or Department, may submit a proposed amendment to the Policies Governing Medical Practices to the Chief of Staff. The Chief of Staff shall submit the proposed amendment to the Medical Executive Committee for approval at the next regular Medical Executive Committee meeting, or at a special Medical Executive Committee meeting called for such purpose. To be approved by the Medical Executive Committee, an amendment shall require a majority (51%) vote of the Medical Executive Committee. An amendment approved by the Medical Executive Committee shall be forwarded to the Governing Body for its approval and shall become effective if and when it is approved by the Governing Body. If a proposed amendment to the Policies Governing Medical Practices is not approved by the Medical Executive Committee, the Medical Staff may submit the proposed amendment directly to the Governing Body if (2/3) of the Active Medical Staff Members vote to submit such proposed amendment directly to the Governing Body.<sup>148</sup> Such a proposed amendment shall become effective if and when it is approved by the Governing Body.<sup>149</sup>
- (c) Amendments Proposed by the Governing Body. An amendment to the Policies Governing Medical Practices proposed by the Governing Body shall be submitted to the Chief of Staff for consideration by the Medical Executive Committee at the next regular Medical Executive Committee meeting, or at a special Medical Executive Committee meeting called for such purpose. To be approved by the Medical Executive Committee, an amendment proposed by the Governing Body shall require a majority (51%) vote of the Medical Executive Committee. An amendment approved by the Medical Executive Committee shall be returned to the Governing Body for its final approval and shall become effective if and when it is approved by the Governing Body.

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<sup>147</sup> JCS MS.01.01.01, EPs 7-9 (October 2011).

<sup>148</sup> JCS MS.01.01.01, EP 9 (October 2011).

<sup>149</sup> JCS MS.01.01.01, EP 8 (October 2011).



- (d) Amendment to Comply with Law or Regulations. The professional conduct of Staff Members shall at all times be governed by applicable state and federal statutes and regulations. In the event the provisions of the Policies Governing Medical Practices are not consistent with any applicable state or federal statute or regulation, the Chief of Staff may provisionally adopt an amendment to such documents without prior notification to the Medical Executive Committee or the Governing Body. In such a circumstance, the Chief of Staff will immediately notify the Medical Executive Committee and the Governing Body and the provisional amendment shall be submitted to the Medical Executive Committee at the next regular Medical Executive Committee meeting, or at a special Medical Executive Committee meeting called for such purpose. An amendment so presented shall require a majority (51%) vote of the Medical Executive Committee members for approval. An amendment approved by the Medical Executive Committee shall be forwarded to the Governing Body for its approval and shall become effective if and when it is approved by the Governing Body.

### **10.2.3 Technical Modifications of Policies Governing Medical Practices.**

Modifications that do not materially change any provision contained in the Policies Governing Medical Practices, such as reorganization, reformatting, renumbering, correction of grammatical, spelling, or punctuation errors, or correction of statutory, regulatory, or accreditation standard citations contained in a footnote reference, shall not be considered an amendment of the Policies Governing Medical Practices and shall not require approval as described above.

## **10.3 DEPARTMENTAL POLICIES**

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Each Department may develop and propose amendments to policies intended to guide and support the provision of care, treatment and services in such Department, or govern the administration of such Department. Such policies or proposed amendments must: (1) be consistent with these Medical Staff Bylaws, the Policies Governing Medical Practices, and applicable Medical Center policies; and (2) be approved by the Medical Executive Committee. If the Medical Executive Committee declines to approve a Department policy or proposed amendment recommended by the relevant Clinical Chairperson, the Medical Executive Committee shall provide a written explanation of its action to the Clinical Chairperson.

## **10.4 HISTORY AND PHYSICAL EXAMINATIONS**

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Physicians, Oral Surgeons, Podiatrists, Nurse Practitioners, Physician Assistants and Certified Nurse Midwives may perform a medical history and physical examination (H&P). An H&P must be performed and documented no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia services.<sup>150</sup> If the H&P is performed within thirty (30) days prior to the patient's

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<sup>150</sup> 42 C.F.R. § 482.22(c)(5)(i) (Interpretive Guidelines, effective October 17, 2008, providing that H & P documentation requirements must be included in the Medical Staff Bylaws); Wis. Admin. Code DHS § 124.12(5)(b)8. (2011); JCS MS.01.01.01, EP 16 (October 2011); JCS PC.01.02.03, EPs 4 & 5 (October 2011); JCS RC.02.01.03, EP 3 (October 2011).

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admission or registration, a Physician, Oral Surgeon, Podiatrist, Nurse Practitioner, Physician Assistant or Certified Nurse Midwife must complete and document an updated examination of the patient, including any changes in the patient’s condition, within 24 hours after the patient’s admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia services.<sup>151</sup> Please refer to the Policies Governing Medical Practices for more information regarding H&P documentation requirements.

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<sup>151</sup> 42 C.F.R. § 482.22(c)(5)(ii) (Interpretive Guidelines, effective October 17, 2008, providing that H & P documentation requirements must be included in the Medical Staff Bylaws); Wis. Admin. Code DHS § 124.12(5)(b)8. (2011); JCS PC.01.02.03, EP 5 (October 2011).

## **ARTICLE 11. MISCELLANEOUS**

### **11.1 COMPLIANCE WITH LAWS AND REGULATIONS**

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Any act or omission that may be considered inconsistent with the provisions set forth in these Medical Staff Bylaws and/or the Policies Governing Medical Practices, but which was undertaken in order to comply with applicable federal or state statutes or regulations, shall not be considered in violation of these Medical Staff Bylaws and/or the Policies Governing Medical Practices. In the event these Medical Staff Bylaws and/or the Policies Governing Medical Practices are inconsistent with such statutes or regulations, the Medical Executive Committee shall initiate in a timely manner the applicable amendment process.

### **11.2 GOVERNING LAW**

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The validity, construction, and enforcement of these Bylaws shall be construed and enforced solely in accordance with the laws of the State of Wisconsin. The parties agree that jurisdiction and venue for any dispute shall be in Milwaukee County, Wisconsin and no party or person may object to personal jurisdiction in, or venue of such courts or assert that such courts are not a convenient forum. Both parties waive trial by jury in any action hereunder.

### **11.3 ELECTRONIC RECORD KEEPING**

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Whenever these Bylaws call for maintenance of written records, such records may be recorded and/or maintained in an electronic format.

### **11.4 HEADINGS**

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The captions or heading used in these Medical Staff Bylaws are for convenience only and are not intended to limit or otherwise define the scope of effects of any provisions of these Medical Staff Bylaws.

### **11.5 IDENTIFICATION**

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Although the masculine gender and singular are generally used throughout these Bylaws and associated policies for simplicity, words which import one gender may be applied to any gender and words which import the singular or plural may be applied to the plural or the singular, all as a sensible construction of the language so requires.

### **11.6 COUNTING OF DAYS**

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In any instance in which the counting of days is required in these Bylaws in connection with the giving of a notice or for any other purpose, the day of the event shall not count, but the day upon which the notice is given shall count. In any case where the date on which some action is to be taken, notice given or period expired occurs on a holiday, a Saturday or a Sunday, such action shall be taken, such notice given or such period extended to the next succeeding Monday, Tuesday, Wednesday, Thursday or Friday which is not a holiday. For the purposes of this

section, the term "holiday" shall mean such days as are commonly recognized as holidays by the U.S. Federal Government.

### **11.7 SEVERABILITY**

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In the event that any provision of these Bylaws shall be determined to be invalid, illegal, or unenforceable, the validity, enforceability of the remaining provisions shall not in any way be affected or impaired by such a determination.

### **11.8 INDEMNIFICATION**

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All Medical Staff Officers, Clinical Chairpersons, and other Staff Members who act for and on behalf of the Medical Center(s) in discharging their responsibilities and professional review activities pursuant to these Bylaws, shall be indemnified when acting in those capacities, to the fullest extent permitted by law, provided that the Governing Body has confirmed the appointment and/or election of the individual to the position in question.

## **ARTICLE 12. UNIFIED MEDICAL STAFF**

### **12.1 INITIAL INTEGRATION**

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Each Medical Center’s previously separate medical staff members have voted by majority, in accordance with each Medical Center’s previous medical staff bylaws, to approve these Medical Staff Bylaws and accept the integrated medical staff structure provided herein.<sup>152</sup>

### **12.2 DUE CONSIDERATION AND LOCALIZED ISSUES**

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The Medical Executive Committee shall take into account each Medical Center’s unique circumstances and any significant differences in patient populations and services offered at each Medical Center.<sup>153</sup> The Medical Executive Committee shall establish and implement policies and procedures to make certain the needs and concerns expressed by Staff Members of each Medical Center are given due consideration and shall ensure that mechanisms are in place to make certain that issues localized to a particular Medical Center are duly considered and addressed.<sup>154</sup>

### **12.3 RIGHT TO OPT OUT**

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#### **12.3.1 Right to Opt Out.**

Each Medical Center has the right to opt out of the integrated medical staff by a majority vote of the Staff Members with activated Clinical Privileges at the applicable Medical Center who are eligible to vote on the adoption and amendment of Medical Staff Bylaws.<sup>155</sup>

#### **12.3.2 Limitation on Opt Out Votes.**

Medical Centers may not hold opt out votes under Section 12.3.1 more than once every two years.

**Approved by: Aurora Health Care Metro, Inc. Board of Directors**

**Approval Date: September 19, 2016**

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<sup>152</sup> 42 C.F.R. § 482.22(b)(4)(i).

<sup>153</sup> JCS MS.01.01.05, EP 2 (September 2014)

<sup>154</sup> JCS MS.01.01.05, EP 3 and 4 (September 2014)

<sup>155</sup> 42 C.F.R. § 482.22(b)(4)(ii).