

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS**

**CREDENTIALS POLICY
OF
HSHS ST. VINCENT HOSPITAL,
HSHS LIBERTAS
HSHS ST. MARY'S HOSPITAL
MEDICAL CENTER,
HSHS ST. NICHOLAS HOSPITAL, AND
HSHS ST. CLARE MEMORIAL
HOSPITAL**

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions apply to terms used in this Policy:

- (1) “ALLIED HEALTH PROFESSIONALS” (“AHPs”) means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services within the Hospital. All AHPs are described as Independent Practitioners, Advanced Practice Practitioners, or Dependent Practitioners in the Medical Staff Bylaws documents:
 - “ADVANCED PRACTICE PRACTITIONER” means a type of Allied Health Professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Practitioner pursuant to a written supervision or collaborative agreement. See Appendix B to the Policy on Allied Health Professionals.
 - “DEPENDENT PRACTITIONER” means a type of Allied Health Professional who is permitted by law or the Hospital to function only under the direction of, or in collaboration with, a Supervising Practitioner, pursuant to a written supervision or collaborative agreement and consistent with the scope of practice granted. See Appendix C to the Policy on Allied Health Professionals.
 - “INDEPENDENT PRACTITIONER” means a type of Allied Health Professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license or certification and consistent with the clinical privileges granted. See Appendix A to the Policy on Allied Health Professionals.
- (2) “BOARD” means the Board of Directors of St. Vincent Hospital, St. Mary’s Hospital Medical Center, St. Nicholas Hospital, or St. Clare Memorial Hospital, as applicable.
- (3) “CHIEF EXECUTIVE OFFICER/CHIEF OPERATING OFFICER” (“CEO/COO”) means the individual appointed by the Board to act on its behalf in the overall management of the respective Hospitals.
- (4) “CLINICAL PRIVILEGES” or “PRIVILEGES” means the authorization granted by the Board to render specific patient care services, for which the Medical Staff

Leaders and Board have developed eligibility and other credentialing criteria, as well as focused and ongoing professional practice evaluation standards.

- (5) “CORE PRIVILEGES” means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff Leaders and Board to require closely-related skills and experience.
- (6) “DAYS” means calendar days.
- (7) “DENTIST” means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).
- (8) “EXECUTIVE COMMITTEE” means the Executive Committee of the respective Medical Staffs.
- (9) “HOSPITAL” means HSHS St. Vincent Hospital, HSHS St. Mary’s Hospital Medical Center, HSHS St. Nicholas Hospital, or HSHS St. Clare Memorial Hospital, as applicable.
- (10) “MEDICAL STAFF” means all physicians, dentists, podiatrists, and psychologists who have been appointed to the respective Medical Staffs by the respective Boards.
Exclusion: “Libertas Medical Staff” only means all physicians and psychologists who have been appointed to the Libertas Medical Staff by the respective Board.
- (11) “MEDICAL STAFF LEADER” means any Medical Staff officer, department chairperson, and committee chairperson.
- (12) “MEMBER” means any physician, dentist, podiatrist, and psychologist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.
- (13) “NOTICE” means written communication by regular U.S. mail, e-mail, facsimile, hospital mail, hand delivery, or other electronic method.
- (14) “ORGANIZED HEALTH CARE ARRANGEMENT” means the term used by the HIPAA Privacy Rule which permits the Hospital and Medical Staff to use joint notice of privacy practices information when patients are admitted to the Hospital. Practically speaking, being part of an Organized Health Care Arrangement allows the members of the Medical Staff to rely upon the Hospital notice of privacy practices and therefore relieves Medical Staff members of their responsibility to provide a separate notice when members consult or otherwise treat Hospital inpatients.

- (15) "PATIENT CONTACT" includes any admission, outpatient surgery, and procedure (inpatient or outpatient) performed in the Hospital. It shall not include referrals for diagnostic tests or x-rays.
- (16) "PERMISSION TO PRACTICE" means the authorization granted to Allied Health Professionals by the Board to exercise a scope of practice or clinical privileges.
- (17) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
- (18) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").
- (19) "PSYCHOLOGIST" means an individual with a Ph.D. in clinical psychology.
- (20) "SCOPE OF PRACTICE" means the authorization granted to a Dependent Practitioner by the Board to perform certain clinical activities and functions under the supervision of, or in collaboration with, a Supervising Practitioner.
- (21) "SPECIAL PRIVILEGES" means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.
- (22) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (23) "SUPERVISING PRACTITIONER" means a member of the Medical Staff or a Licensed Independent Practitioner with clinical privileges, who has agreed in writing to supervise or collaborate with an Advanced Dependent or Dependent Practitioner and to accept full responsibility for the actions of the Advanced Dependent or Dependent Practitioner while he or she is practicing in the Hospital.
- (24) "SUPERVISION" means the supervision of (or collaboration with) an Advanced Dependent or Dependent Practitioner by a Supervising Practitioner, that may or may not require the actual presence of the Supervising Practitioner, but that does require, at a minimum, that the Supervising Practitioner be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each Advanced Dependent or Dependent Practitioner is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist. ("General" supervision means that the physician is immediately available by phone, "direct" supervision means that the physician is on the Hospital's campus, and "personal" supervision means that the physician is in the same room.)

- (25) “TELEMEDICINE” means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.

1.B. TIME LIMITS

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

1.C. DELEGATION OF FUNCTIONS

- (1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees.
- (2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, podiatrists, and psychologists must:

- (a) have a current, unrestricted license to practice in Wisconsin and have never had a license to practice revoked or suspended by any state licensing agency;
- (b) where applicable to their practice, have a current, unrestricted DEA registration;
- (c) be located (office and residence) close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital;
- (d) be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of inpatients and Emergency Department patients in a prompt, efficient, and conscientious manner consistent with Hospital and Medical Staff policies pertaining to response times;
- (e) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
- (f) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;
- (g) have never been, and are not currently, debarred, excluded, or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (h) have never had Medical Staff appointment or clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (i) have never resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;

- (j) have never been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to (i) controlled substances, (ii) illegal drugs, (iii) insurance or health care fraud or abuse, (iv) child abuse, (v) elder abuse, or (vi) violence;
- (k) have completed a Background Information Disclosure form (HFS64) as required by the State of Wisconsin as well as signed a disclosure and authorization to obtain criminal background reports;
- (l) agree to fulfill all responsibilities regarding emergency service call coverage for their specialty or obtain appropriate coverage by another member of the Medical Staff;
- (m) have or agree to make appropriate coverage arrangements (as determined by the Credentials Committee and/or the Executive Committee) with other members of the Medical Staff for those times when the individual will be unavailable;
- (n) demonstrate recent clinical activity in their primary area of practice/training during the last two years;
- (o) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought;
- (p) if applying for privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract;
- (q) document compliance with all applicable training and/or educational protocols that may be adopted by the Executive Committee, including, but not limited to, those involving electronic medical records, patient safety, and infection control;
- (r) have successfully completed:*
 - (1) a residency or fellowship training program approved by the Accreditation Council for Graduate Medical Education (“ACGME”) or the American Osteopathic Association (“AOA”) in the specialty in which the applicant seeks clinical privileges;
 - (2) a dental or oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association (“ADA”);
 - (3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

- (4) a Ph.D. program in psychology from a graduate program approved by the American Psychological Association;
- (s) be board certified in their primary area of practice at the Hospital by the appropriate specialty or subspecialty board of the American Board of Medical Specialties (“ABMS”), the AOA, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable. (General dentist and psychologist applicants are exempt from this requirement as there is no equivalent certification process. In addition, applicants possessing board certification from another country (e.g., Canada, Great Britain) will be evaluated by the Medical Staff leadership and Board on a case-by-case basis, in accordance with the waiver provisions in this Policy.) Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five (5) years from the date of completion of their residency or fellowship training;* and
- (t) maintain board certification in their primary area of practice on a continuous basis, and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so *

* These requirements shall be applicable only to those individuals who apply for initial staff appointment after January 19, 2011. Those Medical Staff members who were appointed prior to that date shall be grandfathered and shall be governed by the residency training and board certification requirements in effect at the time of their initial appointments.

2.A.2. Waiver of Eligibility Criteria:

- (a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) A request for a waiver will be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant department chairperson, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application and other information supplied by the applicant. The Credentials Committee’s recommendation will be forwarded to the Executive Committee. Any recommendation to grant a waiver must include the specific basis for the recommendation.

- (c) The Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (d) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a “denial” of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the State of Wisconsin or the National Practitioner Data Bank.
- (e) The granting of a waiver in a particular case is not intended to set a precedent for any other applicant or group of applicants.
- (f) An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

2.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the appointment and reappointment processes, as reflected in the following factors:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;
- (c) good reputation and character;
- (d) ability to safely and competently perform the clinical privileges requested;
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, the Hospital’s and Medical Staff’s commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

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

- (a) is employed by the Hospital or its subsidiaries or has a contract with the Hospital;
- (b) is or is not a member or employee of any particular physician group;
- (c) is licensed to practice a profession in this or any other state;
- (d) is a member of any particular professional organization;
- (e) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;
- (f) resides in the geographic service area of the Hospital; or
- (g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No individual shall be denied appointment on the basis of gender, race, creed, or national origin.

2.A.6. Ethical and Religious Directives:

All members shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Hospital. No activity prohibited by said directives shall be engaged in at the Hospital by any Member.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment or reappointment, and as a condition of ongoing membership, every member specifically agrees to the following:

- (a) to provide continuous and timely quality care to all patients for whom the individual has responsibility;
- (b) to abide by all Bylaws, policies/directives, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed as

evidenced by signature or acknowledgment statement with copies provided at time of appointment and reappointment;

- (c) to participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, and by performing such other reasonable duties and responsibilities as may be assigned;
- (d) within the scope of his or her privileges, to provide emergency service call coverage, consultations, and care for unassigned patients;
- (e) to comply with clinical practice protocols and evidence-based medicine guidelines pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff Leaders, or clearly document the clinical reasons for variance;
- (f) to comply with clinical practice protocols and evidence-based medicine guidelines that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or to clearly document the clinical reasons for variance;
- (g) to inform the President of the Medical Staff, in writing, of any change in the practitioner's status or any change in the information provided on the practitioner's application form. This information will be provided with or without request, at the time the change occurs, and will include, but not be limited to:
 - any and all complaints regarding, or changes in, licensure status or DEA controlled substance authorization;
 - changes in professional liability insurance coverage;
 - the filing of a professional liability lawsuit against the practitioner;
 - changes in the practitioner's Medical Staff status (appointment and/or privileges) at any other hospital or health care entity as a result of peer review activities;
 - arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;
 - exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;
 - any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to;

impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Policy on Physician Health); and

- any charge of, or arrest for, driving under the influence (“DUI”) (Any DUI incident will be reviewed by the President of the Medical Staff and the CEO/COO so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under the Policy on Physician Health or this Credentials Policy.);
- (h) to immediately submit to an appropriate evaluation which may include diagnostic testing (such as blood and/or urine test) or to a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Administrative team) are concerned with the individual’s ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations will be determined by the Medical Staff Leaders and the Medical Staff member must execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;
- (i) to comply with all applicable training and/or educational protocols that may be adopted by the Executive Committee, including, but not limited to, those involving electronic medical records, patient safety, and infection control;
- (j) to maintain a current e-mail address with the Medical Staff Office, which will be the primary mechanism used to communicate all Medical Staff information to the member;
- (k) to appear for personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;
- (l) to refrain from illegal fee splitting or other illegal inducements relating to patient referral as prohibited by the Wisconsin Medical Practice Act (Stat. §448.08);
- (m) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;
- (n) to refrain from deceiving patients as to the identity of any individual providing treatment or services;
- (o) to seek consultation whenever required or necessary;
- (p) to complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital;
- (q) to cooperate with all utilization oversight activities;

- (r) to perform all services and conduct himself/herself at all times in a cooperative and professional manner in accordance with the Code of Conduct Policy and Hospital Mission and Value Statement, and resolve in a timely fashion any validated complaints received from patients or staff;
- (s) to promptly pay any applicable dues, assessments, and/or fines;
- (t) to satisfy continuing medical education requirements necessary to maintain licensure in Wisconsin;
- (u) to participate in an Organized Health Care Arrangement with the Hospital and abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital;
- (v) to provide, on a timely basis, proof of compliance with health testing requirements established by policies/directives (e.g., TB tests) (Failure to do so shall result in the automatic relinquishment of clinical privileges as set forth in Section 6.E of this Policy.); and
- (w) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration. In the event that the Credentials Committee undergoes the administrative review process and determines that an application should not be processed due to the misstatement or omission, or that an individual already appointed should be subject to automatic relinquishment for the same, the individual may not reapply to the Medical Staff for a period of at least two years.

2.B.2. Burden of Providing Information:

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

- (b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.
- (c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

2.C. APPLICATION

2.C.1. Information:

- (a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.
- (b) In addition to other information, the applications shall seek the following:
 - (1) information as to whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged;
 - (2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;
 - (3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such

proceedings or actions as the Credentials Committee, the Executive Committee, or the Board may request;

- (4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and
 - (5) a copy of a government-issued photo identification.
- (c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

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

(a) Immunity:

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

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Authorization to Share Information Between Hospitals:

The individual specifically authorizes affiliated hospitals (St. Vincent Hospital, St. Mary's Hospital Medical Center, St. Nicholas Hospital, and St. Clare Memorial Hospital) to share credentialing and peer review information pertaining to the individual's clinical competence and/or professional conduct. This information may be shared at initial appointment or reappointment and at any other time during the individual's appointment.

(e) Hearing and Appeal Procedures:

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

(f) Legal Actions:

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

(g) Scope of Section:

All of the provisions in this Section 2.C.2 are applicable in the following situations:

- (1) whether or not appointment or clinical privileges are granted;
- (2) throughout the term of any appointment or reappointment period and thereafter;
- (3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

- (4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his or her tenure as a member of the Medical Staff.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

- (a) Applications for appointment shall be in writing and shall be on forms approved by the Hospital Sisters Health System.
- (b) An individual seeking initial appointment shall be sent a letter that outlines the eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form. At the time the individual obtains the application form, he or she shall also obtain a Background Information Disclosure form (HFS64) as required by the state of Wisconsin.
- (c) Applications may be provided to residents or fellows who are in the final six months of their training. Such applications may be processed, but final action will not be taken until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

- (a) A completed application form with copies of all required documents must be returned to the Medical Staff Office or designated Credentials Verification Office (“CVO”) within 90 days. The application must be accompanied by the application fee.
- (b) As a preliminary step, the application shall be reviewed by the Medical Staff Office or CVO to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in this Policy.
- (c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.
- (d) The names of applicants shall be posted so that members of the Medical Staff may submit, in writing, information bearing on the applicant’s qualifications for appointment or clinical privileges.

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

- (a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from peer references from the same discipline where practicable and from other available sources, including the applicant's past or current department chairpersons at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.
- (b) An interview with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the department chairperson, the Credentials Committee, a Credentials Committee representative, the Executive Committee, the President of the Medical Staff, and/or the CEO/COO.

3.A.4. Department Chairperson Procedure:

- (a) The Medical Staff Office shall transmit the complete application and all supporting materials to the chairperson of each department in which the applicant seeks clinical privileges. Each chairperson shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested on a form provided by the Medical Staff Office.
- (b) The department chairperson shall be available to the Credentials Committee, Executive Committee, and the Board to answer any questions that may be raised with respect to that chairperson's report and findings.

3.A.5. Credentials Committee Procedure:

- (a) The Credentials Committee shall review and consider the report prepared by the relevant department chairperson and shall make a recommendation.
- (b) The Credentials Committee may use the expertise of the department chairperson, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee shall review the applicant's "Ability to Perform Privileges Requested" form to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available

to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

- (d) Applicants over the age of 65 must obtain appropriate health assessments as part of the appointment process which includes a physical and mental health assessment performed by a physician, APRN or PA-C who is acceptable to the Credentials Committee. The examining provider shall provide a written report, addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff membership, or work cooperatively in a hospital setting. The examining provider shall provide this report directly to the Chairperson of the Credentials Committee and shall be available to discuss any questions or concerns that the Committee may have.
- (e) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

3.A.6. Executive Committee Recommendation:

- (a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Executive Committee shall:
 - (1) adopt the findings and recommendation of the Credentials Committee as its own; or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Executive Committee prior to its final recommendation; or
 - (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.
- (b) If the recommendation of the Executive Committee is to appoint, the recommendation shall be forwarded to the Board through the CEO/COO.

- (c) If the recommendation of the Executive Committee is unfavorable and would entitle the applicant to request a hearing, the Executive Committee shall forward its recommendation to the CEO/COO, who shall promptly send special notice to the applicant. The CEO/COO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:

- (a) Expedited Review: The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee or designee and the Executive Committee or designee and there is no evidence of any of the following:
 - (1) a current or previously successful challenge to any license or registration;
 - (2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or
 - (3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

- (b) Full Board Review: When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:
 - (1) appoint the applicant and grant clinical privileges as recommended;
 - (2) refer the matter back to the Credentials Committee or Executive Committee or to another source inside or outside the Hospital for additional research or information; or
 - (3) reject or modify the recommendation.
- (c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chairperson of the Credentials Committee and the Chairperson of the Executive Committee. If the Board's determination remains unfavorable to the applicant, the CEO/COO shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

- (d) Any final decision by the Board to grant, deny, revise, or revoke appointment and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.8. Time Periods for Processing:

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

3.B. FPPE TO CONFIRM COMPETENCE

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

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

- (a) Appointment or reappointment will not confer any clinical privileges or right to admit or treat patients at the Hospital. Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.
- (b) In order for a request for privileges to be processed, the applicant must satisfy any applicable threshold eligibility criteria.
- (c) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with the contract.
- (d) Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria (or has been granted a waiver in accordance with Section 4.A.2).
- (e) The clinical privileges recommended to the Board will be based upon consideration of the following factors, when available:
 - (1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;
 - (2) appropriateness of utilization patterns;
 - (3) ability to perform the privileges requested competently and safely;
 - (4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;
 - (5) availability of qualified staff members with appropriate privileges (as determined by the Credentials Committee) to provide coverage in case of the applicant's illness or unavailability;

- (6) adequate professional liability insurance coverage for the clinical privileges requested;
 - (7) the Hospital's available resources and personnel;
 - (8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - (9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another Hospital;
 - (10) practitioner-specific data as compared to aggregate data, when available;
 - (11) morbidity and mortality data related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and
 - (12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.
- (f) The applicant has the burden of establishing his or her qualifications and current competence for all clinical privileges requested.
- (g) The report of the chairperson of the clinical department in which privileges are sought will be forwarded to the Chairperson of the Credentials Committee and processed as a part of the initial application for staff appointment.

4.A.2. Privilege Modifications and Waivers:

- (a) Scope. This Section applies to all requests for modification of clinical privileges (increases and relinquishments) during the term of appointment, resignation from the Medical Staff, and waivers of eligibility criteria for privileges.
- (b) Submitting a Request. Requests for privilege modifications and waivers must be submitted in writing to the Medical Staff Office.
- (c) Increased Privileges.
 - (1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.

- (2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.

(d) Waivers.

- (1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (2) If the individual is requesting a waiver of the requirement that each member apply for the full core of privileges in his or her specialty, the request must indicate the specific patient care services within the core that the member does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.
- (3) By applying for a waiver related to limiting the scope of core privileges, the individual nevertheless agrees to participate in the general on-call schedule for the relevant specialty and to maintain sufficient competency to assist other physicians on the Medical Staff in assessing and stabilizing patients who require services within that specialty. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual will work cooperatively with the other physicians in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.
- (4) Requests for waivers in this Section will be processed in the same manner as requests for waivers of appointment criteria, as described in Section 2.A.2 of this Policy, and will consider the factors outlined in Paragraph (f) below.

(e) Relinquishment and Resignation of Privileges.

- (1) Relinquishment of Individual Privileges. A request to relinquish any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of privileges. All such requests will be processed in the same manner as a request for waiver, as described above.
- (2) Resignation of Appointment and Privileges. A request to resign Medical Staff appointment and relinquish all clinical privileges must specify the

desired date of resignation, which must be at least 30 days from the date of the request, and be accompanied by evidence that the individual:

- (i) has completed all medical records;
- (ii) will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation; and
- (iii) has completed scheduled emergency service call or has arranged appropriate coverage to satisfy this responsibility.

After consulting with the President of the Medical Staff, the CEO/COO will act on the resignation request and report the matter to the Credentials Committee.

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

- (1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;
- (2) whether sufficient notice has been given to provide a smooth transition of patient care services;
- (3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed upon the individual;
- (4) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them;
- (5) the expectations of other members of the Medical Staff who are in different specialties but who rely on the specialty in question in the care of patients who present to the Hospital;
- (6) any perceived inequities in modifications or waivers being provided to some, but not others;
- (7) any gaps in call coverage that might/would result from an individual's removal from the call roster for the relevant privilege and the feasibility and safety of transferring patients to other facilities in that situation; and

- (8) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.
- (g) Effective Date. If the Board grants a modification or waiver related to privileges, it will specify the date that the modification or waiver will be effective. Failure of a member to request privilege modifications or waivers in accordance with this Section shall, as applicable, result in the member retaining Medical Staff appointment and clinical privileges and all associated responsibilities.
- (h) Procedural Rights. No individual is entitled to a modification or waiver related to privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of privileges is not granted.

4.A.3. Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (hereafter, "new procedure") will not be processed until (1) a determination has been made that the procedure will be offered by the Hospital and (2) criteria to be eligible to request those clinical privileges have been established.
- (b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the department chairperson and the Credentials Committee addressing the following:
 - (1) minimum education, training, and experience necessary to perform the new procedure safely and competently;
 - (2) clinical indications for when the new procedure is appropriate;
 - (3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;
 - (4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;
 - (5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and
 - (6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The department chairperson and the Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered to the community.

- (c) If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the Hospital. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:
 - (1) the minimum education, training, and experience necessary to perform the procedure or service;
 - (2) the clinical indications for when the procedure or service is appropriate;
 - (3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence; and
 - (4) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.
- (d) The Credentials Committee will forward its recommendations to the Executive Committee, which will review the matter and forward its recommendations to the Board for final action.
- (e) The Board will make a reasonable effort to render the final decision within 60 days of receipt of the Executive Committee's recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.
- (f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to perform the procedure or service may be processed.

4.A.4. Clinical Privileges That Cross Specialty Lines:

- (a) Requests for clinical privileges that previously at the Hospital have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.
- (b) As an initial step in the process, the individual seeking the privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether

the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.

- (c) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairpersons, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
- (d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:
 - (1) the minimum education, training, and experience necessary to perform the clinical privileges in question;
 - (2) the clinical indications for when the procedure is appropriate;
 - (3) the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;
 - (4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;
 - (5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (including an assessment of outcomes data for all relevant specialties); and
 - (6) the impact, if any, on emergency call responsibilities.
- (e) The Credentials Committee will forward its recommendations to the Executive Committee, which will review the matter and forward its recommendations to the Board for final action. The Board will make a reasonable effort to render the final decision within 60 days of receipt of the Executive Committee's recommendation.
- (f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed.

4.A.5. Clinical Privileges After Age 65:

- (a) Individuals who desire to exercise clinical privileges after the age of 65 must obtain appropriate current health assessments as part of the appointment and reappointment process.

- (b) Specifically, as part of the reappointment process, these members will be required to have a physical and mental health assessment performed by a physician, APRN or PA-C who is acceptable to the Credentials Committee. The examining provider shall provide an written report, addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff membership, or work cooperatively in a hospital setting. The examining provider shall provide this report directly to the relevant department chairperson and the Credentials Committee and shall be available to discuss any questions or concerns that the Committee may have.
- (c) Upon attaining the age of 75, members of the Medical Staff shall assume Honorary Staff status and shall no longer have clinical privileges to admit or care for patients at the Hospital (unless a waiver for continued privileges is recommended by the Credentials Committee and Executive Committee and approved by the Board). (No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver, but the individual may meet with the Executive Committee upon request.)
- (d) When an exception is granted, the exception will not be for longer than one year. At the end of that one-year term, the member shall assume Honorary status unless another one-year exception is requested and subsequently granted.

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

- (a) For any patient who meets the classifications of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), dentists and oral and maxillofacial surgeons may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient, if they are deemed qualified to do so by the Credentials Committee and Executive Committee. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond should any medical issue arise with a patient.
- (b) For any patient who meets ASA 3 or ASA 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a physician before dental or oral surgery may be performed. In addition, a designated physician who is a member of the Medical Staff shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) The dentist or oral and maxillofacial surgeon shall be responsible for the oral surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their licenses and consistent with the Medical Staff Rules and Regulations.

4.A.7. Clinical Privileges for Podiatrists:

- (a) For any patient who meets the classifications of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), podiatrists may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee and Executive Committee. They must nevertheless have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond should any medical issue arise with a patient.
- (b) For any patient who meets ASA 3 or ASA 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a physician before podiatric surgery shall be performed. In addition, a designated physician who is a member of the Medical Staff shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with the Medical Staff Rules and Regulations.

4.A.8. Physicians in Training:

- (a) Physicians in training shall not hold appointments to the Medical Staff and shall not be granted specific privileges as the training physician would not meet the credentialing requirements in accordance with this Policy and the requirement to satisfy all of the eligibility criteria set forth in Section 2.A.1 with the exception of 2.A.1(r) and 2.A.1(s) (related to completion of training and board certification). The Policy/Directive on Physicians, Residents and Medical Students defines the required levels of Medical Staff supervision for physicians in training, governs the categories of physicians in training who may function in the Hospital, and sets forth the approved patient care activities for each category of physicians in training.

4.A.9. Telemedicine Privileges:

- (a) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.
- (b) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the CEO/COO in consultation with the President of the Medical Staff:

- (1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.
- (2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:
 - (i) confirmation that the practitioner is licensed in Wisconsin;
 - (ii) a current list of privileges granted to the practitioner;
 - (iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;
 - (iv) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;
 - (v) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and
 - (vi) any other attestations or information required by the agreement or requested by the Hospital.

This information shall be provided to the Executive Committee for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

- (c) Telemedicine privileges, if granted, shall be for a period of not more than two years.

- (d) Individuals granted telemedicine privileges shall be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.
- (e) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

4.B. TEMPORARY CLINICAL PRIVILEGES

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

- (a) Locum Tenens. The CEO/COO, upon recommendation of the President of the Medical Staff, the applicable department chairperson, and the Chairperson of the Credentials Committee, may grant temporary privileges (both admitting and treatment) to an individual serving as a locum tenens for an appointee of the Medical Staff to attend patients of that appointee, or may grant locum tenens privileges to provide coverage in a specialty area in which there is no coverage or a shortage of individuals to provide coverage. The following conditions apply:
 - (1) the applicant has submitted an appropriate application, along with the application fee;
 - (2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence (verification of good standing in all hospitals where the individual practiced for at least the previous two years), ability to exercise the privileges requested, DEA (where applicable), and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;
 - (3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;
 - (4) the applicant will be subject to any focused professional practice requirements established by the Hospital; and
 - (5) the individual may exercise locum tenens privileges for a maximum of 120 days, consecutive, in exceptional situations, this period of time may be extended up to an additional 120 days at the discretion of the

CEO/COO and the President of the Medical Staff, subject to the following conditions:

- (i) the individual must notify the Medical Staff Office prior to each time that he or she will be exercising these privileges; and
 - (ii) along with this notification, the individual must inform the Medical Staff Office of any change that has occurred to any of the information provided on the initial application for locum tenens privileges.
- (b) Patient Care Need. Temporary privileges may also be granted in other limited situations by the CEO/COO, upon recommendation of the President of the Medical Staff, the Chairperson of the Credentials Committee, and the applicable department chairperson, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following:
- (1) the care of a specific patient;
 - (2) when a proctoring or consulting physician is needed, but is otherwise unavailable; or
 - (3) when necessary to prevent a lack or lapse of services in a needed specialty area.

The following factors will be considered and verified prior to the granting of temporary privileges in these situations: current licensure, relevant training or experience, current competence (verification of good standing in the primary hospital(s) where the individual practiced for at least the previous year), DEA (where applicable), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank, from a criminal background check, and from OIG queries. The grant of clinical privileges in these situations will not exceed 120 days. In exceptional situations, this period of time may be extended in the discretion of the CEO/COO and the President of the Medical Staff.

- (c) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies/directives, procedures and protocols of the Medical Staff and the Hospital.
- (d) FPPE. Individuals who are granted temporary privileges will be subject to the Hospital policy/directive regarding focused professional practice evaluation.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Withdrawal of Temporary Clinical Privileges:

- (a) The CEO/COO may, at any time after consulting with the President of the Medical Staff, the Chairperson of the Credentials Committee, or the department chairperson, withdraw temporary admitting privileges. Clinical privileges shall then expire when the individual's inpatients are discharged.
- (b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the CEO/COO, the department chairperson, the President of the Medical Staff, or the Chairperson of the Credentials Committee may immediately withdraw all temporary privileges. The department chairperson or the President of the Medical Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

4.C. EMERGENCY SITUATIONS

- (1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.
- (2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.
- (3) When the emergency situation no longer exists, the patient shall be assigned by the department chairperson or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

- (1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CEO/COO or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.
- (2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

- (a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).
 - (b) A volunteer's license may be verified in any of the following ways: (i) current Hospital picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.
- (3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.
 - (4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
 - (5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

4.E. CONTRACTS FOR SERVICES

- (1) From time to time, the Hospital may enter into contracts with practitioners and/or groups of practitioners for the performance of clinical and administrative services at the Hospital. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Policy.
- (2) To the extent that:
 - (a) any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or

- (b) the Board by resolution limits the practitioners who may exercise privileges in any clinical specialty to employees of the Hospital or its affiliates,

no other practitioner except those authorized by or pursuant to the contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized practitioners are eligible to apply for the clinical privileges in question at the time of initial appointment, during the term of appointment, or at reappointment. No other applications will be processed.

- (3) If any such exclusive contract or resolution would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and review procedures:
 - (a) The affected member shall be given at least 30 days' advance notice of the exclusive contract or Board resolution and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the contract in question being signed by the Hospital or the Board resolution becoming effective.
 - (b) At the meeting, the affected member shall be entitled to present any information that he or she deems relevant to the decision to enter into the exclusive contract or enact the Board resolution.
 - (c) If, following this meeting, the Board confirms its initial determination to enter into the exclusive contract or enact the Board resolution, the affected member shall be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or Board resolution is in effect.
 - (d) The affected member shall not be entitled to any procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 7 of this Policy.
 - (e) The inability of a physician to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.
- (4) Except as provided in paragraph (1), in the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

5.A.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

- (a) completed all medical records and be current at the time of reappointment;
- (b) completed all continuing medical education requirements necessary to maintain licensure in Wisconsin;
- (c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;
- (e) if applying for clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization or insurer) before the application will be considered complete and processed further; and
- (f) paid any applicable reappointment processing fees.

5.A.2. Factors for Evaluation:

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

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

- (b) participation in Medical Staff duties, including committee assignments, emergency call, consultation requests, participation in quality improvement, utilization activities, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;
- (c) the results of the Hospital's performance improvement and professional practice evaluation activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);
- (d) any focused professional practice evaluations;
- (e) verified complaints received from patients, families, and/or staff; and
- (f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

- (a) An application for reappointment shall be furnished to members at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office or designated CVO within 30 days.
- (b) Failure to return a completed application within 30 days shall result in the assessment of a reappointment late fee, which must be paid prior to the application being processed. In addition, failure to submit a complete application at least two months prior to the expiration of the member's current term will result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical Staff Office and the Medical Staff Leaders.
- (c) Reappointment shall be for a period of not more than two years.
- (d) If an application for reappointment is submitted timely, but the Medical Staff and/or Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. Subsequent Board action may be to grant reappointment and renewal of clinical privileges using the filed application, in accordance with the expedited process set forth in Section 3.A.7.
- (e) The application will be reviewed by the Medical Staff Office and/or the CVO to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

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

5.A.4. Processing Applications for Reappointment:

- (a) The CEO/COO shall forward the application to the relevant department chairperson and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.
- (b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

5.A.5. Conditional Reappointments:

- (a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.
- (b) In addition, reappointments may be recommended for periods of less than the two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.
- (c) In the event the applicant for reappointment is the subject of an unresolved professional practice evaluation concern, a formal investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.A.6. Potential Adverse Recommendation:

- (a) If the Credentials Committee or the Executive Committee is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chairperson will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.
- (b) Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.

- (c) At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation.
- (d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be accompanied at this meeting (by legal counsel or any other individual) and no recording (audio or video) of the meeting shall be permitted or made.

5.A.7. Time Periods for Processing:

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

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION

- (1) This Policy encourages the use of progressive steps by Medical Staff leaders and the Hospital management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.
- (2) Collegial intervention efforts are a part of ongoing and focused professional practice evaluation activities.
- (3) Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of Medical Staff members and pursuing counseling, education, and related steps, such as the following:
 - (a) advising colleagues of all applicable policies/directives, such as policies/directives regarding appropriate behavior, communication issues, emergency call obligations, and the timely and adequate completion of medical records; and
 - (b) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.
- (4) The relevant Medical Staff Leader(s) shall document collegial intervention efforts in an individual's confidential file. The individual shall have an opportunity to review any formal documentation that is prepared by the Medical Staff Leader(s) and respond in writing. The response shall be maintained in that individual's file along with the original documentation.
- (5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders and Administrative team.
- (6) The relevant Medical Staff Leader(s) shall determine whether to direct that a matter be handled in accordance with another Policy (e.g., the Policy on Physician Health, Code of Conduct Policy, OPPE policy, FPPE policy). Medical Staff Leaders may also direct these matters to the Executive Committee for further determination.

6.B. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATIONS

All ongoing and focused professional practice evaluations shall be conducted in accordance with the Professional Practice Evaluation Policy. Matters that cannot be appropriately resolved through collegial intervention or through the Professional Practice Evaluation Policy shall be referred to the Executive Committee for its review in accordance with Section 6.C below. Such interventions and evaluations, however, are not mandatory prerequisites to Executive Committee review.

6.C. INVESTIGATIONS

6.C.1. Initial Review:

- (a) Whenever a serious question has been raised, and/or where previous collegial efforts or actions under the Professional Practice Evaluation Policy have not resolved an issue, regarding:
 - (1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;
 - (2) the safety or proper care being provided to patients;
 - (3) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies/directives, Rules and Regulations of the Hospital or the Medical Staff; and/or
 - (4) conduct by any member of the Medical Staff that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the failure of the member to work harmoniously with others,

the matter may be referred to the President of the Medical Staff, the chairperson of the department, the chairperson of a standing committee, or the CEO/COO.
- (b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any Medical Staff member, the matter will be referred to the President of the Medical Staff, the chairperson of the department, the chairperson of a standing committee, or the CEO/COO for review and appropriate action in accordance with this Policy.
- (c) The person to whom the matter is referred will conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, will forward it in writing to the Executive Committee.
- (d) No action taken pursuant to this Section shall constitute an investigation.

6.C.2. Initiation of Investigation:

- (a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Executive Committee, the Executive Committee shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy/directive (such as the Policy on Physician Health, the Code of Conduct Policy, or the FPPE Policy), or to proceed in another manner. The Executive Committee may determine to refer matters involving disruptive behavior or sexual harassment to the Board for further action. In making this determination, the Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Executive Committee to do so.
- (b) The Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.
- (c) The President of the Medical Staff shall keep the CEO/COO fully informed of all action taken in connection with an investigation.

6.C.3. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the Executive Committee shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation, keeping in mind the conflict of interest guidelines outlined in Article 8. Any ad hoc committee may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, podiatrist, or psychologist).
- (b) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that:
 - (1) the clinical expertise needed to conduct the review is not available on the Medical Staff;
 - (2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff;

- (3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded; or
 - (4) the thoroughness and objectivity of the investigation would be aided by such an external review.
- (c) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of the health examination will be borne by the individual.
- (d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. No recording (audio or video) or transcript of the meeting shall be permitted or made. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be accompanied by legal counsel at this meeting.
- (e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.
- (f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions, and recommendations.
- (g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the

smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

- (1) relevant literature and clinical practice guidelines, as appropriate;
- (2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);
- (3) any information or explanations provided by the individual under review; and
- (4) other information as deemed relevant, reasonable, and necessary by the investigating committee.

6.C.4. Recommendation:

- (a) The Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Executive Committee may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose conditions for continued appointment;
 - (4) impose a requirement for monitoring, proctoring, or consultation;
 - (5) impose a requirement for additional training or education;
 - (6) recommend reduction of clinical privileges;
 - (7) recommend suspension of clinical privileges for a term;
 - (8) recommend revocation of appointment and/or clinical privileges; or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the Executive Committee that would entitle the individual to request a hearing shall be forwarded to the CEO/COO, who shall promptly inform the individual by special notice. The CEO/COO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

- (c) If the Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.
- (d) In the event the Board considers a modification to the recommendation of the Executive Committee that would entitle the individual to request a hearing, the CEO/COO shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.
- (e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies/directives regarding conduct, as appropriate.

6.D. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.D.1. Grounds for Precautionary Suspension or Restriction:

- (a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the President of the Medical Staff, the chairperson of a clinical department, the Chairperson of the Credentials Committee, the CEO/COO, or the Executive Committee will each have the authority to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation, or (2) suspend or restrict all or any portion of an individual's clinical privileges as a precaution.
- (b) A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Executive Committee that would entitle the individual to request a hearing.
- (c) Precautionary suspension or restriction is an interim step in the professional review activity but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.
- (d) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO/COO and the President of the Medical Staff, and shall remain in effect unless it is modified by the CEO/COO or Executive Committee.
- (e) The individual in question will be provided a brief written description of the reason(s) for the precautionary suspension, including the names and medical

record numbers of the patient(s) involved (if any), within three days of the imposition of the suspension.

6.D.2. Executive Committee Procedure:

- (a) The Executive Committee shall review the matter resulting in a precautionary suspension or restriction (or the individual's agreement to voluntarily refrain from exercising clinical privileges) within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients and/or employees, depending on the circumstances. No recording (audio or video) or transcript of the meeting shall be permitted or made. Neither the Executive Committee nor the individual shall be accompanied by counsel at this meeting.
- (b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Executive Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).
- (c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

6.D.3. Care of Patients:

- (a) Immediately upon the imposition of a precautionary suspension or restriction, the President of the Medical Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.
- (b) All members of the Medical Staff have a duty to cooperate with the President of the Medical Staff, the department chairperson, the Executive Committee, and the CEO/COO in enforcing precautionary suspensions or restrictions.

6.E. AUTOMATIC RELINQUISHMENT

6.E.1. Failure to Complete Medical Records:

Failure to complete medical records after notification by the Health Information Management Department will initially result in the relinquishment of admitting privileges. Repeat instances of failure to complete records shall result in automatic relinquishment of all clinical privileges as defined in the EWD Medical Records Regulations Policy (MR-009).

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

- (a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or failure to satisfy any of the threshold eligibility criteria set forth in this Policy, must be promptly reported to the Medical Staff Office by the Medical Staff member.
- (b) An individual's appointment and clinical privileges shall be automatically relinquished, without the right to a hearing and appeal, if any of the following occur:
 - (1) Licensure: Revocation, expiration, suspension, or the placement of restrictions on an individual's license.
 - (2) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of restrictions on an individual's DEA or Wisconsin state controlled substance authorization.
 - (3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.
 - (4) Medicare and Medicaid Participation: Debarment, proposed debarment, termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.
 - (5) Criminal Activity: Arrest, charge, indictment, conviction, or a plea of guilty or no contest pertaining to any felony; or to any misdemeanor involving (i) controlled substances, (ii) illegal drugs, (iii) Medicare, Medicaid, or insurance or health care fraud or abuse, (iv) child abuse, (v) elder abuse, or (vi) violence against another. (DUIs will be addressed in the manner outlined in Section 2.B.1(g).)

- (c) An individual's appointment and clinical privileges will also be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, if the individual fails to satisfy any of the other threshold eligibility criteria including those set forth in Section 2.A.1, except for board certification status, which shall be assessed at the time of reappointment.
- (d) Automatic relinquishment shall take effect immediately upon notice to the Hospital and continue until the matter is resolved and the individual is reinstated, if applicable.
- (e) If the underlying matter leading to automatic relinquishment is resolved within 90 days, the individual may request reinstatement. Failure to resolve the matter within 90 days of the date of relinquishment shall result in an automatic resignation from the Medical Staff.
- (f) Requests for reinstatement.
 - (1) Requests for reinstatement following the expiration of a license, controlled substance authorization, insurance coverage, proof of compliance with health testing requirements (e.g., TB tests), or certifications required by an individual's clinical privileges (e.g., ACLS) will be processed by the CVO or Medical Staff Office. If any questions or concerns are noted by the CVO, the CVO will refer the matter to the Medical Staff Office for further review in accordance with (f)(2) below.
 - (2) All other requests for reinstatement shall be reviewed by the relevant department chairperson, the Chairperson of the Credentials Committee, the President of the Medical Staff, and the CEO/COO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Executive Committee, and Board for review and recommendation.

6.E.3. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for appointment, reappointment, or clinical privileges, in response to a written request from the Credentials Committee, a Professional Practice Evaluation Committee, the Executive Committee, or any other committee authorized to request such information, shall result in the automatic relinquishment of all clinical privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment will

continue in effect until the information is provided to the satisfaction of the requesting party. If the requested information is not provided within 90 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

6.E.4. Failure to Complete or Comply with Training or Educational Requirements:

Failure to complete and/or comply with training or educational requirements that are adopted by the Executive Committee, including, but not limited to, those pertinent to electronic medical records, patient safety, and infection control, shall result in the automatic relinquishment of all clinical privileges. Any relinquishment will continue in effect until documentation of compliance is provided to the satisfaction of the requesting party. If the requested information is not provided within 90 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

6.E.5. Failure to Attend Special Meeting:

- (a) Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, the Medical Staff Leaders may require the individual to attend a special meeting with one or more of the Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff.
- (b) The notice to the individual regarding this meeting shall be given by special notice at least five days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.
- (c) No legal counsel shall be present at this meeting, and no recording (audio or video) or transcript shall be permitted or made.
- (d) Failure of the individual to attend the meeting shall result in the automatic relinquishment of all clinical privileges until such time as the individual does attend a special meeting. If the individual does not attend a special meeting within 90 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

6.F. LEAVES OF ABSENCE

- (1) Any absence from Medical Staff and/or from patient care responsibilities for longer than 60 days, for a reason that is unrelated to physical or mental health or otherwise to the individual's ability to care for patients safely and competently, shall require an individual to request a leave of absence. (Leaves of absence for health-related matters are addressed in provision (2) below.)
- (2) Except for maternity leaves, members of the Medical Staff must report to the CEO/COO any time they are away from Medical Staff and/or patient care responsibilities for longer than 14 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients

safely and competently. Under such circumstances, the CEO/COO, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence if the individual does not request such a leave on his or her own behalf.

- (3) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the CEO/COO. Except in extraordinary circumstances, this request will be submitted at least 30 days prior to the anticipated start of the leave in order to permit adjustment of the call roster and assure adequate coverage of clinical and/or administrative activities. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.
- (4) The CEO/COO will determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the CEO/COO shall consult with the President of the Medical Staff and the relevant department chairperson. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.
- (5) During the leave of absence, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.
- (6) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the relevant department chairperson, the Chairperson of the Credentials Committee, the President of the Medical Staff, and the CEO/COO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Executive Committee, and Board for review and recommendation. If a request for reinstatement is not granted for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.
- (7) With the exception of maternity leaves, if the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's treating physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

- (8) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the CEO/COO. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.
- (9) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.
- (10) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of Medical Staff appointment and clinical privileges.
- (11) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal. In such case, the individual shall revert to his or her previous status on the Medical Staff unless one of the other provisions above (e.g., the individual failed to apply for reappointment timely) applies.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

- (a) An individual is entitled to request a hearing whenever the Executive Committee makes one of the following recommendations:
 - (1) denial of initial appointment to the Medical Staff;
 - (2) denial of reappointment to the Medical Staff;
 - (3) revocation of appointment to the Medical Staff;
 - (4) denial of requested clinical privileges;
 - (5) revocation of clinical privileges;
 - (6) suspension of clinical privileges for more than 30 days (other than a precautionary suspension);
 - (7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
 - (8) denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.
- (b) No other recommendations shall entitle the individual to a hearing.
- (c) If the Board makes any of these recommendations without an adverse recommendation by the Executive Committee, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Executive Committee. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to “the Executive Committee” shall be interpreted as a reference to “the Board.”

7.A.2. Actions Not Grounds for Hearing:

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

- (a) issuance of a letter of guidance, counsel, warning, or reprimand;
- (b) imposition of conditions, monitoring, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
- (c) termination of temporary privileges;
- (d) automatic relinquishment of appointment or privileges;
- (e) imposition of a requirement for additional training or continuing education;
- (f) precautionary suspension;
- (g) denial of a request for leave of absence, for an extension of a leave, or for reinstatement from a leave if the reasons do not relate to professional conduct or competence;
- (h) determination that an application is incomplete;
- (i) determination that an application will not be processed due to a misstatement or omission;
- (j) removal from the on-call roster or any other reading panel;
- (k) the voluntary acceptance of a performance improvement plan; or
- (l) determination of ineligibility based on a failure to meet threshold criteria, a lack of need or resources, or because of an exclusive contract.

7.B. THE HEARING

7.B.1. Notice of Recommendation:

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

- (a) a statement of the recommendation and the general reasons for it;
- (b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
- (c) a copy of this Article.

7.B.2. Request for Hearing:

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

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

- (a) The CEO/COO shall schedule the hearing and provide, by special notice, the following:
 - (1) the time, place, and date of the hearing;
 - (2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;
 - (3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
 - (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.
- (b) The hearing shall begin no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

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

(a) Hearing Panel:

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

- (1) The Hearing Panel shall consist of at least three members and may include any combination of:
 - (i) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level; and/or

- (ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).
- (2) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Panel.
- (3) Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.
- (4) The Panel will not include any individual who is in direct economic competition with the individual requesting the hearing.
- (5) The Panel will not include any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing.
- (6) The Panel will not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.
- (7) In addition, the appointment of the Hearing Panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article 8 of this Policy.

(b) Presiding Officer:

- (1) The CEO/COO, after consulting with the President of the Medical Staff, will appoint a Presiding Officer who may be an attorney. The Presiding Officer will not act as an advocate for either side at the hearing. The Presiding Officer will be compensated by the Hospital, but the individual requesting the hearing may participate in that compensation should the individual wish to do so.
- (2) The Presiding Officer shall:
 - (i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
 - (ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
 - (iii) maintain decorum throughout the hearing;

- (iv) determine the order of procedure;
 - (v) rule on all matters of procedure and the admissibility of evidence; and
 - (vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.
- (3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.
- (4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.
- (c) Hearing Officer:
- (1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the CEO/COO, after consulting with the President of the Medical Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients who are in direct economic competition with the individual requesting the hearing.
 - (2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.
- (d) Objections:

Any objection to any member of the Hearing Panel, or to the Hearing Officer or Presiding Officer, shall be made in writing, within 10 days of receipt of notice, to the CEO/COO. A copy of such written objection must be provided to the President of the Medical Staff and must include the basis for the objection. The President of the Medical Staff shall be given a reasonable opportunity to comment. The CEO/COO shall rule on the objection and give notice to the parties. The CEO/COO may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.B.5. Counsel:

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

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

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

7.C.2. Time Frames:

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

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

7.C.3. Witness List:

- (a) At least 10 days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
- (b) The witness list will include a brief summary of the anticipated testimony.
- (c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.C.4. Provision of Relevant Information:

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

- (b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:
- (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
 - (2) reports of experts relied upon by the Executive Committee;
 - (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters redacted); and
 - (4) copies of any other documents relied upon by the Executive Committee.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

- (c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.
- (d) At least 10 days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses will be submitted in writing at least five days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.
- (f) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the Executive Committee's witness list or in documents provided pursuant to this Section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.C.5. Pre-Hearing Conference:

The Presiding Officer will require the individual and the Executive Committee or their representatives (who may be counsel) to participate in a pre-hearing conference, which

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

7.C.6. Stipulations:

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

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

The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference, (without the need for authentication); and (c) stipulations agreed to by the parties.

7.D. HEARING PROCEDURES

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

- (a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - (1) to call and examine witnesses, to the extent they are available and willing to testify;
 - (2) to introduce exhibits;
 - (3) to cross-examine any witness on any matter relevant to the issues;
 - (4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and
 - (5) to submit proposed findings, conclusions, and recommendations to the Hearing Panel after the conclusion of the hearing session(s).
- (b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

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

7.D.2. Record of Hearing:

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Hospital. Copies of the transcript will be available at the individual's expense. Oral evidence will be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.D.3. Failure to Appear:

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

7.D.4. Presence of Hearing Panel Members:

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

7.D.5. Persons to be Present:

The hearing will be restricted to those individuals involved in the proceeding, the President of the Medical Staff, and the CEO/COO. In addition, administrative personnel may be present as requested by the CEO/COO, or the President of the Medical Staff.

7.D.6. Order of Presentation:

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

7.D.7. Admissibility of Evidence:

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

7.D.8. Post-Hearing Statement:

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

7.D.9. Postponements and Extensions:

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

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.E.1. Basis of Hearing Panel Recommendation:

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

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

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

7.E.3. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the CEO/COO. The CEO/COO shall send by special notice a copy of the report to the individual who requested the hearing. The CEO/COO shall also provide a copy of the report to the Executive Committee.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

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

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

7.F.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

- (a) there was substantial failure by the Hearing Panel to comply with this Policy and/or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; and/or
- (b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.F.3. Time, Place and Notice:

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

7.F.4. Nature of Appellate Review:

- (a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.
- (b) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.
- (c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

7.G. BOARD ACTION

7.G.1. Final Decision of the Board:

- (a) Within 30 days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board will consider the matter and take final action.
- (b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Executive Committee, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.
- (c) The Board will render its final decision in writing, including specific reasons, and will send special notice to the individual. A copy will also be provided to the Executive Committee for its information.

7.G.2. Further Review:

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

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

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

ARTICLE 8

CONFLICT OF INTEREST GUIDELINES

8.A. CONFLICT OF INTEREST GUIDELINES

8.A.1. General Principles:

- (a) All those involved in credentialing and professional practice evaluation activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review process.
- (b) It is also essential that peers participate in credentialing and professional practice evaluation review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

8.A.2. Immediate Family Members:

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

8.A.3. Employment by or Contractual Relationship with the Hospital:

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

8.A.4. Actual or Potential Conflict Situations:

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

- (a) membership in the same group practice;
- (b) having a direct or indirect financial relationship;
- (c) being a direct competitor;
- (d) close friendship;

- (e) a history of personal conflict;
- (f) personal involvement in the care of a patient which is subject to review;
- (g) raising the concern that triggered the review; or
- (h) prior participation in review of the matter at a previous level.

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

8.A.5. Guidelines for Participation in Credentialing and Professional Practice Evaluation Activities:

An Interested Member shall have the obligation to disclose any actual or potential conflict of interest. When an actual or potential conflict situation exists as outlined in the paragraph above, the following guidelines will be used.

- (a) Initial Reviewers. An Interested Member may participate as an initial reviewer as long as there is a check and balance provided by subsequent review by a Medical Staff committee. This applies, but is not limited to, the following situations:
 - (1) participation in the review of applications for appointment, reappointment, and clinical privileges, because of the Credentials Committee’s and Executive Committee’s subsequent review of credentialing matters; and
 - (2) participation as case reviewers in professional practice evaluation activities because of a Professional Practice Evaluation Committee’s subsequent review of peer review matters.
- (b) Credentials Committee or Professional Practice Evaluation Committee Member. An Interested Member may fully participate as a member of these committees because these committees do not make any final recommendation that could adversely affect the clinical privileges of a practitioner, which is only within the authority of the Executive Committee. However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested Member’s presence would inhibit full and fair discussion of the issue or would skew the recommendation or determination of the committee.
- (c) Ad Hoc Investigating Committee. Once a formal investigation has been initiated, additional precautions are required. Therefore, an Interested Member may not be appointed as a member of an ad hoc investigating committee, but may be interviewed and provide information to the ad hoc investigating committee if necessary for the committee to conduct a full and thorough investigation.

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

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

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

- (a) provide information and input to the Credentials Committee or an ad hoc committee charged with development of such criteria;
- (b) participate in the discussions or actions of the Credentials Committee or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the Chairperson of the Credentials Committee or ad hoc committee always has the discretion to recuse an Interested Member in a particular situation, in accordance with the rules for recusal outlined below); but
- (c) not serve on the Executive Committee when it is considering its final recommendation to the Board regarding the criteria.

8.A.7. Rules for Recusal:

- (a) When determining whether recusal in a particular situation is required, the President of the Medical Staff or committee chairperson will consider whether the Interested Member's presence would inhibit full and fair discussion of the issue before the committee or Board meeting or would skew the recommendation or determination of the committee.
- (b) Any Interested Member who is recused from participating in a committee or Board meeting must leave the meeting room prior to the committee's or Board's final deliberation and determination, but may answer questions and provide input before leaving.
- (c) Any recusal will be documented in the committee's or Board's minutes.

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

8.A.8. Other Considerations:

- (a) Any member of the Medical Staff who is concerned about a potential conflict of interest on the part of any other member, including but not limited to the situations noted in the paragraphs above, must call the conflict of interest to the attention of the President of the Medical Staff (or to the Vice President of the Medical Staff if the President of the Medical Staff is the person with the potential conflict) or the applicable committee chairperson/Board Chair. The member's failure to notify will constitute a waiver of the claimed conflict. The President of the Medical Staff or the applicable committee chairperson/Board Chair has the authority to make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Member, if necessary.
- (b) No staff member has a right to compel the disqualification of another staff member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Board Chair, guided by this Article.
- (c) The fact that an individual chooses to refrain from participation or is excused from participation in any credentialing or peer review activity will not be interpreted as a finding of actual conflict that inappropriately influenced the review process.

ARTICLE 9

CONFIDENTIALITY AND PEER REVIEW PROTECTION

9.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in, or subject to, credentialing and professional practice evaluation activities shall make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

- (1) when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of researching, investigating, or otherwise conducting legitimate credentialing and professional practice evaluation activities; or
- (2) when the disclosures are authorized by a Medical Staff or Hospital policy/directive; or
- (3) when the disclosures are authorized, in writing, by the CEO/COO or by legal counsel to the Hospital.

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

9.B. PEER REVIEW PROTECTION

- (1) All credentialing and professional practice evaluation activities pursuant to this Policy and related Medical Staff documents shall be performed by “Peer Review Committees” in accordance with Wisconsin law. These committees include, but are not limited to:
 - (a) all standing and ad hoc Medical Staff and Hospital committees;
 - (b) Hearing Panels;
 - (c) the Board and its committees;
 - (d) all departments; and

- (e) any individual acting for or on behalf of any such entity, including but not limited to department chairpersons, committee chairs and members, officers of the Medical Staff, and experts or consultants retained to assist in peer review activities.

All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of Wisconsin Statute §146.38 and/or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

- (2) All peer review committees shall also be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq.

ARTICLE 10

AMENDMENTS

Proposed amendments to this Policy shall be presented to the Executive Committees for the four hospitals. This Policy may then be amended by a majority vote of the members of each Executive Committee present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments shall also be posted on the Medical Staff bulletin board for each hospital at least 14 days prior to the Executive Committee meeting and any member of the Medical Staff may submit written comments to the Executive Committee. If there is any disagreement between the Executive Committees, a joint meeting shall be scheduled to discuss and resolve the disagreement. No amendment shall be effective unless and until it has been approved by the Board of each hospital.

ARTICLE 11

ADOPTION

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

Originally adopted by the Medical Staffs:

June 27, 2006
HSHS St. Vincent Hospital

July 25, 2006
HSHS St. Mary's Hospital
Medical Center

February 24, 2011
HSHS St. Nicholas Hospital

December 15, 2015
HSHS St. Clare Memorial
Hospital

February 22, 2017
HSHS Libertas

Originally approved by the Boards:

July 31, 2006
HSHS St. Vincent Hospital

July 26, 2006
HSHS St. Mary's Hospital
Medical Center

March 17, 2011
HSHS St. Nicholas Hospital

January 13, 2016
HSHS St. Clare Memorial
Hospital

March 22, 2017
HSHS Libertas

Revisions adopted by the Medical Staffs:

HSHS St. Vincent Hospital: December 21, 2010, April 23, 2013, February 24, 2015,
January 26, 2016, January 24, 2017, June 26, 2018, January 22, 2019,
February 26, 2019

HSHS St. Mary's Hospital: December 21, 2010, April 23, 2013, February 24, 2015,
January 26, 2016, January 24, 2017, June 26, 2018, January 22, 2019,
February 26, 2019

HSHS St. Nicholas Hospital: February 26, 2015, January 28, 2016, January 26, 2017, June 28, 2018,
January 24, 2019, February 28, 2019

HSHS St. Clare Memorial Hospital: January 4, 2017, June 19, 2018, February 19, 2019, April 16, 2019

HSHS Libertas Treatment Center: June 27, 2018, January 16, 2019, February 27, 2019

Revisions approved by the Board:

HSHS St. Vincent Hospital: January 19, 2011, May 15, 2013, March 18, 2015, March 23, 2016,
March 22, 2017, July 18, 2018, March 20, 2019

HSHS St. Mary's Hospital: January 19, 2011, May 15, 2013, March 18, 2015, March 23, 2016, March 22, 2017, July 18, 2018, March 20, 2019

HSHS St. Nicholas Hospital: March 19, 2015, March 10, 2016, March 23, 2017, July 19, 2018, March 21, 2019

HSHS St. Clare Memorial Hospital: March 8, 2017, July 11, 2018, March 20, 2019, May 15, 2019

HSHS Libertas Treatment Center: July 18, 2018, March 20, 2019