

# **AURORA HEALTH CARE MEDICAL STAFF**

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## **MEDICAL STAFF BYLAWS**

**Aurora St. Luke's Medical Center  
Aurora St. Luke's South Shore  
Aurora Sinai Medical Center  
Aurora Psychiatric Hospital  
Aurora West Allis Medical Center  
Aurora Medical Center Washington County  
Aurora Medical Center Oshkosh  
Aurora Medical Center Grafton  
Aurora Medical Center Manitowoc County  
Aurora Sheboygan Memorial Medical Center  
Aurora Medical Center Burlington  
Aurora Lakeland Medical Center  
Aurora Medical Center Kenosha  
Aurora Medical Center Summit**

# MEDICAL STAFF BYLAWS

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## DEFINITIONS

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

**“Advanced Practice Clinician”** 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 to provide direct health care services at the Medical Center. Clinical Assistants are not Advanced Practice Clinicians and do not qualify for Clinical Privileges or Staff Membership.

**“Advanced Practice Clinician Staff”** means all Advanced Practice Clinicians who have been appointed to the Advanced Practice Clinician 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.

**“Affiliate Staff”** means all Practitioners who have been appointed to the Affiliate Staff.

**“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 Clinician who completes and submits an Application for or has been granted the following at the Medical Center:

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).

## DEFINITIONS

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

**“Aurora Health Care Metro”** means Aurora Health Care Metro, Inc., d/b/a Aurora Health Care Metro with the following practice locations:

- Aurora Sinai Medical Center located in Milwaukee, WI
- Aurora St. Luke’s Medical Center located in Milwaukee, WI
- Aurora St. Luke’s South Shore located in Cudahy, WI

**“Aurora West Allis Medical Center”** means West Allis Memorial Hospital, Inc. d/b/a Aurora West Allis Medical Center located in West Allis, Wisconsin.

**“Aurora Psychiatric Hospital”** means Aurora Psychiatric Hospital, Inc. d/b/a Aurora Psychiatric Hospital located in Wauwatosa, WI.

**“Aurora Medical Center Washington County”** means Aurora Medical Center of Washington County, Inc. d/b/a Aurora Medical Center Washington County located in Hartford, WI.

**“Aurora Medical Center Oshkosh”** means Aurora Medical Center of Oshkosh, Inc. d/b/a Aurora Medical Center Oshkosh located in Oshkosh, WI.

**“Aurora Medical Center Grafton”** means Aurora Medical Center Grafton LLC d/b/a Aurora Medical Center Grafton located in Grafton, WI.

**“Aurora Medical Center Manitowoc County”** means Aurora Health Care North, Inc. d/b/a Aurora Medical Center Manitowoc County located in Two Rivers, WI.

**“Aurora Sheboygan Memorial Medical Center”** means Aurora Health Care Central, Inc. d/b/a Aurora Sheboygan Memorial Medical Center located in Sheboygan, WI.

**“Aurora Medical Center Burlington”** means Aurora Health Care Southern Lakes, Inc. d/b/a Aurora Medical Center Burlington located in Burlington, WI.

**“Aurora Lakeland Medical Center”** means Aurora Health Care Southern Lakes, Inc. d/b/a Aurora Lakeland Medical Center located in Elkhorn, WI.

**“Aurora Medical Center Kenosha”** means Aurora Health Care Southern Lakes, Inc. d/b/a Aurora Medical Center Kenosha located in Kenosha, WI.

**“Aurora Medical Center Summit”** means Aurora Health Care Southern Lakes, Inc. d/b/a Aurora Medical Center Summit located in Summit, WI.

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**“Aurora Patient Service Market Chief Medical Officer(s)”** means the individuals appointed by Aurora to serve as the senior physician leaders responsible for clinical quality and outcomes for a specific Aurora Patient Service Market.

**“Aurora Credentials Committee”** means the committee for the Medical Staff that reviews and evaluates the qualifications of each Applicant for initial appointment or reappointment to the Medical Staff or Advanced Practice Clinician Staff and application for Clinical Privileges in accordance with the procedures outlined in these Bylaws. The Aurora Credentials Committee shall report to the Medical Executive Committee.

**“Aurora Practice Evaluation Committee”** or **“APEC”** means the multi-specialty peer review committee for the Medical Staff that provides oversight to and support for each Site Practice Evaluation Committee. The Aurora Practice Evaluation Committee shall report to the Medical Executive Committee.

**“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 Executive Committee as the chief administrative officer of the Medical Staff.

**“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 Clinician Staff and are not granted Clinical Privileges. A Clinical Assistant is an individual, other than a Practitioner and Advanced Practice Clinician, 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 to provide direct health care services at the Medical Center. 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 one or more Sites.

**“Conditional Appointment”** a term of appointment or reappointment for a Staff Member that may be subject to certain conditions that do not affect a Staff Member's ability to exercise Clinical Privileges. Recommendation or approval of Conditional Appointment does not afford the Staff Member hearing and appeal rights.

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**“Credentials Verification Organization”** or **“CVO”** means a qualified organization that performs certain credentials verification services on behalf of a Medical Center.

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

**“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 license to practice dentistry in the State of Wisconsin.

**“Director of Medical Education”** means the individual employed by Aurora Health Care, Inc. to oversee graduate medical education activities at the Sites.

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

**“Emeritus Staff”** means all Practitioners who have been appointed to the Emeritus Staff.

**“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.

**“Good Standing”** means the Staff Member, at the time such standing is determined, has not, at any 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

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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 remedial action; (v) been denied reappointment to the Medical Staff or Advanced Practice Clinician Staff; (vi) withdrawn his or her application for reappointment to the Medical Staff or Advanced Practice Clinician Staff while under formal investigation and/or subject to pending remedial action; or (vii) voluntarily resigned while under formal investigation and/or subject to pending remedial action.

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; (ii) is the subject of a Performance Improvement Plan, so long as the Staff Member is in compliance with its terms; or (iii) voluntarily deactivates his or her Clinical Privileges at any Site pursuant to Section 2.8 of these Bylaws, so long as such deactivation did not occur while the Staff Member was under investigation under Article 4 and/or subject to pending remedial action.

**“Governing Body”** means the Board of Directors of Aurora Health Care Metro, 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 Clinician Staff.

**“Graduate Medical Student”** means an individual who: (i) has been appointed to a post-graduate training program that has been approved by the Wisconsin Medical Examining Board and in which Aurora participates; (ii) to the extent required by law, obtains a Temporary Educational Permit to practice medicine in all its phases or a Wisconsin license to practice medicine in all its phases; (iii) practices medicine at one or more Sites under the direction of a Medical Staff Member who possesses Clinical Privileges commensurate with his or her supervision activities; and (iv) confines substantially all of his or her professional time to the training program operated at one or more Sites and to the duties of the training program in which Aurora participates.

**“Hearing Request”** means a written request for a hearing submitted in the manner set forth in these Bylaws by a Medical 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 one of the following:

- Aurora Health Care Metro

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



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- Aurora Psychiatric Hospital
- Aurora West Allis Medical Center
- Aurora Medical Center Washington County
- Aurora Medical Center Oshkosh
- Aurora Medical Center Grafton
- Aurora Medical Center Manitowoc County
- Aurora Sheboygan Memorial Medical Center
- Aurora Medical Center Burlington
- Aurora Lakeland Medical Center
- Aurora Medical Center Kenosha
- Aurora Medical Center Summit

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 the 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, Associate, Courtesy, Telemedicine, or Consulting 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>

**“Medical Staff Services”** means the Medical Center’s 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.

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<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).

## DEFINITIONS

**“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 Aurora Practice Evaluation Committee. Relevant information obtained from OPPE shall be integrated into performance improvement activities.

**“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 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 a Medical Center, (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 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 license to practice podiatry in the State of Wisconsin.

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

**“Primary Site”** means the Sited designated as a Staff Member’s primary practice location in accordance with Section 2.4.3 of these Bylaws.

**“Probation”** with respect to a Staff Member, that such Staff Member has received written notice that he or she will be subject to remedial 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 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>

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<sup>4</sup> 42 U.S.C. § 11151(9).

<sup>5</sup> 42 U.S.C. § 11151(10).

## DEFINITIONS

**“Professional Review Body”** means the Governing Body, Medical Executive Committee, Aurora Credentials Committee, Aurora Practice Evaluation Committee, Site Practice Evaluation Committees, any Hearing or Appellate Review Committee, any subcommittee or member of the forgoing, and any other committee or entity which, or individual who, conducts or assists the Medical Center in the performance of any Professional Review Activity and/or otherwise participates in a Professional Review Action.

**“Site”** means one of the following Medical Center practice locations:

- Aurora St. Luke’s Medical Center
- Aurora Sinai Medical Center
- Aurora St. Luke’s South Shore
- Aurora Psychiatric Hospital
- Aurora West Allis Medical Center
- Aurora Medical Center Washington County
- Aurora Medical Center Oshkosh
- Aurora Medical Center Grafton
- Aurora Medical Center Manitowoc County
- Aurora Sheboygan Memorial Medical Center
- Aurora Medical Center Burlington
- Aurora Lakeland Medical Center
- Aurora Medical Center Kenosha
- Aurora Medical Center Summit

**“Site Administrator(s)”** means the administrator(s) appointed by the Governing Body to act on its behalf in the overall management of a Medical Center or one or more Sites.

**“Site Chief Medical Officer”** means the individual appointed by Aurora to serve as the senior physician leader responsible for clinical quality and outcomes at a Medical Center and assist the Medical Center in formulating standards of care, providing strategic direction, and facilitating communication between the Medical Staff and administration to ensure positive relations.

**"Site Leadership Council"** means the Site-based leadership council composed of the elected Medical Staff leaders, Clinical Chairpersons, and administration at one or more Site(s), as more

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specifically defined in a Site's Operating Policies. Each Site Leadership Council shall report to the Medical Executive Committee.

**"Site Leadership Council President(s)"** means the Medical Staff Member elected from and among the Medical Staff Members of a Site to serve as President of that Site Leadership Council.

**"Site Leadership Council President-Elect(s)"** means the Medical Staff Member elected from and among the Medical Staff Members of a Site to serve as President-Elect of that Site Leadership Council.

**"Site Operating Protocols"** means the procedures that govern the Medical Staff operations of a Site, including, without limitation, the procedures that govern the Site Leadership Council.

**"Site Practice Evaluation Committee"** means a Site's individual practice evaluation committee. Each Site Practice Evaluation Committee shall report to the Aurora Practice Evaluation Committee.

**"Staff Member"** means a current appointee to the Active, Associate, Courtesy, Telemedicine or Consulting Medical Staff, the Emeritus/Affiliate Staff, or the Advanced Practice Clinician Staff.

**"Staff Membership"** means appointment to the Active, Associate, Courtesy, Telemedicine or Consulting Medical Staff, the Emeritus/Affiliate Staff, or the Advanced Practice Clinician Staff.

**"Telemedicine Service Organization"** or **"TSO"** means a Joint Commission-accredited hospital or ambulatory care organization that has contracted with the 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>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 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, creed, color, national origin, ancestry, religion, sex, sexual orientation, gender identity, marital status, age, disability, military status, 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 2.9, 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 a Medical Center 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.

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

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

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 2.10.8 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 Clinician 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
- Optometrists
- 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 applicable Medical Center does 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 at each Site are maintained by Medical Staff Services.<sup>23</sup>

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

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 on the forms and in the manner requested. Except as set forth in Section 2.9 (Temporary, Emergency and Disaster Privileges), Section 3.7 (Affiliate Staff), and Section 3.8 (Emeritus 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 Medical Staff Services in consultation with the Medical Executive Committee).

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

Each Applicant must: (a) possess a current 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 license/registration

<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).

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, Residency/Training Program, and Board Certification Waiver.**

- (a) 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.
  - i. 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. If a Physician allows his/her Board Certification to expire, the maximum time the Physician may be given to recertify is five (5) years.
  - ii. 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. If a Podiatrist allows his/her Board Certification to expire, the maximum time the Podiatrist may be given to recertify is five (5) years.

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<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).

- iii. 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 (1) year of a post-graduate program approved by the Commission on Dental Accreditation of the American Dental Association or the Medical Executive Committee.
  - iv. 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. If an Oral Surgeon allows his/her Board Certification to expire, the maximum time the Oral Surgeon may be given to recertify is five (5) years.
  - v. Advanced Practice Clinicians. Advanced Practice Clinicians must have successfully obtained certification or membership, as applicable, from the appropriate professional organization, as applicable.
- (b) Temporary Waiver of Board Certification Requirements. Board Certification requirements may be waived only for a specific Staff Member temporarily, in accordance with these criteria:
- i. The Staff Member has demonstrated competence or expertise;
  - ii. The Governing Body determines that a Site has a demonstrated need for the Staff Member's services, and such need cannot be met without waiving the board certification requirements for the Staff Member;
  - iii. The waiver is recommended to the Governing Body by the Medical Executive Committee; and
  - iv. The waiver is granted for the length of time necessary for either: (1) the Staff Member to become board certified; or (2) the applicable Site to meet its patient care needs by securing the services of another practitioner.

Temporary waivers of board certification requirements granted to a Staff Member prior to the initial adoption of these Bylaws shall continue for such Staff Member for the duration and according to the terms as initially granted.

- (c) Grandfather Waiver. Waiver of board certification requirements shall continue for those Practitioners who were granted a waiver under a grandfather provision as a

member of an Aurora Medical Center medical staff prior to the initial adoption of these Bylaws.

**2.3.5 Peer Recommendations.**

Peer recommendations are required for all Applicants seeking: (a) initial appointment and/or Clinical Privileges and (b) renewed Clinical Privileges if there is insufficient professional practice review data generated by a Site 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) are 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>

- (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 a Site 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

<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).

subject to evaluation through peer review acceptable to the Medical Executive Committee, or (ii) applied for Staff Membership and/or Clinical Privileges upon completion of 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 which will allow the Applicant to prescribe medications for Medical Center patients.<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;

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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.

- (c) Acknowledges the Applicant’s responsibility to promptly notify and provide information to Medical Staff Services 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 the applicable Medical Center(s) on the Medical Centers’ 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 applicable Medical Center’s IRB.

**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 Clinical 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 Center from extending Staff Membership or Clinical Privileges to the Applicant.<sup>34</sup>

<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.).

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> Applicants 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 Governing Body from extending Staff Membership and Clinical Privileges to the Applicant.

**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 the Medical Center or an entity affiliated with the 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 the Medical Center or an entity affiliated with the 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 Clinicians must provide a copy of a written collaboration or supervisory agreement (as applicable) upon request 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 Advocate Aurora Health 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 Aurora

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<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).

<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).

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. Additionally, each Applicant eligible to participate in the Wisconsin Injured Patients and Families Compensation Fund (the Fund) as either a mandatory participant<sup>40</sup> or an optional participant<sup>41</sup> must participate in the Fund.

**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 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 Aurora Credentials Committee, Medical Executive Committee, or Governing Body.<sup>42</sup>

**2.3.20 Confirmation of Identity.**<sup>43</sup>

Each initial Applicant must provide 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 or its designee 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). Such confirmation may be performed in person, via a notarized form provided to the Applicant by Medical Staff Services, or via real-time electronic visual communication (ex: Skype or FaceTime).

**2.3.21 Continuing Education.**<sup>44</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

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<sup>40</sup> Wis. Stat. § 655.002(1)

<sup>41</sup> Wis. Stat. § 655.002(2)

<sup>42</sup> Wis. Admin. Code DHS § 124.12(4)(a)4. (2011); JCS MS.06.01.05, EP 9 (October 2011).

<sup>43</sup> JCS MS.06.01.03, EP 5 (January 2018).

<sup>44</sup> JCS MS.12.01.01, EP 5 (October 2011).



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 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 STAFF APPOINTMENT, CLINICAL PRIVILEGES, AND PRIMARY SITE**

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**2.4.1 Initial Appointment and Term.** Initial appointment, if granted, shall be for a period of not more than two (2) years. Unless otherwise specified, appointment terms run through the fourteenth day of the Staff Member's birth month.

**2.4.2 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. Reappointment, if granted, shall be for a period of not more than two (2) years, with reappointment scheduled according to the month of the Staff Member's birth. The Medical Executive Committee may, in its sole discretion, recommend that an Applicant be granted Conditional Appointment, upon approval of the Governing Body. The Governing Body may, in its sole discretion and with or without a recommendation from the Medical Executive Committee, grant an Applicant Conditional Appointment. Applicants receiving Conditional Appointment shall not be entitled to the hearing and appeal rights provided in these Bylaws.

**2.4.3 Determination of Primary Site.** Medical Staff Services shall assign each Applicant a Primary Site at the time the Staff Member submits an Application. The Primary Site shall be the Site at which the Medical Staff anticipates Applicant will have the highest volume of Patient Encounters. If an Applicant practices at multiple Sites and disagrees with Medical Staff Services Primary Site assignment, the Applicant may request a different Primary Site designation, subject to approval by the Medical Executive Committee.

- (a) Aurora Burlington Lakeland. Aurora Medical Center Burlington and Aurora Lakeland Medical Center have opted to consolidate their two Medical Centers into one unified Site for all purposes of these Bylaws except representation on the Medical Executive Committee and other Medical Staff Committees for which each Site is entitled to equal representation. Accordingly, Active Staff Members who designate Aurora Burlington Lakeland as their Primary Site will be eligible to vote in elections and matters effecting the unified Site (i.e. Site Operating Protocols) as well as for matters effecting only one of the Medical Centers (i.e. Clinical Chairperson elections). The unified Site shall have one Site Leadership Council and one Site Practice Evaluation Committee.

**2.4.4** Temporary, Emergency, and Disaster Privileges. Refer to Section 2.8.

**2.4.5** 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.

## **2.5** OBTAINING AND SUBMITTING AN APPLICATION

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### **2.5.1** Opportunity to Review Medical Staff Governing Documents.

Applicants shall have the opportunity to read a copy of these Medical Staff Bylaws, the Policies Governing Medical Practices, and any applicable Medical Staff rules and regulations as are in force at the time of application, and the Applicant expressly agrees to be bound by the terms of such documents as they may be amended from time to time.

### **2.5.2** Pre-Application Process and Obtaining an Application.

(a) Pre-Screening Requirements. Practitioners and Advanced Practice Clinicians seeking appointment, reappointment, and/or Clinical Privileges (including initial or modified Clinical Privileges) must submit a complete written Application. An individual seeking initial appointment and/or Clinical Privileges may request an Application by contacting Medical Staff Services. Applicants requesting an Application shall have their request for appointment screened against eligibility criteria outlined below. This screening may occur using a telephone interview, written communication, or electronic communication as determined by Medical Staff Services. An Application shall be sent to only Practitioners and Advanced Practice Clinicians who satisfy the following criteria:

- i. Possess a current license to practice his/her profession in Wisconsin or are in the process of applying for such a license;

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- ii. Has (1) practiced in an inpatient or appropriate outpatient setting within the past twelve (12) months in which the Applicant's care was subject to evaluation through a peer review process acceptable to the Medical Executive Committee and relevant to the scope of Clinical Privileges the Applicant is seeking to obtain, or (2) applied for Staff Membership and/or Clinical Privileges upon completion of a graduate or post-graduate program, as applicable;
  - iii. Can provide peer recommendations as provided in Section 2.3.5 of these Bylaws as required by the staff category to which the Applicant desires appointment;
  - iv. Meet the board certification and residency/training program eligibility requirements provided in Section 2.3.4 as required by the Medical Staff category to which the Applicant desires appointment;
  - v. Each Applicant must be eligible for participation in the Medicare and Medicaid programs and may not 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 (as provided in Section 2.3.7);
  - vi. Indicate an intention to utilize one or more of the Site(s) as required by the staff category to which the Applicant desires appointment;
  - vii. 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 is an active participant in the Wisconsin Injured Patients and Families Compensation Fund;
  - viii. Practices in a specialty that is open to new Applicants at the Site(s) in which the Applicant intends to activate Clinical Privileges (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);
  - ix. If an Advanced Practice Clinician required to have a collaborative or supervisory relationship and written agreement, maintains the same; and
  - x. Has not been convicted of, or plead "guilty" or "no contest" or its equivalent to, a felony in any jurisdiction.
- (b) Failure to Meet Pre-Screening Requirements. Only Applicants who meet the pre-screening requirements provided above in Section 2.5.2(a) shall be given an Application. Applicants who fail to meet such requirements shall be so notified and shall not receive an Application. The failure to meet such requirements and not receive an Application on that basis shall not entitle an Applicant to hearing or appeals rights under these Bylaws.

- (c) Provision of Application. If the Applicant confirms he/she meets the pre-screening requirements provided above in Section 2.5.2(a), Medical Staff Services shall send the appropriate Application to the Applicant, or make the Application accessible to the 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 Telemedicine Medical Staff may receive an abbreviated Application.
- (d) Provision of Application for 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.

### **2.5.3 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 3.9. 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 Center and/or the Medical Staff.

#### **2.5.4 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 or Governing Body, which may also select the examining physician. The Applicant's failure, as determined by the Medical Executive Committee or Governing Body as applicable, 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.

#### **2.5.5 Effect of Misrepresentation, Misstatement or Omission.**

Applicants expressly agree that if the Medical Executive Committee determines that (1) the Applicant made a misrepresentation or misstatement in, or omission from, an Application and (2) the Applicant knowingly intended to make such misrepresentation, misstatement, or omission, the Application shall be deemed a voluntary withdrawal of such Application without hearing and appeal rights. An Applicant or Staff Member whose Application is withdrawn under this Section 2.5.5 may not submit a new application for Medical Staff membership or Clinical Privileges for a period of twelve (12) months. Waiver of such twelve (12) month period may be granted only by the Medical Executive Committee.

## **2.6 REVIEW AND EVALUATION PROCESS<sup>45</sup>**

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### **2.6.1 Generally.**

Prior to making a recommendation or decision regarding an Application, Medical Staff Services, the Clinical Chairperson at the Applicant's Primary Site, the Site Leadership Council at the Applicant's Primary Site (if Category II or Category III) the Aurora 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 applicable Site Leadership Council, the Aurora 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.

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<sup>45</sup> JCS MS.01.01.01, EPs 14, 26, & 27 (October 2011).

**2.6.2 Anticipated Time Periods for Application Processing.**<sup>46</sup>

All individuals and groups required to act on an Application shall do so in a timely and good faith manner<sup>47</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 remedial action, or hearing and appellate review processes specified in these 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 at Applicant’s Primary Site	Prior to next Aurora Credentials Committee Meeting
-Site Leadership Council at Applicant’s Primary Site (for Category 2 and 3 Applicants)	Next Scheduled Meeting
-Aurora Credentials Committee	Next Scheduled Meeting
-Medical Executive Committee	Next Scheduled Meeting
-Governing Body	Next Scheduled Meeting

**2.6.3 Initial Review by Medical Staff Services.**<sup>48</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 2.6.10, Medical Staff Services may maintain a single credentials file for the TSO that contains credentialing information for all of the TSO’s Telemedicine Medical Staff Applicants.<sup>49</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 (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 categorized pursuant to Section 2.6.3(c) below and 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 Center(s) are under no obligation to act on an Application until all such information and supporting documentation

<sup>46</sup> JCS MS.06.01.05, EP 11 (October 2011).

<sup>47</sup> JCS MS.06.01.07, EP 3 (October 2011).

<sup>48</sup> JCS MS.01.01.01, EP 26; JCS MS.06.01.03, EPs 1-4, 6 (October 2011).

<sup>49</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).

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.

- (c) Categorization of Applicants. Medical Staff Services shall categorize all new Applicants into one of three categories ("Category I", "Category II", and "Category III") according to guidelines approved by the Medical Executive Committee and the Governing Body.

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

The Clinical Chairperson at the Applicant's Primary Site 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 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 shall complete the evaluation described in Section 2.6.1 and submit a written recommendation to the Aurora Credentials Committee (for Category I Applicants) or the applicable Site Leadership Council (for Category II and Category III Applicants) that includes the following:

- (a) Staff Membership. Whether the Applicant's request should be approved or disapproved, the appropriate staff category (as applicable), and the appropriate Department. If the recommendation regarding Staff Membership or Staff category is adverse to the Applicant, the written recommendation shall clearly state the reason(s) for such 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 Staff's peer review policy.<sup>50</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 action.

#### **2.6.5 Site Leadership Council Review and Recommendation.**

For Category II and Category III Applicants only, the Site Leadership Council shall complete the evaluation described in Section 2.6.1 and review the Clinical Chairperson's written recommendation. The Site Leadership Council will then submit a written

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<sup>50</sup> JCS MS.08.01.01, EP 1 (October 2011).

recommendation to the Aurora Credentials Committee that includes the information set forth in Sections 2.6.4(a) and (b). If the Site Leadership Council disagrees with the recommendation of the Clinical Chairperson or the recommendation is adverse to the Applicant, in whole or in part, the Site Leadership Council’s written recommendation shall include the reason(s) for the alternative recommendation

**2.6.6 Aurora Credentials Committee Review and Recommendation.**

Upon completion of the evaluation described in Section 2.6.1 and review of the Clinical Chairperson’s written recommendation (and review of the Site Leadership Council’s written recommendation, if applicable for Category II and Category III Applicants), the Aurora Credentials Committee will submit a written recommendation to the Medical Executive Committee that includes the information set forth in Sections 2.6.4(a) and (b). If the Aurora Credentials Committee disagrees with the recommendation of the Clinical Chairperson or the recommendation is adverse to the Applicant, in whole or in part, the Aurora Credentials Committee’s written recommendation shall include the reason(s) for the alternative recommendation.

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

Upon completion of the evaluation described in Section 2.6.1, and review of the written recommendations of the Clinical Chairperson and the Aurora Credentials Committee, the Medical Executive Committee will draft a written recommendation that includes the information set forth in Sections 2.6.4(a) and (b). If the Medical Executive Committee disagrees with the recommendations of the Clinical Chairperson or the Aurora 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 these Bylaws, the Site 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 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 Bylaws.

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

Upon completion of the evaluation described in Section 2.6.1, and review of the written recommendations of the Clinical Chairperson, the Aurora Credentials Committee, and the Medical Executive Committee, the Governing Body will issue a written decision that includes the information set forth in Section 2.6.4. The written decision may precondition appointment or reappointment, and granting or continued exercise of Clinical Privileges, upon the Applicant undergoing mental or physical examinations

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<sup>51</sup> Wis. Admin. Code DHS § 124.12(4)(a)1. (2011).



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.

**2.6.9 Expedited Governing Body Review and Decision.**<sup>52</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 2.6.7, the Governing Body may delegate to a committee of at least two 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 Center(s) 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.

**2.6.10 Applicants to the Emeritus and Affiliate Staff**<sup>53</sup>

An Applicant to the Emeritus Staff or Affiliate 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 Emeritus Staff or Affiliate Staff must complete the appropriate Application provided by Medical Staff Services and be approved for membership on the Emeritus Staff or Affiliate Staff by the Medical Executive Committee and the Governing Body.

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<sup>52</sup> JCS MS.06.01.11 (October 2011).

<sup>53</sup> JCS MS.01.01.01, EPs 14, 26, & 27 (October 2011).

**2.6.11 Applicants to the Telemedicine Medical Staff.<sup>54</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 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 2.6.4 and the Aurora Credentials Committee under Section 2.6.6. 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 Center, shall be credentialed and privileged in accordance with the standard process.

**2.7 NOTIFICATION OF STAFF MEMBERSHIP AND CLINICAL PRIVILEGING DECISIONS**

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**2.7.1 Notification to Applicant.**

- (a) Favorable Decision. If the Governing Body’s decision is favorable to the Applicant, Medical Staff Services (or its 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 Staff Membership or change in Staff category;
  - ii. the Primary Site at which the Applicant is assigned;
  - iii. the Staff category to which the Applicant is appointed or reappointed;
  - iv. the Department assignment;
  - v. the delineation of Clinical Privileges granted and the specific Sites for which they are activated;
  - vi. any special conditions or restrictions that apply; and
  - vii. 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>55</sup>

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<sup>54</sup> 42 C.F.R. §§ 482.12(a)(8)–(9), 482.22(a)(3)–(4); JCS MS.13.01.01.01 (October 2011).

- (b) Unfavorable Decision. If Governing Body’s decision is deemed an Adverse Action, the Chief of Staff (or his/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.

**2.7.2 Communication with Medical Center Departments.**

Medical Staff Services will ensure that the appropriate Departments and other patient care areas of applicable Medical Centers 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>56</sup>

**2.8 ACTIVATION AND DEACTIVATION OF CLINICAL PRIVILEGES AT SITES**

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**2.8.1 Initial Activation of Clinical Privileges at Sites.**

Upon initial appointment and reappointment, each Staff Member shall be required to indicate in writing the Site(s) where he or she desires to activate Clinical Privileges on specific forms that shall be established by and obtained through Medical Staff Services.

**2.8.2 Activation of Clinical Privileges at Additional Sites.**

Subject to the limitations set forth in Section 2.8.3 of these Bylaws, a Staff Member may also activate his or her Clinical Privileges at additional Site(s) at any time during the Staff Member’s appointment by written notice to Medical Staff Services.

**2.8.3 Deactivation of Clinical Privileges at Sites.**

A Staff Member may deactivate his or her Clinical Privileges at the Site(s) at which the Staff Member no longer wishes to exercise Clinical Privileges by written notification to Medical Staff Services. In such event, the deactivating Staff Member shall be responsible for all previously assigned Emergency Call Coverage, as well any other previously assigned Medical Staff duties, at the applicable Site. A Staff Member who deactivates Clinical Privileges at a Site must wait a minimum of twelve (12) months before reapplying to reactivate Clinical Privileges at that Site, however, the Medical Executive Committee or the applicable Site Leadership Council may waive such waiting period in its sole discretion.

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<sup>55</sup> JCS MS.08.01.01, EP 1 (October 2011).

<sup>56</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).

## 2.9 TEMPORARY, EMERGENCY, AND DISASTER PRIVILEGES

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### 2.9.1 Minimum Qualifications for Temporary Clinical Privileges.<sup>57</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>58</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 a Medical Center or any other institution, organization, or entity is not eligible for temporary Clinical Privileges.<sup>59</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 Clinical 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.

### 2.9.2 Request for Temporary Clinical Privileges.

The following Practitioners and Advanced Practice Clinicians 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 2.9.1 of these Bylaws:

- (a) A Category I Applicant (including a locum tenens Practitioner or Advanced Practice Clinician) 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>60</sup>

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<sup>57</sup> Wis. Admin. Code DHS § 124.12(4)(c)4. (2011).

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

<sup>59</sup> JCS MS.06.01.13, EP 3 (October 2011).

<sup>60</sup> JCS MS.06.01.13, Rationale (October 2011).

- (b) A Practitioner or Advanced Practice Clinician (including a locum tenens Practitioner or Advanced Practice Clinician) needed in order to fulfill an important care, treatment or services need.

### 2.9.3 Granting of Temporary Clinical Privileges.<sup>61</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 Site Leadership Council President.
- (b) Review by Site Leadership Council President. The Site Leadership Council President (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 Site 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 Site Administrator. Upon receipt of a recommendation from the Site Leadership Council President, the Site Administrator (or his/her designee) shall review the Clinical Privileges request, the credentials file, and the Site Leadership Council President's recommendation.<sup>62</sup> The Site 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>63</sup> If the Site Administrator disapproves the request, Medical Staff Services shall notify the Applicant of the denial.
- (d) No Entitlement. No Practitioner or Advanced Practice Clinician is entitled to temporary privileges simply by meeting the minimum qualifications provided under these Bylaws. The Site Administrator (upon receipt of a recommendation from the applicable Site Leadership Council President) retains full discretion when approving or denying such temporary privileges.

### 2.9.4 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 Staff category or designated Clinical Privileges, as long as such care, treatment or services is within the scope of the Staff Member's

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<sup>61</sup> Wis. Admin. Code DHS § 124.12(5)(b)3. (2011).

<sup>62</sup> JCS MS.06.01.13, EP 4, 5 (October 2011).

<sup>63</sup> Wis. Admin. Code DHS § 124.12(4)(c)4. (2011); JCS.MS.06.01.13, EP 6 (October 2011).

license.<sup>64</sup> If time permits, such Staff Member, or other Medical Center personnel in attendance, shall attempt to locate an appropriately privileged Staff Member.

### **2.9.5 Disaster Privileges.**

Disaster privileges may be granted to volunteer Practitioners or Advanced Practice Clinician only when a Medical Center's Emergency Operations Plan has been activated in response to a disaster and such Medical Center is unable to meet immediate patient needs.<sup>65</sup> Such disaster privileges may only be granted by the Site Administrator (or his/her designee) or the Site Leadership Council President (or his/her designee) in accordance with the Medical Staff's policy regarding disaster privileges.<sup>66</sup>

### **2.9.6 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>67</sup> The Site Leadership Council President or the Site Administrator may impose special requirements in order to monitor and assess the quality of care rendered by the Practitioner or Advanced Practice Clinician exercising temporary or disaster Clinical Privileges.

### **2.9.7 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 Site Administrator (or his/her designee) upon notice of any failure by the Practitioner or Advanced Practice Clinician to comply with any special requirements. The Site Administrator (or his/her designee) may at any time, upon the recommendation of the Site Leadership Council President (or his/her designee), terminate a Practitioner or Advanced Practice Clinician's temporary or disaster privileges, effective upon the discharge of the Practitioner or Advanced Practice Clinician's patient(s) from the Medical Center. However, if the life or health of such patient(s) would be endangered by continued treatment by the Practitioner or Advanced Practice Clinician, any person authorized to impose a summary suspension in accordance with Section 4.2 of these Bylaws may terminate the Practitioner or Advanced Practice Clinician's temporary privileges, effective immediately. The Site Leadership Council President (or his/her designee) shall assign a Staff Member to assume responsibility for the care of such terminated Practitioner or Advanced Practice Clinician's patient(s) until discharge from the applicable Medical Center. The wishes of the patient(s) shall be considered where feasible in selection of an alternative Staff Member.

### **2.9.8 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

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<sup>64</sup> JCS MS.06.01.13, Rationale (October 2011).

<sup>65</sup> JCS MS.01.01.01, EP 14 (October 2011); JCS EM.02.02.13, EP 1 (October 2011); JCS EM.02.02.15, EP 1 (October 2011).

<sup>66</sup> JCS EM.02.02.13, EP 2 (October 2011); JCS EM.02.02.15, EP 2 (October 2011).

<sup>67</sup> JCS EM.02.02.13, EPs 4, 6 (October 2011); EM.02.02.15, EPs 4, 6 (October 2011).

of his/her inability to obtain temporary or disaster Clinical Privileges and/or the termination of such temporary or disaster Clinical Privileges.

## **2.10 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>68</sup>

### **2.10.1 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.

### **2.10.2 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.

### **2.10.3 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.

### **2.10.4 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, documents, and materials 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 applicable Medical Center(s) may obtain an evaluation of the Applicant's performance by a consultant selected by the Medical Center(s) if the Medical Center(s) considers it appropriate.

### **2.10.5 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 Staff and Medical Center(s); (b) delegate in his/her absence the responsibility for diagnosis and care of his/her patients to

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<sup>68</sup> JCS MS.01.01.01, EP 15 (October 2011).

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 Center’s policies regarding consultation.<sup>69</sup>

**2.10.6 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.

**2.10.7 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, the Medical Centers, and Advocate Aurora Health, including but not limited to the Aurora Health Care EMTALA policy;<sup>70</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.

**2.10.8 Mandatory Self-Disclosure.<sup>71</sup>**

The Applicant agrees to notify the applicable Site Chief Medical Officer in writing immediately after he/she becomes aware (in no event later than the end of the next business day) 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 investigation, adverse action, 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;
- (e) Dishonorable discharge from any branch of the US Armed Forces, including any reserve component;

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<sup>69</sup> Wis. Admin. Code DHS § 124.12(5)(b)10 (2011); JCS MS.03.01.03, EPs 4, 5 (October 2011).

<sup>70</sup> JCS MS.01.01.01, EP 5 (October 2011).

<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.



- (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 Applicant’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 (improperly taking or using) of 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>72</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.

#### **2.10.9 Immunity from Liability.**

The Applicant agrees and acknowledges that the Medical Center(s) 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, remedial 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>73</sup> For purposes of this Section 2.10.9, the term “Medical Center representatives” shall include, without limitation, the Medical Centers’ Staff Members, the Governing Body and its members, the Medical Executive Committee and its members, the Site Leadership Councils and their members, the Aurora Credentials

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<sup>72</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>73</sup> Wis. Admin. Code DHS § 124.12(4)(a)4. (2011).

Committee, any and all committees serving as a Professional Review Body on behalf of the Medical Center, the Practitioner Wellness Committee and its members, the Site Administrators, the Site Chief Medical Officers, 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 a Medical Center, execute releases in favor of such Medical Center, Medical Center representatives and third parties from whom information has been requested by a Medical Center or an authorized Medical Center representative.

**2.10.10 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 Staff Members, except as may be permitted by law.<sup>74</sup>

**2.10.11 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>75</sup>

**2.10.12 Cooperate With Medical Center.**

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

**2.10.13 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.

**2.10.14 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>74</sup> Wis. Stat. § 448.08(1m) (2011); Wis. Admin. Code DHS § 124.12(5)(b)5. (2011).

<sup>75</sup> Wis. Admin. Code DHS § 124.12(3)(a) (2011).

**2.10.15 Submission of Annual Staff Member Dues.**

The Applicant agrees to pay Annual Staff Member dues, if any, as required by the Sites at which the Applicant has activated Clinical Privileges (pursuant to Section 2.15). Emeritus/Affiliate Staff and Telemedicine Medical Staff Members will not be required to pay dues.

**2.10.16 Assessment of Competence.**

The Applicant agrees to sufficiently use one or more of 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.

**2.10.17 Unanticipated Outcome Disclosure to Patients.**

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

**2.10.18 Staff Member Identification.**

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

**2.10.19 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

**2.10.20 Emergency Department On-Call Coverage.**

Active Medical Staff Members and Associate Medical Staff Members must participate in emergency department back-up call and other specialty coverage programs at the Staff Member's Primary Site and any other Site which the Staff Member (1) has activated Clinical Privileges and (2) resides within thirty (30) miles of such Site. Staff Members with activated Clinical Privileges at a Site in which the Staff Member resides greater than thirty (30) miles from such Site shall be required to take emergency department back-up call only if such call is agreed to by the Staff Member and the corresponding Site Leadership Council. Upon request of the applicable Site Leadership Council, Courtesy Medical Staff Members may be required to participate in emergency department back-up call and other specialty coverage programs at the Staff Member's Primary Site under exigent circumstances including, but not limited to, gaps in coverage caused by the lack of a particular specialty on the Active or Associate Medical Staff. All emergency department back-up call coverage shall be provided 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, 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.

## **2.11 LEAVE OF ABSENCE; VOLUNTARY RESIGNATION**

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### **2.11.1 Leave of Absence.**

- (a) Request for Leave. A Staff Member may obtain a leave of absence from the Medical Staff or Advanced Practice Clinician 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 conclusion 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 Aurora Credentials Committee. The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the Practitioner's or Advanced Practice Clinician'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 Clinical Chairperson, Aurora Credentials Committee, Medical Executive Committee, and/or the Governing Body.
  - ii. *Review Process.* The Aurora Credentials Committee will forward the request for reinstatement to the Staff Member's Clinical Chairperson for a recommendation. The Clinical Chairperson shall forward his/her recommendation back to the Aurora Credentials Committee. The Aurora 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 Staff Member following an approved leave of absence shall entitle the Staff Member to hearing and appellate review rights as provided in these Bylaws.
- (c) Failure to Return. Failure of a Staff Member to request reinstatement in accordance with Section 2.11.1(b)(i) above shall constitute a voluntary resignation from the Medical Staff or Advanced Practice Clinician Staff, as applicable, and shall not entitle the Practitioner to hearing or appellate review rights.

### **2.11.2 Voluntary Resignation**

Resignations from the Medical Staff or Advanced Practice Clinician 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, 2.11.1(c), 2.13, and 4.4 of these Bylaws are automatic and, therefore, do not require a written submission in accordance with the requirements of this Section 2.11.2. The Staff

Member’s Clinical Chairperson, the Site Administrator, and the Medical Executive Committee shall be informed of all resignations. A Staff Member who voluntarily resigns may not submit a new Application for Staff Membership for at least nine (9) months from the Staff Member’s resignation date. In unusual circumstances, exceptions may be granted by the Medical Executive Committee. The refusal to grant an exception under this Section 2.11.2 does not entitle a Staff Member to hearing and appellate review rights as provided in these Bylaws.

**2.11.3 Reapplication Following Voluntary Resignation.**

A Practitioner or Advanced Practice Clinician who seeks to regain his/her Staff Membership or Clinical Privileges following voluntary resignation or voluntary relinquishment under Sections 2.11.1(c), 2.13 or 4.4 of these Medical Staff Bylaws must complete an initial Application, meet all of the requirements for initial appointment and Clinical Privileges, and pay any applicable Application fee.

**2.12 MEDICO-ADMINISTRATIVE APPOINTMENTS**

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**2.12.1 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.

**2.12.2 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 the 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 the Medical Center contracts to provide such administrative services). If the termination is deemed an Adverse Action, the Chief of Staff (or his or her designee) will provide Practitioner with Written Notice of the Adverse Action in accordance with these Bylaws (except as otherwise provided in any contract between a Medical Center and such Practitioner, or a Medical Center and the entity with which the Medical Center contracts to obtain such administrative services).

**2.13 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(s) 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 the Medical Center has the contract; or (c) the Staff Member is no longer assigned to any Medical Center by the entity with which the 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 Bylaws.

A Staff Member who only has a portion of his or her Clinical Privileges exercisable pursuant to a contract with the 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 Bylaws.

A Staff Member who is employed or becomes employed by an Aurora Affiliate following any of the events listed in (a) through (c) above shall not be subject to the above automatic relinquishment event.

## **2.14 MEDICAL STAFF DUES**

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Each Site Leadership Council shall determine (1) which Staff Members to shall pay Medical Staff Dues at its respective Site (for example: only Primary Site Staff Members, all Staff Members with activated Clinical Privileges, no dues assessment at all, etc.) and (2) the amount of such Medical Staff Due assessment.

## **2.15 GRADUATE MEDICAL STUDENTS**

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### **2.15.1 Relationship to Medical Staff.**

Graduate Medical Students in approved post-graduate training programs shall not hold appointments to the Medical Staff, but shall be permitted to exercise limited Clinical Privileges at Sites participating in such educational activities in accordance with Section 2.15.2 below. Such limited Clinical Privileges may be terminated by the Governing Body with or without cause. Notwithstanding the foregoing, Graduate Medical Students shall not be entitled to any procedural rights granted to Staff Members pursuant to these Bylaws, including without limitation, hearing or appeal rights.

### **2.15.2 Training Protocols; Limited Clinical Privileges.**

Graduate Medical Students shall be permitted to exercise only those Clinical Privileges set out in the training protocols developed by the Director of Medical Education at the applicable Site, and approved by the Aurora Credentials Committee, the Medical Executive Committee, and the Governing Body. Training protocols shall delineate the roles, responsibilities and patient care activities of Graduate Medical Students, including, without limitation, the qualifications a Graduate Medical Student is required to possess in order to write patient care orders, under what circumstances a qualified Graduate Medical Student may write patient care orders and what entries a supervising Medical Staff Member must countersign. Training protocols also shall describe the mechanisms by which Graduate Medical Student directors and supervisors shall make decisions about a Graduate Medical Student's progressive involvement and independence in delivering patient care.

**2.15.3 Medical Staff Coordination and Oversight.**

The Director of Medical Education shall notify the Aurora Credentials Committee of any problem arising in connection with a Graduate Medical Student related to such student's ability to provide professional services or to participate in a training program, including, without limitation, his or her physical or mental health and/or any other performance issue that could potentially affect patient care, no later than thirty (30) days of becoming aware of such problem. The Director of Medical Education also shall communicate at least annually with the applicable Site Leadership Council(s) regarding the performance of Graduate Medical Students and related patient safety issues, and the quality of patient care delivered by Graduate Medical Students. The Director of Medical Education shall also work with the Medical Executive Committee to ensure that all Practitioners who supervise Graduate Medical Students possess Clinical Privileges commensurate with their supervising activities.

## 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 Medical Staff categories set forth below or the Advanced Practice Clinician Staff. 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>76</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>77</sup>:

- Active
- Associate
- Courtesy
- Telemedicine
- Consulting

#### 3.1.3 Affiliate Staff.

The Affiliate Staff shall consist of Practitioners who devote their practice to the office environment and refer management of inpatients to other Staff Members.

#### 3.1.4 Emeritus Staff.

The Emeritus Staff shall consist of Practitioners who (1) have retired from practice, or (2) are recognized for their reputations and their contributions to the health and medical sciences, as well as their contributions to one or more Medical Center(s).

#### 3.1.5 Advanced Practice Clinician Staff.

Each Advanced Practice Clinician shall be designated as a member of the Advanced Practice Clinician 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) have completed at least one (1) year of Associate Staff Membership;

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<sup>76</sup> 42 C.F.R. § 482.22(c)(3).

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



- (b) are located closely enough to the Medical Staff Member's Primary Site to provide continuous care to their patients;
- (c) assume all the functions and responsibilities of appointment to the Active Medical Staff<sup>78</sup>; and
- (d) regularly treat patients at the Primary Site. "Regularly treat" means the Active Medical Staff Member has more than forty (40) 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 Staff Member's Primary Site, the Site Administrator (or his/her designee) shall notify the Staff Member, and the Staff Member shall be deemed to have voluntarily requested reassignment to the Courtesy Medical Staff.

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

- (a) Active Medical Staff Members shall be:

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<sup>78</sup> Wis. Admin. Code DHS § 124.12(3)(a) (2011).

- i. eligible to apply for Clinical Privileges (including the privilege to admit, perform procedures, and/or write orders<sup>79</sup>);
  - ii. encouraged to attend Medical Staff and Department meetings;
  - iii. eligible to vote at Medical Staff and Department meetings;
  - iv. eligible to vote for Site leadership at the Staff Member's Primary Site;
  - v. eligible to serve in a voting capacity on and as chairperson of one or more Medical Staff committees;
  - vi. eligible to hold Medical Staff office; and
  - vii. eligible to serve as a Clinical Chairperson at the Staff Member's Primary Site.
- (b) As may be required by the Medical Executive Committee or the Governing Body, Active Medical Staff Members 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 Members must participate in emergency department back-up call as required by Section 2.10.20.

### **3.3 ASSOCIATE MEDICAL STAFF**

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#### **3.3.1 Composition.**

The Associate Medical Staff shall consist of Medical Staff Members who are:

- (a) new to the Medical Staff and being considered for advancement to the Active Medical Staff;
- (b) located closely enough to the Medical Staff Member's Primary Site to provide continuous care to their patients; and
- (c) assume all the functions and responsibilities of appointment to the Associate Medical Staff.

Associate Medical Staff Members may be advanced to the Active Medical Staff after one (1) year, or may serve an additional period(s) on the Associate Medical Staff upon recommendation of the Clinical Chairperson of the applicable Department. Associate Medical Staff Members shall be observed by the appropriate Clinical Chairperson or designee to assess clinical and professional performance and eligibility for advancement to another Medical Staff category.

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<sup>79</sup> Wis. Admin. Code DHS § 124.12(5)(b)11. (2011).

### 3.3.2 Rights and Obligations.

- (a) Associate Medical Staff Members shall be:
- i. eligible to apply for Clinical Privileges (including the privilege to admit, perform procedures, and/or write orders<sup>80</sup>);
  - ii. eligible to attend Medical Staff meetings in a non-voting capacity (an Associate Medical Staff Member who serves as a Clinical Chairperson may vote at Medical Staff meetings.);
  - iii. required to attend Medical Staff meetings in a non-voting capacity, if his/her presence is requested by the Chief of Staff;
  - iv. encouraged to attend Medical Staff and Department meetings in a non-voting capacity;
  - v. eligible to serve on one or more Medical Staff committees in a voting or non-voting capacity;
  - vi. eligible to serve as a Medical Staff committee chairperson, if the Medical Executive Committee determines that such Staff Member has expertise that is not otherwise available;
  - vii. eligible to serve as a Clinical Chairperson, if the Medical Executive Committee determines that such Staff Member has expertise that is not otherwise available; and
  - viii. eligible to hold Medical Staff office, if the Medical Executive Committee determines that such Staff Member has expertise that is not otherwise available.
- (b) As may be required by the Medical Executive Committee or the Governing Body, Associate Medical Staff Members 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) Associate Medical Staff Members must participate in emergency department back-up call as required by Section 2.10.20.

## 3.4 COURTESY MEDICAL STAFF

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### 3.4.1 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

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

staff privileges at another medical center, the Medical Executive Committee may waive this requirement if additional quality assurance measures are established;

- (b) are located closely enough to the Medical Staff Member’s Primary Site 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 one or more Sites. A Medical Staff Member occasionally treats patients if he/she has no more than forty (40) Patient Encounters at a Site during the most recent two (2) year reappointment period. In the event a Courtesy Medical Staff Member has more than forty (40) Patient Encounters in the most recent two (2) year reappointment period, the applicable Site 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.

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

- (a) Courtesy Medical Staff Members shall be eligible to:
  - i. apply for Clinical Privileges (including the privilege to admit, perform procedures, and/or write orders)<sup>81</sup>;
  - ii. attend Medical Staff and Department 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 Medical Staff Member has expertise that is not otherwise available.
- (b) Courtesy Medical Staff Members shall **not** be eligible to:
  - i. serve as a Clinical Chairperson; or
  - ii. hold Medical Staff office.
- (c) At the request of the Site Leadership Council at the Staff Member’s Primary Site, Courtesy Medical Staff Members may be required to participate in emergency department back-up call as provided in Section 2.10.20.

## **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 one or more Sites;

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<sup>81</sup> Wis. Admin. Code DHS § 124.12(5)(b)11. (2011).

- (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 Members 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 Staff Member has expertise that is not otherwise available.
- (b) Telemedicine Medical Staff Members shall **not** be eligible to:
  - i. serve as a Clinical Chairperson; or
  - ii. hold Medical Staff office.

**3.6 CONSULTING MEDICAL STAFF**

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**3.6.1 Composition.**

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

- (a) have been granted consulting privileges as their only Clinical Privileges at one or more Sites and shall not have admitting privileges; however, psychiatrists who admit patients for psychiatric triage services may have Clinical Privileges to admit and manage patients at any Site for a period of time not to exceed twenty-four (24) hours, after which the management of the inpatient shall be turned over to an appropriate attending physician at the Site where the patient is an inpatient;
- (b) come to one or more Sites 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.

**3.6.2 Rights and Obligations.**

- (a) Consulting Medical Staff Members shall be eligible for consulting Clinical Privileges only.
- (b) Consulting Medical Staff Members are eligible to attend Medical Staff, Department, or Medical Staff committee meetings in a non-voting capacity.
- (c) Consulting Medical Staff Members 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.

### **3.7 AFFILIATE STAFF**

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#### **3.7.1 Composition.**

The Affiliate Staff shall consist of Practitioners who devote their practice to the office environment and refer management of inpatients to other Staff Members. Affiliate Staff Members must complete the appropriate Application as requested by Medical Staff Services.

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

- (a) Affiliate Staff Members shall **not** be eligible for Clinical Privileges.
- (b) Affiliate Staff Members are not entitled to the procedures and rights set forth in Sections 4.1 and 4.2 or the hearing and appeal rights set forth in Article 5 of these Bylaws.
- (c) Affiliate Staff Members 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 Staff Member has expertise that is not otherwise available

### **3.8 EMERITUS STAFF**

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#### **3.8.1 Composition.**

The Emeritus Staff shall consist of Practitioners who (1) have retired from practice, or (2) are recognized for their reputations and their contributions to the health and medical sciences, as well as their contributions to the Medical Center(s). Emeritus Staff Members must complete the appropriate Application as requested by Medical Staff Services.

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

- (a) Emeritus Staff Members shall **not** be eligible for Clinical Privileges.
- (b) Emeritus Staff Members are not entitled to the procedures and rights set forth in Sections 4.1 and 4.2 or the hearing and appeal rights set forth in Article 5 of these Bylaws.
- (c) Emeritus Staff Members 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 Staff Member has expertise that is not otherwise available.

### **3.9 ADVANCED PRACTICE CLINICIAN STAFF**

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#### **3.9.1 Composition.**

The Advanced Practice Clinician Staff shall consist of Advanced Practice Clinicians who:

- (a) are located closely enough to the Staff Member's Primary Site to provide continuous care to their patients; and
- (b) assume all the functions and responsibilities of appointment to the Advanced Practice Clinician Staff.

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

- (a) Advanced Practice Clinician Staff Members shall be eligible to:
  - i. apply for Clinical Privileges;<sup>82</sup>
  - ii. attend when invited to Medical Staff, Department and Medical Staff committee 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 Staff Member has expertise that is not otherwise available.
- (b) Advanced Practice Clinician Staff Members 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 Clinician Members must actively participate in recognized functions of Advanced Practice Clinician 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.

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<sup>82</sup> Wis. Admin. Code DHS § 124.12(5)(b)11 (2011).

- (d) At the request of the Medical Executive Committee, Advanced Practice Clinician Staff Members shall participate in emergency department back-up call at the Staff Member's Primary Site under exigent circumstances including, but not limited to, gaps in coverage caused by the lack of a particular specialty on the Active Medical Staff.

### **3.10 CHANGE IN MEDICAL STAFF CATEGORY**

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Except for automatic reassignment processes specified in Sections 3.2.1(d) and 3.4.1(d), 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. REMEDIAL ACTIONS

### 4.1 PROCESS FOR REMEDIAL ACTION<sup>83</sup>

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#### 4.1.1 Request for and Notice of Investigation.

- (a) Request for Investigation. Site Administrators, the Site Leadership Council Presidents, the Chief of Staff, the Site Chief Medical Officers, and/or the Governing Body, may submit a written request for an investigation (“Request for Investigation”) to the applicable Site Leadership Council 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 Center, or applicable laws, regulations, or accreditation standards.<sup>84</sup>
- (b) Basis for Request. A Request for Investigation must be based on a reasonable belief that the action is in furtherance of quality health care<sup>85</sup> and supported by reference to the specific acts or omissions which constitute the grounds for the request.
- (c) Notice to Leadership. Within seven (7) days of the Site Leadership Council’s receipt of a Request for Investigation, the Site Leadership Council President (or his/her designee) shall send a copy of the Request for Investigation to: (1) the following individuals at each Site where the Medical Staff Member has active Clinical Privileges: the Site Administrator, the appropriate Clinical Chairperson, the Site Chief Medical Officer, and the Site Leadership Council President; and (2) any other Aurora Affiliate where the Medical Staff Member is on staff/has clinical privileges or is employed. The Site Leadership Council President (or his/her designee) shall continue to keep the applicable Site Administrator(s) and Aurora Affiliate(s) fully informed, as appropriate, of all action taken in connection therewith.

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<sup>83</sup> JCS MS.01.01.01, EPs 30 & 33 (October 2011).

<sup>84</sup> JCS MS.01.01.01, EP 30 (October 2011).

<sup>85</sup> 42 U.S.C. § 11112(a)(1).

- (d) Written Notice to Medical Staff Member. The Site Administrator (or his/her designee) shall provide the affected Medical Staff Member with Written Notice of the Request for Investigation. The Written Notice shall:
- i. Advise the Medical Staff Member of the Request for Investigation and the basis therefore; and
  - ii. Advise the Medical Staff Member that he/she may request a preliminary interview with the Site Leadership Council.

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

The Medical Staff Member may request a preliminary interview with the applicable Site Leadership Council prior to its taking action on a Request for Investigation. At such preliminary interview, the Medical Staff Member shall again be apprised of the general nature of the Request for 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 Site Leadership Council.

#### **4.1.3 Site Leadership Council Review and Action.**

The Site Leadership Council at the Medical Staff Member's Primary Site (or its designee) shall investigate the concerns described in the Request for 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>86</sup> Following such investigation, the Site Leadership Council may recommend one or more of the following actions to the Medical Executive Committee, which may include, but are not limited to:

- (a) Rejection or modification of the Request for 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;
- (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.

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<sup>86</sup> 42 U.S.C. § 11112(a)(2).

**4.1.4 Medical Executive Committee Review and Action.**

Following a Site Leadership Council’s investigation described in Section 4.1.3, the Medical Executive Committee shall meet to review and evaluate the Site Leadership Council’s recommendation. The Medical Executive Committee may request additional information related to the investigation and/or an additional interview with the Medical Staff Member. Following its review, the Medical Executive Committee may accept, reject, or modify the Site Leadership Council’s recommendation. In the event the Medical Executive Committee’s recommended action is deemed to be an Adverse Action, the Medical Executive Committee shall follow the process in Section 4.1.7.

**4.1.5 Actions Taken Without a Request for Investigation.**

Notwithstanding any other provision in these Bylaws, the Medical Executive Committee may, with or without the initiation of a Request for Investigation or recommendation from a Site Leadership Council, 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. Additionally, a Site Leadership Council may recommend to the Medical Executive Committee any of the actions set forth below with or without the initiation of a Request for Investigation. Such action shall take effect immediately when approved by the Medical Executive Committee, 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 4.1.5 shall be kept in the Medical Staff Member’s credentials file, together with any written response from the Medical Staff Member.

- (a) Remedial actions to be voluntarily undertaken;
- (b) Issuance of a warning;
- (c) Issuance of a letter of reprimand;
- (d) Probation;
- (e) A monitoring agreement;
- (f) Requirement to complete specific education;
- (g) Administrative suspension for a period no longer than fourteen (14) days;
- (h) Recommend to the Governing Body that a Medical Staff Member be granted Conditional Appointment; and/or
- (i) Any other action which may be appropriate under the circumstances and does not constitute an Adverse Action.

**4.1.6 Administrative Suspension.**

At any time during an investigation, the affected Medical Staff Member’s Clinical Privileges may be suspended by the applicable Site Leadership Council President, the Chief of Staff or the applicable Site 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 4.1.6, 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.

**4.1.7 Opportunity to Exercise Rights Prior to Adverse Action.**

Before any action of the Medical Executive Committee that may be deemed an Adverse Action is forwarded to the Governing Body, the Chief of Staff 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 Bylaws.

**4.1.8 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>87</sup> Medical Staff Services and the applicable Clinical Chairperson shall ensure that the necessary Medical Center personnel take appropriate actions to prevent a Staff Member from scheduling any cases or procedures while such Staff Member's Clinical Privileges are suspended.

**4.1.9 Enforcement and Alternative Coverage.**

The Chief of Staff shall enforce all remedial actions with the assistance of the Site Administrator, the Site Chief Medical Officer, 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 alternative Medical Staff Members to provide medical coverage for the suspended/terminated Medical Staff Member's patients who remain at 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.

**4.1.10 Notice to Aurora Affiliates.**

When a Medical Staff Member receives notice of a remedial 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/clinical privileges or employment of the same.

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<sup>87</sup> 42 C.F.R. § 482.22(a)(2) (Interpretive Guidelines, effective October 17, 2008).

## **4.2 SUMMARY SUSPENSION<sup>88</sup>**

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### **4.2.1 Authority and Indications.**

The Chief of Staff, the Site Leadership Council Presidents, Site Administrators, a majority of the Medical Executive Committee, a majority of a Site Leadership Council, 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>89</sup>

### **4.2.2 Written Notice of Summary Suspension.**

The applicable Site Leadership Council President (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 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.

### **4.2.3 Informal Interview.**

A Medical Staff Member whose Clinical Privileges have been summarily suspended shall be entitled to request (in writing and received by the Site Leadership Council President within ten (10) days of the Delivery Date of the Summary Suspension Notice) an informal interview with the Site Leadership Council within such reasonable time period thereafter as the Site Leadership Council President 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 Site Leadership Council President. During such interview, the Medical Staff Member shall be invited to discuss, explain or refute the allegations against the Medical Staff Member. The Site Leadership Council President 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 Site Leadership Council President.

### **4.2.4 Site Leadership Council Recommendation**

The Site Leadership Council may recommend modification, continuance or termination of the terms of the summary suspension to the Medical Executive Committee.

### **4.2.5 Medical Executive Committee Recommendation.**

The Medical Executive Committee may approve, modify, or reject the Site Leadership Council's recommendation regarding the summary suspension. If the recommendation would meet the definition of an Adverse Action, the Site Administrator shall notify the

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<sup>88</sup> JCS MS.01.01.01, EPs 29 & 32 (October 2011).

<sup>89</sup> 42 U.S.C. § 11112(c)(2).

affected Medical Staff Member of such 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 prior to the action being forwarded to the Governing Body. 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.

**4.2.6 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/clinical privileges or employment of the same.

**4.3 ADVANCED PRACTICE CLINICIANS**

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**4.3.1 Applicability.**

Advanced Practice Clinicians are not entitled to the procedures and rights set forth in Sections 4.1 and 4.2 of this Article 4 or the hearing and appeal rights set forth in Article 5 of these Medical Staff Bylaws.<sup>90</sup>

**4.3.2 Remedial or Other Action Against an Advanced Practice Clinician.**

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 Clinician Staff Membership and Clinical Privileges, against an Advanced Practice Clinician, with or without cause. Such actions taken do not entitle the Advanced Practice Clinician to any process, hearing or appeal rights other than the limited rights specified in Section 4.3.3 below.

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

In the event an action taken against an Advanced Practice Clinician would be deemed an Adverse Action giving rise to procedures and/or rights if taken against a Medical Staff Member, the Advanced Practice Clinician shall have the right to personally appear before the Site Leadership Council to discuss the matter and have the action reviewed by the Site Leadership Council. To exercise such right, the Advanced Practice Clinician must file a written request for review with the Site Leadership Council 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 Site Leadership Council and the decision of the Site Leadership Council in reviewing the action shall be final.

**4.3.4 Notice to Aurora Affiliates.**

When an Advanced Practice Clinician receives notice of a remedial action taken or recommended, the Chief of Staff (or his or her designee) shall notify, as appropriate, the other Aurora Affiliates where the Advanced Practice Clinician is on staff, employed, or

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<sup>90</sup> Wis. Admin. Code DHS § 124.12(4)(c)6. (2011).

applies for Advanced Practice Clinician Staff membership/clinical privileges or employment of the same.

#### **4.4 AUTOMATIC SUSPENSION AND VOLUNTARY RELINQUISHMENT<sup>91</sup>**

##### **4.4.1 Failure to Complete Medical Records.**

- (a) Delinquency Notice / Opportunity to Cure. Whenever a Staff Member fails to complete medical records within fourteen (14) days after a patient’s discharge or from the date a medical record deficiency was made available to the Staff Member in the Staff Member’s Chart Completion folder in Epic, the Health Information Manager (or his/her designee) shall send a written notice of delinquency (“Delinquency Notice”).
- (b) Automatic Suspension / Suspension Notice. If the Staff Member fails to correct the medical record deficiencies within twenty one (21) days after a patient’s discharge (or after the date the deficiency was made available to the Staff Member in Epic, whichever is later), the Staff Member shall be automatically be suspended and the Health Information Manager shall notify the applicable Site Administrator (or his/her designee) and send a Written Notice of suspension (“Suspension Notice”) to the Staff Member. **NOTE:** An automatic suspension of a Medical Staff Member that lasts fifteen (15) days or more is considered an Adverse Action under Section 5.2.1(g) and the Medical Staff Member shall be afforded the hearing and appeal rights contained in Article 5. The Suspension Notice shall inform the Staff Member that:
- i. The Staff Member’s Clinical Privileges have been automatically **suspended** and remain suspended until the medical record is complete;
  - ii. If the Staff Member fails to correct the medical record deficiencies within twenty one (21) days after the date of the automatic suspension, the Staff Member’s appointment to the Medical Staff and Clinical Privileges (in their entirety) shall be deemed to be **voluntarily relinquished**;
  - iii. If during the twenty one (21) day suspension period, the suspended Staff Member appears before the Medical Executive Committee and provides a justifiable reason (at the discretion of the Medical Executive Committee) for his/her inability to complete the deficient records during the suspension period, the Medical Executive Committee may extend the suspension period up to forty-five (45) days (after which the Staff Member’s appointment and Clinical Privileges shall be deemed to be voluntarily relinquished); and
  - iv. If the Staff Member has three (3) automatic suspensions within a twelve (12) month period, the Staff Member’s appointment and Clinical Privileges shall be deemed to be **voluntarily relinquished**.

<sup>91</sup> JCS MS.01.01.01, EPs 28 & 31 (October 2011).

- (c) Voluntary Relinquishment. If the Staff Member fails to correct the deficiencies in the medical record(s) within twenty one (21) days of delivery of the Suspension Notice (or within such time period otherwise specified by the Medical Executive Committee), or has three (3) automatic suspensions within a twelve (12) month period, then the Staff Member shall be deemed to have voluntarily relinquished his or her Staff Membership and Clinical Privileges.
- (d) Completion of Medical Records. If the Staff Member corrects the medical record deficiencies at issue 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. The Medical Records Manager (or his/her designee) shall notify the applicable Site Administrator when all medical records which had previously been reported as delinquent have been completed.

#### 4.4.2 Adverse Change in Licensure or Certification.

- (a) Revocation. A revocation 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 becomes effective.
- (b) Suspension. A suspension of a Staff Member's license, certification or other credential authorizing practice in this State of thirty (30) days or more shall be deemed to be a voluntary relinquishment of such Staff Member's Staff Membership and Clinical Privileges as of the date such suspension becomes effective. If a Staff Member's license, certification or other credential authorizing practice in this State is suspended for a term of less than thirty (30) days, all of the Staff Member's Clinical Privileges shall be automatically suspended by the Medical Center for the same term of suspension as of the date such suspension becomes effective and throughout its term. **NOTE:** An automatic suspension of a Medical Staff Member that lasts fifteen (15) days or more is considered an Adverse Action under Section 5.2.1(g) and the Medical Staff Member shall be afforded the hearing and appeal rights contained in Article 5.
- (c) 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 limited, restricted or conditioned by the Medical Center in the same manner, as of the date such state action becomes effective and throughout its term.
- (d) 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 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 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 Site Administrator when the license, certification or other credential is received.

**4.4.3 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.

**4.4.4 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 remedial action as may be appropriate under the circumstances.

**4.4.5 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. **NOTE:** An automatic suspension of a Medical Staff Member that lasts fifteen (15) days or more is considered an Adverse Action under Section 5.2.1(g) and the Medical Staff Member shall be afforded the hearing and appeal rights contained in Article 5.
- (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 Site Administrator when the Certificate of Insurance has been received.

**4.4.6 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. **NOTE:** An automatic suspension of a Medical Staff Member that lasts fifteen (15) days or more is considered an Adverse Action under Section 5.2.1(g) and the Medical Staff Member shall be afforded the hearing and appeal rights contained in Article 5. A failure to pay such dues within ninety (90) 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.

**4.4.7 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.

**4.4.8 Failure to Maintain Collaborative or Supervisory Relationship.**

If an Advanced Practice Clinician: (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 Clinician's sole supervising physician's Medical Staff membership is terminated, or the sole supervision physician terminates the supervisory relationship with the Advanced Practice Clinician); or (ii) fails to comply with the terms of his/her collaborative or supervisory agreement, the Advanced Practice Clinician's Clinical Privileges shall be automatically suspended and shall remain so suspended until the Advanced Practice Clinician provides Medical Staff Services with adequate evidence that an appropriate collaborative or supervisory relationship and agreement exists and that the Advanced Practice Clinician 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 Clinician 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 Clinician's Staff Membership and Clinical Privileges.

**4.4.9 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 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.

**4.4.10 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.

**4.4.11 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.

**4.4.12 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.

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

If a Staff Member fails to satisfy an appearance required under Section 2.10.3, 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.

**4.4.14 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.

**4.4.15 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 2.10.8 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.

**4.4.16 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 2.11.2 of these Medical Staff Bylaws.

**4.4.17 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 applicable Site Administrator(s), the applicable Site Leadership Council President(s), the applicable Site Chief Medical Officer(s), 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) a Medical Staff Member who is subject to an Adverse Action has a fair opportunity to appeal such action.<sup>92</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 Clinician Staff Members or Emeritus/Affiliate Staff Members.<sup>93</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 Substantial Compliance.

Technical or insignificant deviations from the procedures set forth in this Article 5 shall not be grounds for invalidating action taken.

### 5.1.5 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.

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<sup>92</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>93</sup> Wis. Admin. Code DHS § 124.12(4)(c)6 (2011)

## 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 Medical Staff Membership;
- (d) Refusal to reinstate a Medical Staff Member following an approved leave of absence and receipt of a written request for reinstatement from the Medical Staff Member in accordance with Section 2.11 of these Bylaws;
- (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 4.2 of these Bylaws for a period of fourteen (14) days or less.<sup>94</sup>
- (b) Any automatic suspension or voluntary relinquishment in accordance with Section 4.4 of these Bylaws.

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<sup>94</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).

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- (c) The revocation of Medical Staff Membership and/or Clinical Privileges in accordance with Section 2.13 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.
- (h) The imposition of monitoring, supervision, proctoring, review or consultation requirements if the Medical Staff Member may exercise his or her restricted Clinical Privileges without the prior approval of the monitor/supervisor/proctor/reviewer/consultant and without the monitor/supervisor/proctor/reviewer/consultant being present and watching 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 Emeritus/Affiliate 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 Medical 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.

- (r) The refusal to reinstate a Medical Staff Member after a Leave of Absence when the Medical Staff Member fails to request reinstatement in accordance with Section 2.11 of these Bylaws.
- (s) Denial of a Medical Staff Members request for a waiver of the twelve (12) month waiting period for reactivation of Clinical Privileges at a Site under Section 2.8.4.
- (t) Denial of a Medical Staff Members request for a waiver of the nine (9) month waiting period to reapply for Medical Staff Membership following a voluntary resignation pursuant to Section 2.11.2.

### **5.3 PRE-HEARING PROCESS<sup>95</sup>**

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#### **5.3.1 Written Notice of Adverse Action.<sup>96</sup>**

The Chief of Staff 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 Chief of Staff via personal/hand delivery or certified mail, return receipt requested within thirty (30) days following the Delivery Date of the Adverse Action Notice;
- (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

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<sup>95</sup> JCS MS.01.01.01, EP 34 (October 2011).

<sup>96</sup> 42 U.S.C. § 11112(b)(1)(A)–(B).



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 Chief of Staff via personal/hand delivery or by certified mail, return receipt requested.<sup>97</sup> The Medical Staff Member's failure to 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>98</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 applicable Site Administrator(s), shall provide the affected Medical Staff Member with a list of seven (7) Active Medical Staff 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>99</sup> The Medical Staff Member shall then 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>100</sup> The Governing Body shall designate one of the Hearing Committee members to serve as the Hearing Committee Chairperson.

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<sup>97</sup> 42 U.S.C. § 11112(b)(1)(B)(i)–(ii).

<sup>98</sup> JCS MS.01.01.01, EP 35 (October 2011); JCS MS.10.01.01, EP 4 (October 2011).

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

<sup>100</sup> 42 U.S.C. § 11112(b)(3)(A)(iii).

**5.3.4 Scheduling of Hearing; Postponement<sup>101</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 Chief of Staff’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>102</sup>**

The Hearing Committee Chairperson (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
  - 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 Member, 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

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<sup>101</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>102</sup> 42 U.S.C. § 11112(b)(2)(A)–(B).

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>103</sup>**

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### **5.4.1 Presiding Officer.**

The Hearing Committee Chairperson (or his/her 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 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>104</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 Hearing Committee Chairperson by personal/hand delivery or by certified mail, return receipt requested, or brought to the hearing.

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<sup>103</sup> JCS MS.01.01.01, EP 34 (October 2011); JCS MS.10.01.01, EP 3 (October 2011).

<sup>104</sup> 42 U.S.C.S § 11112(b)(3)(B).

**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.

**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 Hearing Committee Chairperson 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 Hearing Committee Chairperson (or his/her designee) 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 Hearing Committee Chairperson (or his/her designee) 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>105</sup>

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### 5.6.1 Written Notice of Adverse Action.<sup>106</sup>

The Hearing Committee Chairperson (or his/her designee) 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 Hearing Committee Chairperson 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;
- (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

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<sup>105</sup> JCS MS.10.01.01, EP 5 (October 2011).

<sup>106</sup> 42 U.S.C. § 11112(b)(1)(A)–(B).

- (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 Hearing Committee Chairperson 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>107</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 (or his/her designee) shall 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;
- (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;

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<sup>107</sup> JCS MS.01.01.01, EP 34 (October 2011).

- (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 Appellate Review Committee Chairperson 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 Member, 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>108</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 Appellate Review Committee Chairperson 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>108</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 Appellate Review Committee Chairperson 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 applicable Site Administrator(s). The Appellate Review Committee Chairperson (or his/her designee) 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 Chief of Staff 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>109</sup>

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<sup>109</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 fourteen (14) voting members chosen as provided below.<sup>110</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>111</sup>

- (a) Voting Members. The fourteen (14) voting members of the Medical Executive Committee shall consist of one (1) Site Representative from each Site.
- (b) Election of Voting Members. Each Site may determine in its Site Operating Protocols how to elect its Site Representative (one Site Representative from each Site). Sites may choose to have the Site Leadership Council President serve ex officio as the Site's Site Representative or may choose to elect the Site Representative from among the Medical Staff Members who have designated such Site as his/her Primary Site.

#### 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) The Site Administrators at each Site
- (b) Each Site Chief Medical Officer
- (c) The Aurora Patient Service Market Chief Medical Officers
- (d) Vice President of Medical Staff Services

#### 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.

### 6.2 DUTIES AND RESPONSIBILITIES

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<sup>110</sup> JCS MS.01.01.01, EPs 20 & 22 (October 2011).

<sup>111</sup> JCS MS.01.01.01, EPs 20 & 21 (October 2011).

## ARTICLE 6– MEDICAL EXECUTIVE COMMITTEE

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>112</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>113</sup> The duties and responsibilities of the Medical Executive Committee shall be to:<sup>114</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 among the Medical Staff, the Site Administrators and the Governing Body;
- (e) Action on reports and recommendations received from the Site Leadership Councils, the Aurora Bylaws Committee, the Aurora Credentials Committee, and the Aurora Practice Evaluation Committee, including, but not limited to, recommendations that require approval by the Governing Body
- (f) Make recommendations to the Site Administrators on matters of a medico-administrative nature;
- (g) Make recommendations to the Governing Body or the Site Administrators on matters concerning the management of the Medical Centers;
- (h) 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;
- (i) Ensure that the Medical Staff actively participates in Medical Centers accreditation programs and assists the Medical Centers in maintaining their accreditation status;
- (j) 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;
- (k) 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;
- (l) Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all Staff Members, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;

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<sup>112</sup> JCS MS.01.01.01, EP 23 (October 2011).

<sup>113</sup> JCS MS.01.01.01, EP 20 (October 2011).

<sup>114</sup> JCS MS.01.01.01, EP 20 (October 2011).

- (m) Report at each general Medical Staff meeting;
- (n) Supervise and make recommendations regarding infection control practices in all phases of Medical Center activities;
- (o) 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
- (p) 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 monthly, 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 Medical Staff Bylaws or any law, ordinance, or governmental rule or regulation requires a greater number of affirmative votes.

#### **6.3.3 Voting on Matters that Only Affect a Specific Site.**

- (a) The Medical Executive Committee may not take action on a matter that relates to or impacts only a single Site unless: (i) the matter is contained in the agenda provided pursuant to Section 6.3.5 below and (ii) the Site Representative from the affected Site is present at the meeting and votes in favor of the matter.
- (b) This Section 6.3.3 of these Bylaws shall not apply to decisions related to Medical Staff appointment or reappointment, granting of Clinical Privileges, or disciplinary

matters, including revocation and termination of Medical Staff membership or Clinical Privileges.

**6.3.4 Attendance Requirements.**

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

**6.3.5 Agenda.**

All Medical Executive Committee meetings will be preceded by a written or electronic notice to all Medical Executive Committee members, transmitted at least seventy-two (72) hours prior to the meeting, containing a meeting agenda of all matters for consideration by the Medical Executive Committee at the meeting. The Chief of Staff shall be responsible for establishing the agenda for the meeting and disseminating the notice of the meeting in accordance with this Section.

**6.3.6 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.

**6.3.7 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 Center has a single, self-governing organized Medical Staff, composed of current Medical Staff Members.<sup>115</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.<sup>116</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 Medical Center's patients,<sup>117</sup> assists the Governing Body by serving as a professional review body,<sup>118</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>115</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>116</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>117</sup> 42 C.F.R. § 482.22(b) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.12(2)(a) (2011).

<sup>118</sup> 42 C.F.R. § 482.12(a)(5).



**7.2.3 Recommendations for Staff Membership and Clinical Privileges.<sup>119</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>120</sup> (ii) utilizes the criteria to evaluate and recommend individuals for Staff Membership and Clinical Privileges;<sup>121</sup> and monitors and evaluates the ethical and professional practice of individuals with Clinical Privileges<sup>122</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>123</sup>

- (a) Establishes and maintains patient care standards and ensures that all Medical Center 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>124</sup>
- (c) Measures, assesses, and improves processes that primarily depend on the activities of individuals credentialed and privileged through the Medical Staff process;<sup>125</sup>
- (d) Pursues remedial 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 the 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 Medical Center nursing, technical, and administrative staff.

**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,

<sup>119</sup> Wis. Admin. Code DHS § 124.12(5)(b)3. (2011); JCS MS.07.01.01 (October 2011).

<sup>120</sup> JCS LD.01.05.01, EP 5 (October 2011); JCS MS.03.01.01 (October 2011).

<sup>121</sup> JCS MS.03.01.01 (October 2011); JCS MS.06.01.05 (October 2011).

<sup>122</sup> Wis. Admin. Code DHS § 124.12(2)(a) (2011).

<sup>123</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.05.01.01 (October 2011).

<sup>124</sup> JCS MS.03.01.01, Rationale (October 2011); JCS MS.05.01.01 (October 2011).

<sup>125</sup> JCS MS.05.01.01, EP 1 (October 2011); see also PI.03.01.01, EPs 1-4 (October 2011).

and complement quality assessment/improvement activities; and (b) supervises the Medical Center’s professional library services if present on site.

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

The organized Medical Staff assists the 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>126</sup>

**7.2.7 Other.**

The organized Medical Staff:

- (a) Monitors Medical Center infection control programs and investigates and controls nosocomial infections;
- (b) Participates in the development of response plans for fire and other disasters;<sup>127</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>128</sup>

**7.3 MEDICAL STAFF OFFICERS**

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**7.3.1 Medical Staff Officers.**<sup>129</sup>

The officers of the Medical Staff shall be:

- Chief of Staff
- Chief of Staff Elect
- Secretary-Treasurer

**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 Site Administrators 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;
  - 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;

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<sup>126</sup> 42 C.F.R. § 482.11(a).

<sup>127</sup> JCS EM.02.01.01, EP 1 (October 2011).

<sup>128</sup> JCS MS.01.01.01, EP 10 (October 2011).

<sup>129</sup> Wis. Admin. Code DHS § 124.12(6)(a) (2011); JCS MS.01.01.01, EP 19 (October 2011).

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- 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 remedial action has been requested against a Staff Member;
  - vi. present the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the Site Administrators;
  - vii. 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;
  - viii. be responsible for the educational activities of the Medical Staff;
  - ix. be the spokesperson for the Medical Staff in its external professional and public relations;
  - x. ensure that attendance is taken at and accurate and complete minutes are kept of all Medical Executive Committee meetings; and
  - xi. 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.
- (c) Secretary/Treasurer. The Secretary/Treasurer shall:
- i. be a voting member of the Medical Executive Committee;
  - ii. ensure that attendance is taken and accurate and complete minutes of all Medical Executive Committee meetings are kept;
  - iii. be responsible for all fiscal affairs of the Medical Staff; and
  - iv. attend to all correspondence 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 in Good Standing,<sup>130</sup> or, if the Medical Executive Committee determines that such Medical Staff Member has expertise that is not otherwise available, an Associate Medical Staff Member in Good Standing;
  - 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 a Medical Center; and/or
  - Have an ownership interest in any non-Aurora hospital or ambulatory surgery center that provides health care services in competition with a Medical Center.

(b) Nomination and Election. The Medical Executive Committee shall vote for Medical Staff Officers nominated from among the current Medical Executive Committee members. Medical Staff Officers shall be elected every other year at the February meeting of the Medical Executive Committee (or via electronic voting if applicable) and shall be confirmed by the Governing Body. 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 candidate.<sup>131</sup>

(c) Term. All Medical Staff Officers shall serve for a two (2) year term unless removed from office or a successor is elected.

**7.3.4 Vacancies in Office.**

Vacancies in office during a Medical Staff Officer's two (2) year term shall be filled by the Medical Executive Committee pursuant to the nomination and voting procedures in Section 7.3.3(b) above. The individual filling the vacancy shall serve out the remaining term.

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<sup>130</sup> Wis. Admin. Code DHS § 124.12(6)(b) (2011).

<sup>131</sup> JCS MS.01.01.01, EP 18 (October 2011).

**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>132</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 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 Staff (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.

i. *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.

ii. *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.

<sup>132</sup> JCS MS.01.01.01, EP 18 (October 2011).

- iii. *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.
- iv. *Notification.* The Chief of Staff (or Chief of Staff Elect if the Chief of Staff is the subject of the vote) shall provide the Medical Staff Officer with written notification of the Medical Executive Committee’s final decision.
- v. *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 SITE MEDICAL STAFF OFFICERS**

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### **7.4.1 Site Medical Staff Officers.**

The Site Operating Protocols of each Site shall provide, at a minimum, for the following Site Medical Staff Officers:

Site Leadership Council President  
Site Leadership Council President-Elect

### **7.4.2 Site Leadership Council Presidents.**

- (a) Qualifications of the Site Leadership Council Presidents. At a minimum, the Site Operating Protocols shall provide that the Site Leadership Council President must possess at least the qualifications set forth below and must maintain such qualifications during his or her term of office. Failure to do so shall automatically create a vacancy in the office of the Site Leadership Council President. A Medical Staff Member must satisfy the following criteria to be eligible to serve as Site Leadership Council President:
  - i. Be a Medical Staff Member in Good Standing of the Active Staff at all times during his or her term of office or, if approved by the Governing Body upon the recommendation of the Medical Executive Committee, be a Medical Staff Member in Good Standing of the Associate Staff at all times during the term of office;
  - ii. Have no pending adverse recommendations concerning Staff Membership or Clinical Privileges;
  - iii. Have demonstrated interest in maintaining quality medical care at the Site;
  - iv. Have constructively participated in Site Medical Staff affairs at the Site;
  - v. Be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected or appointed;

## ARTICLE 7 – ORGANIZED MEDICAL STAFF

- vi. Be knowledgeable concerning the duties of the office;
- vii. Possess written and oral communication skills;
- viii. Possess and have demonstrated an ability for harmonious interpersonal relationships;
- ix. Consistently adhere to the conflict of interest policies adopted by the Governing Body; and
- x. Have participated in or are willing to participate in Medical Staff leadership training and/or other Medical Staff leadership activities.

(b) Responsibilities of the Site Leadership Council Presidents. The Site Leadership Council Presidents shall:

- i. Preside at and be responsible for the agenda of all general meetings of the Site Leadership Council;
- ii. Be a member of the Site Leadership Council and serve as its chair, and be a member, without vote, of all other Site Medical Staff Committees;
- iii. Enforce these Bylaws, the Site Operating Policy and the Policies Governing Medical Practices;
- iv. Serve as a liaison between the Site Leadership Council and the Medical Executive Committee and any other appropriate individuals or organizations;
- v. Present a report at each meeting of the Medical Executive Committee with sufficient detail on the deliberations of the Site Leadership Council for the Medical Executive Committee to adequately understand the actions of the Site Leadership Council;
- vi. Keep the Medical Executive Committee informed with respect to the Site Leadership Council's responsibility to maintain and advance the quality of patient care; and
- vii. Perform other duties as may be required.

### **7.4.3 Site Leadership Council President-Elects.**

- (a) Qualifications of the Site Leadership Council President-Elects. The Site Leadership Council President-Elects must possess and maintain throughout their term in office all of the qualifications of the Site Leadership Council President listed in section 7.4.2(a) above. Failure to do so shall automatically create a vacancy in the office of the Site Leadership Council President-Elect.

- (b) Responsibilities of the Site Leadership Council President-Elects. The Site Leadership Council President-Elects shall:
- i. Serve as the Site Leadership Council President's deputy and carry out all reasonable duties assigned by the Site Medical Staff President to aid the Site Leadership Council President in performing his/her duties;
  - ii. Keep accurate records of the proceedings of all Site Leadership Council and meetings;
  - iii. Serve as acting Site Leadership Council President when the Site Leadership Council President is temporarily absent or is incapacitated and unable to serve; and
  - iv. Perform other duties as may be required.

## **7.5 MEDICAL STAFF MEETINGS**

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### **7.5.1 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>133</sup>

### **7.5.2 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>134</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 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.

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

<sup>134</sup> Wis. Admin. Code DHS §§ 124.12(5)(b)6. & 124.12(7)(a) (2011).



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

**7.5.3 Minutes.**

Written minutes of each Medical Staff meeting shall be prepared, recorded and maintained in a permanent file.<sup>135</sup> Copies thereof shall be submitted to the Medical Executive Committee.

**7.5.4 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>136</sup>

**7.5.5 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.

**7.5.6 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 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.

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<sup>135</sup> Wis. Admin. Code DHS § 124.12(7)(d) (2011).

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

## ARTICLE 8. CLINICAL DEPARTMENTS

### 8.1 ORGANIZATION OF DEPARTMENTS AND SECTIONS

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#### 8.1.1 Organization.

Each Site shall organize its Medical Staff Members into Departments as provided in each Site's Site Operating Protocols. The Site Operating Protocols shall provide that each Department 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 applicable Site Leadership Council.

### 8.2 ASSIGNMENT TO DEPARTMENTS

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#### 8.2.1 Assignment.

The Site Leadership Councils shall, 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>137</sup>

##### (a) Qualifications.

- i. At the time of nomination and election, and throughout his or her term of office, a Clinical Chairperson must:

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<sup>137</sup> JCS MS.01.01.01, EP 36 (October 2011).

ARTICLE 8 – CLINICAL DEPARTMENTS

- Be an Active Medical Staff Member in Good Standing, or, if the Medical Executive Committee determines that such Staff Member has expertise that is not otherwise available, an Associate Medical Staff Member in Good Standing;
- Be and remain Board Certified in his/her specialty;<sup>138</sup>
- Demonstrate an interest in maintaining quality patient care at the Site; 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 Aurora; and/or
- Have an ownership interest in any non-Aurora hospital or ambulatory surgery center that provides health care services in competition with Aurora.

(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 Site 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 Site Leadership Council a slate of nominees. The Site Leadership Council 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 Site Leadership Council, the Department shall submit a new slate of nominee(s) to the Site Leadership Council for approval, and such process shall be repeated until the Site Leadership Council has approved at least one candidate for Clinical Chairperson.

(c) Election. The Clinical Chairperson of each Department shall be elected by a majority vote of all Active Medical Staff Members of the respective Department in the election year for such Department's Clinical Chairperson from the slate of nominees approved by the Site Leadership Council. In the event no nominee 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

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<sup>138</sup> JCS MS.01.01.01, EP 36 (October 2011).

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>139</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 Site Leadership Council.
- (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 Site Leadership Council, the Medical Executive Committee, and the Governing Body.
- (e) Be responsible for the enforcement within the Department of Aurora policies, these Medical Staff Bylaws, the Policies Governing Medical Practices, and the Site Operating Protocols.
- (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 Site.
- (i) Maintain continuing surveillance of the professional performance of all individuals in the Department who have delineated Clinical Privileges, and report thereon to the Aurora Credentials Committee and/or Medical Executive Committee (as appropriate) as part of the reappointment process and at other such times as may be indicated.
- (j) Recommend to the Medical Executive Committee the criteria for Clinical Privileges that are relevant to the care provided by the Department.

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<sup>139</sup> Wis. Admin. Code DHS § 124.12(9)(b) (2011); JCS MS.01.01.01, EP 36 (October 2011).

ARTICLE 8 – CLINICAL DEPARTMENTS

- (k) Make recommendations to the Aurora Credentials Committee and 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.
- (m) Be responsible for the integration of the Department into the primary functions of the Medical Center 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 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 Center.
- (w) Monitor, on a continuing and concurrent basis, adherence to:
  - i. Medical Center, 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 Center; 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 Clinical Chairperson.**

Vacancies in a Clinical Chairperson position shall be filled by the Site Leadership Council, in consultation with the Site 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 Site Leadership Council.

**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 Site Leadership Council and approved by the Medical Executive Committee. 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.

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**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. Departmental meetings shall be held as often as deemed necessary or desirable. 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 Site Leadership Council President. 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 Site Administrator.**

The Site 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 Site Leadership Council. 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>140</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. Without limiting the foregoing, there shall be an Aurora Credentials Committee and an Aurora Practice Evaluation Committee. Each Site's Operating Policies shall set forth how the Site Representatives for the Aurora Credentials Committee and the Aurora Practice Evaluation Committee (one Site Representative for each Committee) are elected. The Chair and Vice Chair of the Aurora Credentials Committee and the Aurora Practice Evaluation Committee shall be elected by the members of each Committee.

### 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.
- (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 the regular schedule 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.

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<sup>140</sup> Wis. Admin. Code DHS § 124.12(8)(a) (2011).



**9.3.2 Participation by Site Administrator.**

The Site 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 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.

# 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>141</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>142</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>143</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>144</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>141</sup> JCS MS.01.01.01, EPs 1, 2, 3 & 24 (October 2011).

<sup>142</sup> JCS MS.01.01.01, EP 3 (October 2011).

<sup>143</sup> JCS MS.01.01.01, EP 3 (October 2011).

<sup>144</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>145</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>146</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>145</sup> JCS MS.01.01.03, EP 1 (October 2011); JCS MS.01.03.03, EP 1 (October 2011).

<sup>146</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 Center, subject to the approval of the Governing Body.<sup>147</sup> The Policies Governing Medical Practices must be consistent with these Medical Staff Bylaws, Medical Center policies, and applicable statutes and regulations.<sup>148</sup> The Medical Executive Committee will ensure that all approved Policies are communicated to the Medical Staff.<sup>149</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

<sup>147</sup> JCS LD.04.01.07, EP 1 (October 2011); JCS MS.01.01.01, EP 25 (October 2011).

<sup>148</sup> JCS MS.01.01.01, EP 4 (October 2011).

<sup>149</sup> JCS MS.01.01.01, EP 9 (October 2011).

to submit such proposed Policy directly to the Governing Body. Such a proposed Policy shall become effective if and when it is approved by the Governing Body.<sup>150</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>151</sup> Such a proposed amendment shall become effective if and when it is approved by the Governing Body.<sup>152</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.
- (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

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<sup>150</sup> JCS MS.01.01.01, EPs 7-9 (October 2011).

<sup>151</sup> JCS MS.01.01.01, EP 9 (October 2011).

<sup>152</sup> JCS MS.01.01.01, EP 8 (October 2011).

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, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives may perform a 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>153</sup> If the H&P is performed within thirty (30) days prior to the patient's admission or registration, a Physician, Oral Surgeon, Podiatrist, Nurse Practitioner, Physician Assistant, Certified Registered Nurse Anesthetists, or Certified

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<sup>153</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).

ARTICLE 10 – MEDICAL STAFF BYLAWS AND POLICIES

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>154</sup> Please refer to the Policies Governing Medical Practices for more information regarding H&P documentation requirements.

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<sup>154</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 UNIFICATION

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Each Medical Center's previously separate medical staff members have voted by majority, in accordance with the Medical Center's previous medical staff bylaws, to approve these Bylaws and accept the unified medical staff structure provided herein.<sup>155</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>156</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>157</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>158</sup>

#### 12.3.2 Limitation on Opt Out Votes.

- (a) Medical Centers may not hold opt out votes under Section 12.3.1 more than once every two (2) years.

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

<sup>156</sup> JCS MS.01.01.05, EP 2 (September 2014)

<sup>157</sup> JCS MS.01.01.05, EP 3 and 4 (September 2014)

<sup>158</sup> 42 C.F.R. § 482.22(b)(4)(ii).