## Medical Staff Organization Bylaws

Please see the attached file.

Approved by the BHD Medical Staff Organization on 8/1/18 and by the Mental Health Board on 8/23/18.

### Attachments:

**Bylaws of the Medical Staff Organization**

### Approval Signatures

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<th>Step Description</th>
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MEDICAL STAFF ORGANIZATION

BYLAWS

August 2018
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MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
MEDICAL STAFF ORGANIZATION

BYLAWS

PREAMBLE

Whereas, the Milwaukee County Behavioral Health Division is organized under the laws of the County of Milwaukee and the State of Wisconsin and functions within the organizational framework established by the duly constituted authorities of the County of Milwaukee; and

Whereas, its purpose is to provide patient care, treatment, services, education, and research; and

Whereas, it is recognized that the Medical Staff Organization is self-governing in its responsibilities for overseeing quality medical and behavioral health care, treatment, and services provided by practitioners with privileges as well as for those providing education and research in the Milwaukee County Behavioral Health Division and within community sites; and

Whereas, the Medical Staff shall accept and discharge this responsibility subject to the Governing Authority of the Milwaukee County Behavioral Health Division; and

Whereas, the Milwaukee County Behavioral Health Division serves as a teaching resource for physicians and behavioral health professionals; and

Whereas, the cooperative efforts of the Medical Staff, the Administrative Staff and the Governing Authority are necessary to fulfill the obligations of the Behavioral Health Division to its patients and to the community;

Therefore, the Medical Staff of the Milwaukee County Behavioral Health Division hereby organize themselves in conformity with these Bylaws.
DEFINITIONS:

1. The term "Medical Staff" shall be interpreted to include licensed physicians (medical and osteopathic), licensed dentists, licensed podiatrists, and licensed psychologists. All "Medical Staff" shall have delineated clinical privileges and shall be eligible for membership in the Medical Staff Organization.

2. The term "Allied Health Professional" shall be interpreted to include licensed health care providers other than physicians, psychologists, dentists and podiatrists who are permitted by scope of license, state law AND by the Hospital to provide patient care services within approved Hospital programs/services. Allied Health Professional Staff shall be categorized as independent or dependent and shall be permitted to practice with or without direction or supervision, based on the scope of his/her license, certification and/or registration and in conjunction with hospital approval and Medical Staff approval, when applicable. "Allied Health Professional" Staff shall not be eligible for membership in the Medical Staff Organization.

   A. Independent Allied Health Professional: an individual who may provide care to patients, in accordance with and as permitted by state licensure laws, without the supervision or direction of a physician but in collaboration with a physician who is privileged and working with the same or very similar patient population and who is assigned to the same service or program. In accordance with these Bylaws and State and Federal standards, independent Allied Health Professional staff shall have delineated clinical privileges. Advanced Practice Nurses shall maintain a current collaboration agreement with a member of the Active or Affiliate staff.

   B. Dependent Allied Health Professional: an individual who may provide care to patients, in accordance with and as permitted by state licensure laws, under the supervision or direction of a physician. It shall be determined by the Chief Medical Officer or designee whether supervision shall be direct or indirect based on BHD scope of practice. In accordance with these Bylaws and State and Federal standards, dependent Allied Health Professional staff shall have delineated clinical privileges whenever such services and supplies are furnished as an incident to a physician's service as would otherwise be covered if furnished by a physician or as an incident to a physician's service.

3. The term "Governing Authority" shall be interpreted to refer to the Milwaukee County Mental Health Board as created under Wisconsin Statute 15.195(9)

4. The term "Executive Committee" shall be interpreted to refer to the Executive Committee of the Medical Staff of the Milwaukee County Behavioral Health Division.

5. The term "Allied Staff" shall be interpreted to refer to clinical professional staff who provide service to patients under the direction of a member of the Medical Staff and do not have delineated clinical privileges. This group shall include but not be limited to registered nurses, social workers, occupational and music therapists, clinical dietitians and non-licensed psychologists.

6. The term "Chief Medical Officer" shall be interpreted to refer to the Executive Medical Director appointee of the Administrator of the Milwaukee County Behavioral Health Division who shall serve as Chief Medical Officer and have authority and responsibility for the overall medical and clinical management of the MCBHD.
7. The term "Administrator" shall be interpreted to refer to the Administrator of the Milwaukee County Behavioral Health Division appointed by the Director of Health and Human Services and confirmed by the Governing Authority and is equivalent to that of the position of Chief Executive Officer.

8. The term "Chief of Staff" shall be interpreted to refer to the President of the Medical Staff Organization.

9. The term "Chief Quality Officer" shall be interpreted to refer to the Deputy Administrator of the Milwaukee County Behavioral Health Division charged with overseeing quality and clinical compliance.
1.0 ARTICLE I - NAME

The name of the organization shall be the "Medical Staff Organization of the Milwaukee County Behavioral Health Division (MCBHD)."

2.0 ARTICLE II - PURPOSE

The purpose of this organization shall be:

2.1 to ensure that all patients admitted to all programs of the MCBHD receive a uniform standard of quality patient care, treatment and services through participation in the following:

2.1.1 direction, review and evaluation of the quality of patient care through continuous hospital-wide and Medical Staff quality improvement monitoring activities;

2.1.2 ongoing monitoring of patient care practices;

2.1.3 delineation of clinical privileges for Medical Staff and Allied Health Professional Staff commensurate with individual credentials and demonstrated ability and judgment;

2.1.4 provision of continuing medical and professional education based on needs identified through monitoring and review, evaluation, and planning mechanisms; and

2.1.5 review of utilization of the MCBHD's resources to provide for the appropriate allocation to meet patient care needs;

2.2 to initiate and maintain Bylaws, Rules and Regulations and policies and procedures for self-governance of the Medical Staff, with at least biennial review of the Bylaws and Rules and Regulations. These reviews shall be more frequent, when necessary, to reflect the hospital's current practice and/or to comply with changes in law or regulation;

2.3 to provide a means whereby issues may be discussed by the Medical Staff with the Chief Medical Officer of MCBHD and the Governing Authority;

2.4 to promote educational programs and activities for staff and trainees; and

2.5 to promote programs in research, in order to advance knowledge and skills in the behavioral health sciences.
3.0 ARTICLE III - APPOINTMENT, REAPPOINTMENT AND PRIVILEGING

All new applicants seeking clinical privileges or current Medical Staff Members and Allied Health Professionals seeking amended clinical privileges shall be subject to the credentialing and privileging requirements in place for privileges sought, at the time the initial privilege request or the privilege amendment is approved. Therefore, new applicants, current Medical Staff Members and Allied Health Professionals shall be held subject to any and all changes in credentialing and privileging requirements, for new privileges being sought, that are enacted during the period that the initial privilege request or privilege amendment is pending approval.

All credentialing and privileging requirements shall be as defined by these Bylaws. Methods for carrying out requirements shall be in accordance with Medical Staff policy and procedure.

3.1 Physician Qualifications. The applicant shall be a graduate of a recognized medical or osteopathic school and licensed to practice as a physician (medical or osteopathic) in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All physicians practicing within the hospital or its clinics shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. Applicants seeking tele-medicine privileges shall be licensed in the state of Wisconsin AND in the state from which the tele-service is provided, shall be privileged by the medical Staff but shall not be eligible for Active staff membership. All applicants must demonstrate recent (within the last two years) practice experience, which may include formal residency or fellowship training, commensurate to the privileges being requested. All physicians requesting and granted specialty privileges shall obtain board certification in his/her primary specialty and any subspecialty as recognized by the American Board of Medical Specialties or American Osteopathic Association within the time requirements and as recognized by the applicable ABMS or AOA specialty after the completion of his/her training. Practitioner shall remain board certified in his/her principal areas of practice at all times after the date he/she obtains or is required to obtain such board certification. Exceptions to the board certification requirements may be waived on recommendation of the Chief Medical Officer for applicants that have appropriate experience and urgent clinical need exists.

3.2 Dentist Qualifications. The applicant shall be a graduate of a recognized dental school and licensed to practice dentistry in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All dentists shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. All applicants must demonstrate recent (within the last two years) practice experience, which may include formal residency or fellowship training, commensurate to the privileges being requested.

3.3 Podiatrist Qualifications. The applicant shall be a graduate of a recognized podiatric medical school and licensed to practice podiatry in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All podiatrists shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. All applicants must demonstrate recent (within the
last two years) practice experience, which may include formal residency or fellowship training, commensurate to the privileges being requested.

3.4 **Psychologist Qualifications.** The applicant shall be a graduate of a recognized doctoral program in clinical or counseling psychology, licensed to practice psychology in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All psychologists who meet these qualifications shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. All applicants must demonstrate recent (within the last two years) practice experience, which may include formal pre- or post-doctoral internship or fellowship training, commensurate to the privileges being requested.

3.5 **Allied Health Professional Qualifications.** The applicant shall be a graduate of a recognized master's degree program in their professional specialty and licensed, certified and/or registered to practice independently or dependently, in accordance with what scope of practice in the State of Wisconsin allows, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All independent allied health professionals shall be privileged by the Medical Staff but shall not be eligible for membership in the Medical Staff Organization. Dependent allied health professionals shall be privileged when recommended by the Medical Staff and authorized by the Hospital. Allied health professional staff may include, but shall not be limited to, Advanced Practice Nurses (including Nurse Practitioners, Clinical Nurse Specialists and Nurse Midwives), Physician's Assistants, Optometrists, licensed Social Workers and Marriage and Family Therapists if permitted by the hospital to practice independently. All applicants must demonstrate recent (within the last two years) practice experience or specialty training, commensurate to the privileges being requested.

3.6 **Procedure for Appointment and/or Privileging.**

3.6.1 Applicants for membership and/or privileges must meet the qualifications as specified above.

3.6.2 An applicant shall not be denied consideration for an appointment to the Medical Staff or for clinical privileges based on race, sex, age, disability, creed, color, sexual orientation, marital status, military service membership, arrest/conviction record (unless offense is substantially related to circumstances of position and/or licensed activity) or national origin or any other basis prohibited by law or any physical or mental impairment that, after any legally-required reasonable accommodation, does not preclude compliance with the Medical Staff Bylaws or Hospital policies.

3.6.2.1 **Criminal Activities.**

An applicant may have his or her application for membership and/or clinical privileges denied, modified or restricted and a member may have his or her Medical Staff membership or clinical privileges modified, restricted or revoked, when the individual has a conviction of, or a plea of guilty or no contest to any felony, or to any misdemeanor involving controlled substances; illegal drugs; Medicare, Medicaid, or insurance or health care fraud or abuse; violence against another; sexual misconduct; or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a healthcare program) operated or financed in whole or
in part by any Federal, State or local government agency, even if not yet excluded, debarred, or otherwise declared ineligible. 
(Reference Social Security Act Sec. 1128)

3.6.2.2 Administrative Denial.

The Medical Staff Office may, with the approval of the Chief Medical Officer or Credentialing and Privileging Review Chairperson, deny any application for appointment or reappointment to the Medical Staff or Allied Health Professional Staff and/or application for clinical privileges, without further review, if it is determined that the applicant does not hold a valid Wisconsin medical/professional license and/or other registrations or certifications applicable to his/her practice and no application is pending; does not have adequate professional liability insurance, if required; is not eligible to receive payment from the Medicare or Medicaid programs or is currently excluded from any health care program funded in whole or in part by the federal government or by a state or local government; or is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code. Reference Wisconsin DHS 12: Caregiver Background Checks

3.6.3 Applications for initial Medical Staff membership and/or clinical privileges shall be in writing, and the form shall include evidence of current licensure (including, registrations and/or certifications, as required), relevant training and experience (including all medical/professional schools attended, internships, residencies, fellowships and other post-doctoral programs), current competence (including but not limited to names of peer references, one of which shall be directed, a chronological list of all past and present hospital appointments and practice affiliations, military history, faculty or clinical teaching appointments, recent continuing education activities), and reasonable evidence of current ability to perform privileges requested (health status). The application form shall request information relating to involvement in any professional liability action, previously successful or currently pending challenges to or any voluntary or involuntary limitation or relinquishment of any licensure or registration, any limitation, reduction, or loss of medical or professional staff membership or clinical privileges at another hospital, whether voluntary or involuntary, whether ever reprimanded, censured, excluded, suspended or disqualified by Medicare, Medicaid, CLIA or any other health plan, whether they have any present or pending guilty or no contest pleas or convictions involving dishonesty, assault, sexual misconduct or abuse, or abuse of controlled substances or alcohol. The application form shall request names of at least two (2) peers who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time, and who can and will provide reliable information regarding applicant's current clinical ability, ethical character, and ability to work with others. Allied Health professional references may be provided by a physician when recent work activities do not include a direct contact/observation of performance by a peer. At least one peer reference must be from the same professional discipline as the applicant. These peer recommendations and all other documentation obtained in connection with the application shall become a part of the applicant's permanent record and shall be maintained by Medical Staff Services on behalf of the Credentialing and Privileging Review Committee and Medical Staff Organization. Applicants must consent to the inspection of records and documents related to the application. Applications shall include a request for specific clinical privileges. Advanced Practice Nurse application requirements shall further include an approved written collaboration agreement(s), which
shall include practice guidelines defining independent and/or dependent functions for which clinical privileges are being requested. Each applicant for Medical Staff membership and/or privileges shall be provided with a copy of and be oriented to the Bylaws, Rules and Regulations, and major policies of the Medical Staff, and shall agree in writing to abide by them.

3.6.4 Application for membership and/or privileges by physicians, dentists, podiatrists, psychologists, and allied health professionals shall be submitted to the Chief Medical Officer or designee. The Chief Medical Officer or designee shall be responsible for processing the application and obtaining all required and any additional supporting documentation. Application processing shall include the collection of at least two peer references and for verifying from the primary source or an equivalent primary source (i.e., AMA, AOA, ECFMG, ABMS, and/or FSMB) all required professional training (medical/professional schools attended, internships, residencies, fellowships and other post-doctoral programs), required current professional licensure from the appropriate State Medical Board(s), DEA registration, and for querying the National Practitioner Data Bank (NPDB) and the Office of Inspector General List of Excluded Individuals and Entities (OIG-LEIE). Additional supporting documentation, including other hospital appointment and practice affiliation verifications, malpractice claims history verifications and recent continuing education may also be collected and used in the initial evaluation process. Before assigning initial clinical responsibilities, applicant identity is verified, criminal background check is completed and all applicable health screening requirements must be satisfied. Upon completion of the credentialing verification processes, the Chief Medical Officer or designee shall transmit the application and all required and any supporting documentation to the Chief Psychologist (if applicable) and to the Service Medical Director. The Chief Psychologist's recommendation, when applicable, shall be forwarded to the Service Medical Director by Medical Staff Services. The Service Medical Director's recommendation shall be forwarded to the Medical Staff Credentialing and Privileging Review Committee. Temporary privileges, for a period of not more than 120 days, may be granted to an applicant pending appointment and/or privileging after receiving a recommendation by the Credentialing and Privileging Review Committee or by the Chair acting on behalf of the Committee, provided the application is complete and meets all Category 1 application criteria. A Category 1 application means that all required verifications as established by the Medical Staff Credentialing and Privileging Review Committee are in place, applicant has no history of corrective action (hospital/licensing board), has a clean/satisfactory criminal background check (no felony convictions or charges pending and no non-felony matters substantially related to ability to professionally practice), minimal or no malpractice history, privilege requests are appropriate to training, and all references are good. No Medical Staff member shall be permitted to recommend approval of his/her own privileges or appointment.

3.6.5 The Credentialing and Privileging Review Committee shall review the application and supporting documentation, review and confirm the validity of the applicant's credentials and may conduct an interview with the applicant. Applicants shall be acted upon by this committee within 90 days upon application completion and verification of meeting all credentialing requirements, or reasonable attempts thereto, for all privileges requested, and this committee shall recommend to the Executive Committee of the Medical Staff that the application for appointment and/or request for clinical privileges be accepted, deferred or rejected. When a recommendation to defer is made, the Credentialing and Privileging Review Committee must follow-up within 60 days with a final recommendation of acceptance or rejection to the Executive Committee. Applicants have
the burden of producing accurate and adequate information for proper evaluation of professional, ethical and other qualifications for membership and/or clinical privileges and for resolving any doubts about such qualifications. This burden may include submission to a medical, psychiatric or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Staff Executive Committee, which may select the examining practitioner. The Chief Medical Officer or Medical Staff Services, when designated shall notify the applicant of any areas of incompleteness, question and/or failure of others to respond to such information collection or verification efforts. It will then be the applicant's obligation to obtain all required information within the next thirty (30) days. Applicants who do not make reasonable and timely attempts to resolve misstatements or omissions from the application or resolve doubts about qualifications, current abilities or credentials within thirty (30) days, when additional information is requested by the Chief Medical Officer or Medical Staff Services may, in the sole discretion of the Chief Medical Officer, be deemed a voluntary withdrawal of the application due to incompleteness and shall not be subject to hearing rights under these Bylaws. If temporary privileges were granted pending completion of the application approval process, they will be deemed expired at this time.

3.6.6 The Executive Committee shall recommend to the Governing Authority that the application be accepted or rejected; and if accepted, provisional or full clinical privileges shall be granted. The Executive Committee, as represented by the Chairperson of the Credentialing and Privileging Review Committee, shall submit to the Governing Authority all recommendations for Medical Staff appointment and/or clinical privileging.

3.6.7 Temporary Privileges.

The Administrator, or designee, acting on behalf of the Governing Authority and based on the recommendation of the President of the Medical Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff Executive Committee and the Governing Authority. Temporary privileges shall be granted by the Administrator or by one of the following authorized designees: the Chief Medical Officer or the Chairperson of the Medical Staff Credentialing and Privileging Review Committee. No Medical Staff member shall be permitted to approve his/her own privileges.

3.6.7.1 Important Patient Care, Treatment or Service Need.

Temporary privileges may be granted on a case by case basis when an important patient care, treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges the organized Medical Staff verifies current licensure and current competence.

3.6.7.2 Clean Application Awaiting Approval (Category 1).

Temporary privileges may be granted for up to 120 calendar days when the new applicant for Medical Staff membership and/or privileges is waiting for review and recommendation by the Medical Staff Executive Committee and approval by the Governing Authority. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which
has been verified by the hospital: current licensure; education, training and experience; current competence; current DEA (if applicable); current professional liability insurance in the amount required (when applicable); malpractice history; one positive reference specific to the applicant’s competence from an appropriate medical peer; ability to perform the privileges requested; a query to the OIG-LEIE, and results from a query to the National Practitioner Data Bank. Additionally, the application must meet the criteria for Category 1 privileging consideration, as described in section 3.6.4 of these Bylaws.

3.6.7.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the Bylaws, rules, and regulations and policies of the Medical Staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these Bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

3.6.7.4 Termination of temporary privileges: The Administrator, acting on behalf of the Governing Authority and after consultation with the President of the Medical Staff, may terminate any or all of the practitioner’s privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner’s privileges. When a patient’s life or wellbeing is endangered, any person entitled to impose precautionary suspension under the Medical Staff Bylaws may affect the termination. In the event of any such termination, the practitioner’s patients then will be assigned to another practitioner by the Chief Medical Officer acting as the Administrator’s designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

3.6.7.5 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Appendix II or Appendix III of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

3.6.8 Disaster privileges – Medical Staff Leadership, in collaboration with Hospital Leadership and the Governing Authority, has determined that disaster privileging shall not be utilized at the Behavioral Health Division (as a hospital specializing in psychiatric and behavioral care, instances would be too few where such volunteers would be required to come forward or would volunteer to come forward, to assist).

3.6.9 Telemedicine privileges - Licensed independent practitioners who are responsible for the care, treatment and/or services of an MCBHD patient via telemedicine link, including interpretive services, are subject to credentialing and privileging requirements and will be processed through one of the following mechanisms:

3.6.9.1 MCBHD shall fully privilege and credential the practitioner according to the processes described in sections 3.6.1 - 3.6.7 of these Bylaws; or
3.6.9.2 MCBHD may privilege practitioners using credentialing information from the distant site, if the distant site is a Joint Commission-accredited organization.

3.6.9.3 MCBHD may use the credentialing and privileging decision from the distant site if all of the following requirements are met:

1. The distant site is a Joint Commission-accredited hospital or ambulatory care organization and has a direct contract/agreement with MCBHD to provide services;

2. The practitioner is privileged at the distant site for those services to be provided at MCBHD; and

3. MCBHD has evidence of an internal review of the practitioner’s performance of these privileges and sends to the distant site information that is useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the hospital.

3.6.10 An expedited Governing Authority approval process shall not be used.

3.7 Appointment and/or privileging. Medical Staff and Allied Health Professional appointment and/or clinical privileging shall be approved by the Governing Authority based on Medical Staff recommendations. Prior to a written decision of rejection, the Governing Authority shall meet with the President of the Medical Staff and the Chairperson of the Credentialing and Privileging Review Committee to review the recommendations and the concerns regarding the appointee’s professional qualifications. The Credentialing and Privileging Review Committee Chairperson shall transmit the decision to the applicant. In cases of rejection, the applicant shall be informed and advised of his/her right to appeal in accordance with the provisions of Appendix II or Appendix III of these Bylaws. Medical Staff and Allied Health Professional appointment and/or privileging shall be for a period of no more than two (2) years. All initial appointments and privileges shall be subject to a provisional period of at least six (6) months and shall require a focused audit of practitioner performance prior to completion of the provisional privilege period. The decision to grant, limit or deny an initially requested privilege or existing privilege for renewal is communicated to the practitioner within 30 days of approval.

3.8 Reappointment and/or reprivileging. Applicants have the burden of producing accurate and adequate information for proper evaluation of professional, ethical and other qualifications for continued membership and/or clinical privileges and for resolving any doubts about such qualifications. This burden may include submission to a medical, psychiatric or psychological examination, at the applicant’s expense, if deemed appropriate by the Medical Staff Executive Committee, which may select the examining practitioner. The applicant’s failure to sustain this burden shall constitute cause for recommendation that the application for reappointment and/or privileges be denied. Medical Staff and Allied Health Professional reappointment and/or clinical reprivileging shall be approved by the Governing Authority based on Medical Staff recommendations. Any significant misstatements in, falsifications in, or omissions from the reprivileging application requirements, which shall include being current on annual dues assessments, if applicable, shall constitute cause for the application to be deemed incomplete.
The Chief Medical Officer or Medical Staff Services shall notify the applicant of any areas of incompletion and/or failure of others to respond to such information collection or verification efforts. It will then be the applicant's obligation to obtain all required information prior to the Credentialed and Privileging Review Committee meeting at which the application is scheduled for review. Applicants who do not make reasonable and timely attempts to resolve misstatements or omissions from the application or doubts about qualifications, current abilities or credentials, or resolve dues delinquencies when requested, shall result in application being deemed incomplete and no further action shall be required. The Executive Committee, as represented by the Chairperson of the Credentialed and Privileging Review Committee, shall submit to the Governing Authority all recommendations for Medical Staff and Allied Health Professional reappointment and/or clinical reprivileging. The recommendations of the Executive Committee shall be derived, in part, from the recommendations of the Credentialed and Privileging Review Committee, who will review and reappraise the individual based on information collected. Information collection shall include the required two-year NPDB query, re-verification of current professional licensure from the appropriate State Medical Board(s), query of the OIG-LEIE and adherence to these Bylaws, the Rules and Regulations and Medical Staff Organization policies. Additional information collection shall include statements regarding the applicant's current ability to perform privileges (health status), training and experience (continuing education specifically related to privileges being requested), and current competence (professional performance, judgment and clinical/technical skills as assessed by his/her supervisor and as indicated by the results of ongoing professional practice evaluations and other Medical Staff monitors and peer review activities). A Medical Staff peer reference shall also be required, when the Service Medical Director or other supervisor is not a clinical peer. In the case of Allied Health Professionals, the physician collaborator shall also provide a reference or assessment of professional performance, judgment and clinical/technical skills, if s/he is not the supervisor. Applications for reappointment and/or reprivileging shall be acted upon prior to expiration of current appointment and/or privileges. Medical Staff and Allied Health Professional reappointment and/or reprivileging shall be for a period of no more than two (2) years.

All applicants seeking reappointment and/or reprivileging within the Active, Associate or Affiliate Medical Staff Category or Allied Health Professional Staff Category must have exercised all privileges held at least once every three months from date of last appointment (excepting applicants formally granted medical, family or other leave of absence or applicants who are assigned by the Chief Medical Officer or his/her designee to provide vacation coverage on an as needed or seasonal basis) or s/he shall not be considered eligible for reappointment and/or reprivileging within those privilege areas that have not been utilized with sufficient frequency to allow for the required performance and current competency assessments. Applicants who do not utilize privileges held at least once every three months shall remain in good standing, as appropriate, upon expiration of such privileges. S/he shall remain eligible to reapply for appointment and/or such privileges should s/he so desire, and it is evident that s/he will be able to exercise such privileges with the required minimum frequency, and a current need and position vacancy in his/her specialty exists.

Failure without good cause to timely submit a completed application for reappointment shall result in automatic termination of the Medical Staff or Allied Health Professional member's membership and privileges upon expiration of the current appointment period.

3.9 Clinical Privileges. All individuals permitted by law and by the MCBHD (as specified under sections 3.1 through 3.5 of these Bylaws) to provide patient care services independently, or dependently under the direction of a Medical Staff Member when privileging is recommended, shall have hospital specific delineated clinical privileges, whether or not they are members of the Medical
Staff of the MCBHD. Physicians, Dentists, Podiatrists, Psychologists and Allied Health Professionals who are not staff members but who meet the above independent practice definition, may request privileges through the Medical Staff by submitting a written request to the Chief Medical Officer or designee, who will review credentials and transmit the application to the appropriate Service Medical Director and to the Chief Psychologist, when applicable, and to the Credentialing and Privileging Review Committee.

3.9.1 The delineation of an individual's clinical privileges includes the limitations, if any, on the individual's privileges to treat patients or direct the course of treatment for the conditions for which the patient was admitted. Each patient cared for shall have a physical examination and/or medical history documented by a physician or authorized designee, such as an advanced practice nurse, privileged to perform such.

The physical examination shall include a thorough medical history and physical examination with all indicated laboratory examinations required to discover all structural, functional, systemic and metabolic disorders, and performance of a screening neurological exam. History shall include patient's past physical disorders, head trauma, accidents, substance dependence/abuse, exposure to toxic agents, tumors, infections, seizure or temporary loss of consciousness or headaches, and past surgeries. Screenings shall include a complete neurological exam, when indicated (i.e., system review indicates positive neurologic symptomatology); a record of mental status; the onset of illness and circumstances leading to admission; attitudes and behavior; an estimate of intellectual functioning, memory functioning and orientation; and an inventory of the patient's assets in a descriptive fashion. More than one practitioner may participate in the performance, documenting and authentication of a history and physical for a single patient. The authenticating practitioner(s) shall be responsible for its content. All procedures requiring surgery or anesthesiology shall require a history and physical update prior to the procedure.

If a physical examination was completed within 30 days of the patient's admission (or readmission), an update examination to document any changes in patient's condition is required within 24 hours after admission or re-admission. If the examining practitioner finds no change in the patient's condition since the history and physical was completed, s/he shall indicate in the patient's record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed. However, any noted changes in the patient's condition must be documented in an update note and placed in the patient's record within 24 hours after admission (per DHS 124.14(3)(c)(2) and CMS 482.22(c)(5)(ii)).

3.9.2 Clinical privileges to dentists shall be limited to outpatient activities only and must be specifically defined. Each patient cared for by a dentist must have a physical examination entered into the medical record by a physician, certified nurse practitioner or physician's assistant: staff member. The dentist shall perform the part of his or her patient's history and physical examination that relates to dentistry. All procedures requiring surgery or anesthesiology shall require a history and physical update prior to the procedure.

3.9.3 Clinical privileges to podiatrists shall be limited to outpatient activities only and must be specifically defined. Each patient cared for by a podiatrist must have a physical examination entered into the medical record by a physician, certified nurse practitioner or physician's assistant staff member. The podiatrist shall perform the part of his or her patient's history and physical examination that relates to podiatry. All procedures
requiring surgery or anesthesiology shall require a history and physical update prior to the procedure.

3.9.4 Clinical privileges to allied health professionals must be specifically defined and shall be limited to activities within the individual's assigned service/program or to service provisions defined within a provider's service contract. Independent Allied Health Professional practice is permitted only in Hospital approved programs and services and must be in collaboration with the service(s)/program(s) Medical Director and/or attending physician(s). Certified nurse practitioners and physician's assistants may perform patient histories and physical examinations.

3.9.5 In an emergency, any Medical Staff member or Allied Health Professional who has clinical privileges is permitted to provide any type of patient care necessary as a life-saving measure or to prevent serious harm, regardless of his or her Medical Staff status or clinical privileges, provided that the care provided is within the scope of the individual's license.

3.10 **Revised Clinical Privileges.** The Credentialing and Privileging Review Committee shall review all applications and supporting documentation to revise or amend current privileges. Applicants are required to submit documentation as to licensure (including certifications, registrations, as applicable), training and experience, current competence and ability to perform privileges requested. All requests to revise privileges shall require primary source (or equivalent primary source) verification of required training, primary source re-verification of required license(s), registrations and/or certifications, a new NPDB query and OIG-LEIE query. Requests shall be acted upon by this committee within 90 days upon completion of the verification of the applicant's credentials and current ability to perform the privilege requested, and this committee shall recommend to the Executive Committee of the Medical Staff that the application and request for revised clinical privileges be accepted, deferred or rejected. When a recommendation to defer is made, the Credentialing and Privileging Review Committee must follow-up within 60 days with a final recommendation of acceptance or rejection to the Executive Committee. All clinical privilege revisions shall be subject to a provisional period of at least six (6) months and shall require a focused audit demonstrating satisfactory practitioner performance prior to advancing from provisional to full privilege status.

3.11 Reapplication After Adverse Action.

3.11.1 A Medical Staff Member or Allied Health Professional who has received a final adverse professional review action regarding appointment or clinical privileges or both, and who did not exercise any of the hearing rights provided in Appendix II or Appendix III, shall not be eligible to reapply for the membership category or privileges that were subject of the adverse action for a period of one (1) year from the date of the final adverse action.

3.11.2 A Medical Staff Member or Allied Health Professional who has received a final adverse professional review action regarding appointment or clinical privileges or both, and who exercised some or all of the hearing rights provided under Appendix II or Appendix III, shall not be eligible to reapply for the membership category or privileges that were the subject of the adverse action for a period of two (2) years from the date of final adverse action.
3.12 Leave of Absence and Reappointment.

3.12.1 Any member of the Active or Associate Medical Staff or Allied Health Professional who will be absent for a period of time exceeding twelve (12) weeks must provide written notification to the President of the Medical Staff and Chief Medical Officer which may be done through Medical Staff Services as designee for both. Such notification shall state the start and, if known, anticipated end date of the leave and the reasons for the leave (e.g., military duty, additional training, family matters, or personal health). The Medical Staff Member or Allied Health Professional shall be responsible for arranging for coverage with his or her Service Medical Director during the leave. If the practitioner fails to return following the last day of the approved leave (including any extension granted up to the end of the current term of appointment), and does not reapply as described below, the practitioner shall be considered to have resigned his or her membership and/or clinical privileges and shall not be entitled to any hearing or appellate review. A request for appointment to the Medical Staff or Allied Health Professional Staff and clinical privileges subsequently received from a practitioner so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointment.

3.12.2 Upon timely return from leave of absence prior to expiration of the practitioner’s then current appointment period, the practitioner shall be required to submit a written request for reinstatement to the Credentialing and Privileging Review Committee. The practitioner may be required to submit such additional information as may be relevant to his/her request for reinstatement, including interval status information. Reinstatement of membership and privileges following a leave of absence may be granted subject to monitoring and/or a provisional period, when determined to be appropriate and recommended. The Credentialing and Privileging Review Committee will review the request and submit their recommendations to the Medical Staff Executive Committee. Thereafter, the process described for reappointment shall be followed.

3.12.3 A leave of absence may not extend beyond the term of the Medical Staff Member’s or Allied Health Professional’s current term of appointment. If the practitioner is not able to return from leave before his/her current appointment period and/or clinical privileges are set to expire but has submitted an application for reappointment and/or renewal of clinical privileges, action on the application will be deferred for up to two (2) years until the practitioner identifies, with reasonable certainty, the date of anticipated return from leave. Deferring the application due to continued leave of absence shall not give practitioners any rights to hearing or appeal. The practitioner will then be required to supply interval data through the date of the notice of anticipated return from leave to begin the reappointment process. The practitioner’s membership and/or clinical privileges shall be considered expired between the time of expiration of the term in which the leave began and the date of reappointment.

3.13 Impaired Practitioners.

3.13.1 Because it is inevitable that from time to time, some Medical Staff Members and Allied Health Professionals will develop physical or mental conditions that may limit their ability to safely exercise the clinical privileges they have been granted, it shall be the responsibility of all Medical Staff and Allied Health Professionals to bring to the attention of the Chief Medical Officer or his/her designee or the President of the Medical Staff, such conditions. Refer to Medical Staff Policy on Health and Welfare Ad Hoc Committee Responsibilities.
3.13.2 If, as a result of a practitioner's self-reporting of a condition, the Medical Staff Executive Committee recommends modification of status or privileges, the affected practitioner shall be notified, in writing, of the recommendation. The recommendation shall not be considered a professional review action, if the practitioner voluntarily accepts the recommendation. If the Medical Staff Executive Committee recommends modifications of appointment status or privileges due to the practitioner's condition initially discovered by means other than self-reporting, such recommendation shall constitute a professional review action without regard to whether or not the practitioner exercises the hearing rights under Appendix II or Appendix III.

3.14 Ethics and Ethical Relationships.

3.14.1 The Code of Ethics as adopted by the professional organizations of each member profession shall govern the professional conduct of the membership of the Medical Staff and all individuals privileged by the Medical Staff.

3.14.2 Medical Staff and Allied Health Professionals shall sign a statement prior to appointment and/or privileging indicating an understanding of the requirement to observe the ethical principles of their profession as well as those of the Milwaukee County Behavioral Health Division.

3.14.3 The Behavioral Health Division and Governing Authority shall take steps to protect and ensure the integrity of clinical decision making of all members of the Medical Staff and privileged Allied Health Professional Staff. Medical Staff and independent Allied Health Professional clinical decisions shall be autonomous and based solely on identified needs of the patient, regardless of their ability to pay. Dependent Allied Health Professionals shall consult with and defer to their supervising physician or the unit/program/service attending physician regarding clinical decisions, as appropriate. Medical Staff and Allied Health Professional clinical decisions shall be protected from financial issues or influences such as compensation, incentives or financial risk. Ethical conflicts related to patient care decisions may be referred to the Ethics Committee.

4.0 ARTICLE IV – APPOINTMENT CATEGORIES

4.1 Active Medical Staff.

The Active Medical Staff shall consist of fully licensed physicians who are full or part-time employees of, or on contract with the Milwaukee County Behavioral Health Division who function as the primary attending Medical Staff or actively assume clinical responsibility as part of the primary treatment team, including, where appropriate, emergency service care, consultation assignments, and supervisory assignments. Members of the Active Medical Staff shall be eligible to vote, to hold office, and to serve on all Medical Staff committees. Those physicians or psychologists who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing or level of training, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the Active staff for a period recommended by the Credentialing and Privileging Review Committee.
4.2 Associate Medical Staff.

The associate Medical Staff shall consist of fully licensed psychologists who are full or part-time employees of, or on contract with the Milwaukee County Behavioral Health Division that have clinical responsibility as part of the primary treatment team, including, where appropriate, inpatient service care, emergency service care, ambulatory service care, consultation assignments, and supervisory assignments. Members of the associate Medical Staff shall be eligible to vote, to hold member-at-large positions, and to serve on Medical Staff committees. Those psychologists who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing or level of training, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the Active or Associate staff for a period recommended by the Credentialing and Privileging Review Committee.

4.2 Affiliate Medical Staff.

The affiliate Medical Staff shall consist of fully licensed physicians, dentists, podiatrists and psychologists who do not function as a primary attending Medical Staff or actively assume clinical responsibility as part of the primary treatment team. They shall be employed in a manner consistent with their professional preparation and qualifications within the overall plan of the Behavioral Health Division and be subject to the Bylaws and Rules and Regulations of the Medical Staff that are applicable to their profession. Members of the Affiliate Medical Staff shall not be eligible to vote, hold office, or serve on the Medical Staff Credentialing and Privileging Review Committee or Peer Review Committee. They may serve on the Executive Committee of the Medical Staff. Those physicians, dentists, podiatrists or psychologists who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing or level of training, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the Active or Associate Medical Staff for a period recommended by the Credentialing and Privileging Review Committee.

4.3 Consulting Medical Staff.

The consulting Medical Staff shall consist of fully licensed physicians, dentists, podiatrists and psychologists who may treat patients at the Behavioral Health Division, or who are only engaged in consultation with members of the Medical Staff such as for special cases or procedures, or to conduct research or for teaching and/or lecturing to medical students, psychiatric residents and fellows and/or psychology interns and fellows. The consulting Medical Staff will include those physicians, dentists, podiatrists or psychologists who do not wish to accept a regular Active or Associate appointment. Members of the consulting Medical Staff are not eligible to vote, hold office, or serve on the Medical Staff Credentialing and Privileging Review Committee or Peer Review Committee. They may serve on the Executive Committee of the Medical Staff. Appointment to the consulting Medical Staff may be with or without privileges.

4.4 Telemedicine Consulting Medical Staff.

The Telemedicine Consulting Medical Staff shall consist of fully licensed physicians who may treat patients at the Behavioral Health Division via an electronic link, but who are mainly engaged in consultation with members of the Medical Staff by providing radiological or cardiology interpretive services. Members of the Telemedicine Consulting Medical Staff shall be eligible for
Medical Staff membership but do not have the rights and privileges of a member of the Medical Staff to vote or to hold office or serve on committees.

4.5 Community Affiliate Medical Staff.

The community affiliate Medical Staff shall consist of fully licensed physicians and psychologists who are engaged in community practice in conjunction with an MCBHD Community Access to Recovery Services contracted service provider. Community affiliate Medical Staff are involved in the care and treatment of behavioral health clients and have need to engage in consultation with members of the MCBHD Active, Associate or Affiliate Medical Staff. The community affiliate medical staff will include those physicians and psychologists who do not meet criteria for Active, Associate or Affiliate Staff appointment. Members of the community affiliate Medical Staff are not eligible to vote, hold office, or serve on Medical Staff committees. Appointment to the community affiliate Medical Staff may be with or without privileges.

4.6 Allied Health Professional Staff.

The allied health professional staff shall consist of fully licensed and certified Advanced Practice Nurses, Physician's Assistants, Optometrists or other licensed independent practitioners other than physicians, psychologists, dentists or podiatrists who are allied with the Medical Staff and who are permitted by law and by the hospital to practice independently or dependently. Allied health professional staff may be full or part-time employees, or employed by a Medical Staff Member on contract or independent contractors or employed by a Medical Service Contractor whose services have been authorized by Milwaukee County for the Milwaukee County Behavioral Health Division. Members of the allied health professional staff shall not be eligible for Medical Staff membership and do not have the rights and privileges of a member of the Medical Staff to vote or to hold office. Those allied health professionals who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the Active or Affiliate Medical Staff for a period recommended by the Credentialing and Privileging Review Committee.

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*Subject to eligibilities as described under Section 5.0 Article V – Officers and Medical Administration
 Appointment Amendment.

A Medical Staff Member may, at any time, request modification of his/her staff category by submitting a written request. All Medical Staff appointments are subject to the eligibility criteria, as described in sections 4.1 through 4.5.

5.0 ARTICLE V - OFFICERS AND MEDICAL ADMINISTRATION

5.1 Officers and Members-At-Large

The officers of the Medical Staff shall be the President of the Medical Staff Organization and the Vice-President of the Medical Staff Organization. The officers and members-at-large shall be elected biennially at a pre-determined meeting of the Medical Staff Organization or through a time-limited electronic ballot process, when more feasible, and shall hold office for the designated term or until a successor is elected. Each officer must be a member of the Active Medical Staff in good standing and shall have satisfactorily completed the requisite initial provisional appointment and privilege period. For the positions of President and Vice-President of the Medical Staff Organization, the candidate must be either a physician, dentist or podiatrist. The Chief Medical Officer and Chief Psychologist shall not be eligible to hold office.

There shall also be four (4) Members-At-Large positions. The qualifications for these positions are that each Member-At-Large must be a Member of the Active or Associate Medical Staff in good standing and shall have satisfactorily completed the requisite initial provisional appointment and privilege period.

5.1.1 The President shall be elected for a two year term. S/he shall preside at meetings of the Medical Staff Organization and be Chairperson of the Executive Committee of the Medical Staff. S/he may delegate specific duties to the Vice-President of the Medical Staff Organization. The President may be re-elected to that office to succeed himself/herself for one additional term.

5.1.2 The Vice-president of the Medical Staff Organization shall be elected for a two year term. S/he shall act in the event of any absence of the President, and when acting in this capacity, s/he shall assume all the duties, responsibilities, and authority of the President. S/he shall be responsible for keeping complete minutes of all general Medical Staff Organization meetings, Executive Committee meetings and meetings on order of the President. S/he shall make recommendations to the Executive Committee concerning dues assessments, as necessary, and shall be accountable for all funds of the Medical Staff, and s/he shall report on receipts and disbursements of such funds. The Vice-President of the Medical Staff Organization may be re-elected to that office to succeed himself/herself for one additional term. In the event that the office of the President becomes permanently vacant, the Vice-President of the Medical Staff Organization shall succeed to the Presidency for the remainder of the term and a new Vice-President of the Medical Staff Organization shall be elected. In the event that a Vice-President of the Medical Staff Organization is unable to carry out his/her duties, a special election shall be held to fill his/her office.

5.1.3 The Member-At-Large Quality Advisor shall be elected for a two year term. S/he shall be responsible for oversight of quality processes throughout MCBHD and shall work closely with the Chief Medical Officer and Quality Management Services on projects that improve
quality and support the reduction of medical/healthcare errors and other factors that could contribute to unintended adverse patient outcomes. S/he shall serve on the Medical Staff Peer Review Committee for process oversight in an ex-officio capacity, without vote, serve on hospital administrative quality committees and make recommendations to the Executive Committee and Quality Council on such matters. The Member-At-Large Quality Advisor may be re-elected to that office to succeed himself/herself. There shall be no restriction on the number of terms that s/he may serve. In the event that a Member-At-Large Quality Advisor is unable to carry out his/her duties, a special election shall be held to fill his/her.

5.1.4 The Member-At-Large physician position is to represent the physician community at the Medical Staff Executive Committee. There shall be one physician Member-At-Large. She/he shall serve for a two-year term. There shall be no restriction on the number of terms that a Member-At-Large may serve. In the event that a Member-At-Large is unable to carry out his/her duties, a special election shall be held to fill his/her seat on the Medical Staff Executive Committee.

5.1.5 The Members-At-Large psychologist positions are to represent the psychology community at the Medical Staff Executive Committee. There shall be two psychologist Members-At-Large. Each Member-At-Large shall serve for a two-year term. One election shall take place each year, with commencement of one position beginning on January 1 (even years) and the second on January 1 (odd years). There shall be no restriction on the number of terms that a Member-At-Large may serve. In the event that a Member-At-Large is unable to carry out his/her duties, a special election shall be held to fill his/her seat on the Medical Staff Executive Committee.

5.2 Election and Removal of Officers and Members-At-Large.

5.2.1 Election of the President and the Vice-President of the Medical Staff Organization shall take place at the November meeting of the Medical Staff Organization that directly precedes the expiration of the term of the offices (even years). Office terms shall be for two years beginning January 1 (odd years). Election of the Officers shall be by the Active and Associate Medical Staff.

Election of the Member-At-Large Quality Advisor shall take place at the November meeting of the Medical Staff Organization that directly precedes the expiration of the term of office (odd years). The office term shall be for two years beginning January 1 (even years). Election of the Member-At-Large Quality Advisor shall be by the Active and Associate Medical Staff.

Election of the first Member-At-Large physician shall take place at the November 2018 meeting of the Medical Staff Organization and shall take place thereafter at the November meeting that directly precedes the expiration of the term of office (even years). The office term shall be for two years beginning January 1 (odd years). Election of the Member-At-Large physician shall be by the Active Medical Staff.

There shall be one Member-At-Large psychologist election held each year at the November meeting of the Medical Staff Organization and each Member-At-Large term shall be for two years. Election of the Members-At-Large shall be by the psychology members of the Associate Medical Staff.
Special elections shall be held within sixty days for elected positions vacant due to disability, ineligibility, or unavailability. Elections shall be by simple majority vote, including absentee ballots. Elections may be held at a regular or special meeting of the Medical Staff Organization or may be conducted outside of a meeting by ballot, including electronic means, as directed by the President of the Medical Staff.

When only one nomination is put forth for a Member-At-Large position, the President of the Medical Staff may appoint that nominee to the vacant Member-At-Large position and shall communicate such appointment to the Medical Staff Organization.

5.2.2 In the event that an officer is unable to carry out his/her duties, and following a review by the Peer Review Committee or Credentialing and Privileging Review Committee, as appropriate, an officer may be removed from office by two-thirds majority vote of the Active and Associate Medical Staff. The removal of an officer shall be initiated by the joint recommendation of the Chief Medical Officer or designee and Chief Psychologist or designee or on written request of 25% or more of the voting members of the Medical Staff.

In the event that a Member-At-Large is unable to carry out his/her duties, the procedure for removal of Executive Committee members in section 5.3.1 of these Bylaws shall be followed.

5.3 Committees of the Medical Staff.

The committees of the Medical Staff shall be the Executive, Credentialing and Privileging Review, and Medical Staff Peer Review. The President of the Medical Staff shall have the right upon taking office to appoint Chairpersons in collaboration with the Chief Medical Officer and/or Chief Psychologist, as appropriate, and members unless specified otherwise in committee descriptions. The President of the Medical Staff and the Chief Medical Officer shall be Ex-Officio members of all Medical Staff committees, as well as any special ad hoc committees, if not appointed as regular members. For purposes of conducting business, a membership quorum with a physician majority must be present for all committees. If a quorum is not present, the chairperson may entertain a motion to recess, to fix the time to which to adjourn to allow selection of a new date and time, or to adjourn the meeting.

5.3.1 The Medical Staff Executive Committee.

The Medical Staff Executive Committee shall consist of the two elected officers of the Medical Staff, four Members-At-Large, the Chairperson of the Credentialing and Privileging Review Committee, the Chairpersons of the Medical Staff Peer Review Committee, the Chief Medical Officer, the Service Medical Directors, and the Chief Psychologist. A majority of voting Medical Staff Executive Committee members shall be fully licensed physicians within the Active Staff. Selection and appointment of Medical Staff members, in addition to the aforementioned automatic appointments, may be made upon the joint recommendation by the Chief Medical Officer, Chief Psychologist and Medical Staff President, subject to maintaining majority composition requirements, and shall be approved by the Committee. All members of the Medical Staff shall be eligible for membership on the Executive Committee. The Administrator, the Chief Nursing Officer and the Director of Medical Staff Services shall attend each meeting on an ex-officio basis. The President of the Medical Staff shall chair the Medical Staff Executive Committee. The Medical Staff Executive Committee has the primary authority for activities related to self-
governance of the Medical Staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners privileged through the Medical Staff process. Functions of the Medical Staff Executive Committee shall be as follows:

1. it shall be empowered to act for and represent the Medical Staff in the intervals between the general Medical Staff Organization Meetings. Such authority shall include the review, and recommendations for amendment of Medical Staff Bylaws and Rules and Regulations, the assessment of dues, and development, review, amendment and adoption of Medical Staff policies and procedures that form the system of rights, responsibilities, and accountabilities between the organized Medical Staff and the Governing Authority and between the organized Medical Staff and its members;

2. it shall review and make Medical Staff committee appointments and Medical Staff committee chairperson appointments at the first meeting of each year, and at any other time it is deemed necessary;

3. it shall receive quarterly reports from the hospital-wide Quality Improvement Program and shall concern itself with programmatic, departmental and support service quality improvement activities as well as the results and corrective actions taken from such activities;

4. it shall concern itself with all matters affecting the delivery and quality of professional services and medical services in the hospital, the organization of the Medical Staff, and with reports and recommendations from the Credentialing and Privileging Review Committee, the Medical Staff Peer Review Committee, and any hospital committees or services that recommend actions that impact individuals with privileges;

5. it shall ensure Medical Staff representation and participation in any hospital deliberation affecting the discharge of Medical Staff responsibilities;

6. it shall ensure Medical Staff representation for the opportunity to participate and provide advice in any hospital leadership deliberation concerning the selection of medical services to be provided through a contractual arrangement (e.g., laboratory, radiological, pharmacy, rehabilitative, etc.) and in the selection of any medical or clinical staffing contractual arrangements (e.g., for dentists, podiatrists, physicians, psychiatrists, psychologists, advanced practice nurses, optometrists, physician's assistants or any other licensed independent practitioners (LIPs) or non-LIPs if privileges are required);

7. it shall provide liaison between the Medical Staff, the Chief Medical Officer, and the Administrator of MCBHD as well as the Governing Authority;

8. it shall ensure that the Medical Staff is kept abreast of the accreditation/ regulatory compliance program and informed of the accreditation status of the hospital, and it shall direct the Medical Staff concerning its responsibilities in this area;

9. it shall coordinate the activities and policies governing the Medical Staff;
10. it shall communicate with the Allied Staff (defined in the Preamble of these Bylaws) through acceptable mechanisms as determined by their respective Clinical Discipline Heads and through mechanisms as determined by the appropriate Service Administrator for those Allied Staff who are not members of discipline departments;

11. it shall make recommendations directly to the Governing Authority for its approval, on matters relating to the following and other matters, as relevant:
   a. the structure of the Medical Staff;
   b. the participation of the Medical Staff in organization performance-improvement activities;
   c. the mechanisms used for evaluating individual professional practice;
   d. the mechanism used to review credentials and to delineate individual clinical privileges;
   e. recommendations of individuals for Medical Staff membership;
   f. recommendations for delineated clinical privileges for each eligible individual;
   g. the mechanism by which membership on the Medical Staff may be terminated;
   h. the mechanism by which clinical privileges may be terminated;
   i. the mechanism for fair hearing procedures; and
   j. other medical-administrative matters including sentinel events;

12. it shall take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of Medical Staff Members and Allied Health Professional Staff and shall request evaluation, by an appropriate body, in instances where there is doubt about an applicant’s ability to perform privileges requested or privileges currently granted;

13. it shall review the Medical Staff Bylaws and Rules and Regulations at least every two years and make recommendations for revisions, as necessary, and shall review Medical Staff policies and procedures at least every three years and make revisions, as necessary;
   a. if the voting members of the Medical Staff Organization propose to adopt a rule, regulation or policy or an amendment thereto, they first communicate the proposal to the Medical Staff Executive Committee;
   b. if the Medical Staff Executive Committee proposes to adopt a rule, regulation or an amendment thereto, they first communicate the proposal to the Medical Staff;
   c. when the Medical Staff Executive Committee adopts a policy or an amendment thereto, they shall communicate this to the Medical Staff Organization;
d. In cases of documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the Medical Staff Executive Committee may provisionally adopt and the Governing Authority may provisionally approve an urgent amendment without prior notification of the Medical Staff. The Medical Staff shall be notified and have opportunity for retrospective review and comment on the provisional amendment. If there is no conflict between the Medical Staff Organization and the Medical Staff Executive Committee, the provisional amendment shall stand.

e. There shall be a defined process to manage and resolve conflicts between the Medical Staff and the Medical Staff Executive Committee regarding proposals to adopt Rules, Regulations, policies, or procedures of the Medical Staff Organization. Such conflicts may be identified by a petition signed by at least 25% of the members of the Active and Associate Medical Staff. When such conflicts are identified, the President of the Medical Staff must call a special meeting of the Medical Staff Organization, as provided in section 6.2 of these Bylaws. The sole issue for any such special meeting will be discussion of the issue in conflict, which shall be resolved as provided in Section 6.2 of these Bylaws. The MCBHD Conflict Management policy and procedure shall be utilized for conflict between the Governing Authority and the Medical Staff and for all other issues of significant importance to the Medical Staff. Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Governing Authority on a rule, regulation, or policy adopted by the Medical Staff Organization or the Medical Staff Executive Committee. The Governing Authority shall determine the method of communication. No conflict management or dispute resolution process can amend the Medical Staff Bylaws, Rules and Regulations, or policies of the Medical Staff Organization. Bylaws, rules, regulations and policy amendments proposed as a result of a dispute management process must be acted upon by the Medical Staff and Governing Authority, in accordance with the requirements of these Bylaws.

f. The process for managing and resolving disputes or conflict between the Medical Staff Executive Committee and the Governing Authority shall be in accordance with the Governing Authority Conflict Management policy and procedure.

14. It shall receive and act on reports and recommendations from Medical Staff committees, hospital committees, clinical services, and assigned activity groups and make recommendations directly to the Governing Authority;

15. The Administrator or designee shall attend each Executive Committee Meeting on an ex-officio basis and may vote if s/he is a member of the Medical Staff;

16. It shall assure the provision of a single level of care to all patients, irrespective of the staff providing the care, by means of institution-wide and program specific standards of care, policies and procedures, monitors and corrective actions.

The Executive Committee shall meet as often as needed, but at least ten times per year, to represent the Medical Staff in the intervals between the general Medical Staff Organization meetings. All meetings shall be documented and made available to the Medical Staff as a whole. Regular attendance by all Committee members is expected.
the event that a member is unable to or fails to carry out his/her duties, a member may be removed from the committee by two-thirds majority vote of the Executive Committee. The removal of a member shall be initiated, with cause cited, by the joint recommendation of any two members of the Executive Committee.

5.3.2 The Credentialing and Privileging Review Committee.

The Credentialing and Privileging Review Committee shall consist of at least six members of the Active and Associate Medical Staff to be comprised of a physician majority but with at least two psychologists. The Chairperson shall be a physician. The members and Chairperson shall be appointed by the President of the Medical Staff in collaboration with the Chief Medical Officer and Chief Psychologist. The Director of Medical Staff Services shall attend each meeting on an ex-officio basis. This committee shall be responsible for establishing credentialing and privileging requirements for each profession, in conjunction with recommendations from the Service Medical Directors and the Chief Psychologist, when applicable, subject to Medical Staff Executive Committee and Governing Authority approval, and for evaluating and recommending all applicants for Medical Staff appointment, privileging, reappointment, reprivileging and privilege revisions to the Medical Staff Executive Committee and for conveying all recommendations of the Medical Staff Executive Committee to the Governing Authority for approval. It shall further be responsible for the delineation of privileges, recommending promotions to Active Staff and other changes in appointment or privileges and for making recommendations thereon to the Executive Committee of the Medical Staff. It shall review credentials, reports and references, as well as reports and records from Peer Review, Medical Records, Quality Management, and other Medical Staff committees, when appropriate, in order to formulate its decisions and recommendations. It shall act as the review body for all matters involving medical staff professional behavior including, but not limited to, professional and personal conduct, professional ethics, compliance with established Medical Staff and hospital rules, regulations and policies that relate to professional conduct, and initiation of corrective action, when indicated. This committee shall further be responsible for carrying out the same or similar review activities and initiation of corrective action, when indicated, for Allied Health Professional Staff.

This committee shall meet as often as needed, but at least quarterly, and shall present written reports of all appointment and privileging recommendations, in summary fashion, to the Medical Staff Executive Committee, with notations reporting presented verbally and in closed session only. All meetings shall be documented. Records of reviews and conclusions shall be maintained in accordance with State and Federal laws governing confidentiality of information acquired in connection with the review and evaluation of a healthcare provider. Regular attendance by all members is expected. In the event that a member is unable to or fails to carry out his/her duties, a member may be removed from the committee by request of the Chairperson to the Medical Staff President and Chief Medical Officer and to the Chief Psychologist, as applicable.

5.3.3 Medical Staff Peer Review Committee.

There shall be a Medical Staff Peer Review Committee. A physician and a psychologist shall be selected to serve as Co-Chairpersons and shall be appointed by the President of the Medical Staff in collaboration with the Chief Medical Officer and Chief Psychologist, as appropriate. The Chairpersons shall select three additional physicians and two additional psychologists from the Active and Associate Medical Staff to serve as members. The Vice-
President of Quality shall serve ex-officio, without vote. This committee shall be responsible for carrying out quality improvement activities including, but not limited to, the review of clinical performance of members of their discipline to assess compliance with discipline established standards of practice, the review of Medical Staff monitors, compliance with established Medical Staff rules, regulations and policies that pertain to clinical performance, and initiation of corrective action, when indicated. This committee shall further be responsible for carrying out the same or similar review activities and initiation of corrective action, when indicated, for Allied Health Professional Staff. This committee may conduct a professional practice evaluation when questions arise through focused or ongoing professional practice evaluation activities, or through other mechanisms, regarding a practitioner’s quality of care, treatment and service, professional competence, clinical judgment, ability to perform privileges held, or when concerns regarding the provision of safe, high quality patient care are identified through clinical practice trends evidenced during the course of focused or ongoing professional practice evaluation or are triggered by single incident. In these instances, the committee shall assign one or more of its members to serve as peer investigator(s) for the specific practice concern. The Committee may consult with or seek assistance from other members of the Medical Staff or from an external source, in some circumstances, such as need for specialty review, when there are a limited number or no Medical Staff members within the required specialty or with the appropriate technical expertise on the Medical Staff or when the Medical Staff Peer Review Committee and/or Credentialing and Privileging Review Committee is/are unable to make a determination and requests an external opinion. Upon completion and committee discussion of the Investigator(s) findings, the committee shall make a recommendation as to whether or not any action is required. Recommendations may be that no action is warranted, a self-acknowledged action plan, education, an informal or formal time-limited improvement plan or referral to the Credentialing and Privileging Review Committee. . Whenever corrective action could result in consideration for reduction or suspension of clinical privileges, the Peer Review Committee shall forward its findings and recommendations to the Credentialing and Privileging Review Committee.

Ongoing professional review and required focused professional review activities associated with initial and provisional privileging may be delegated to members of the Medical Staff who are not members of this committee. All practitioners upon initial privilege approval or upon revised privilege approval shall be subject to a period of focused professional practice evaluation by his/her immediate supervisor or designee. Focused professional practice evaluation guidelines and evaluation monitors, for this purpose, shall be program or service specific and approved by the Medical Staff Peer Review Committee.

(Note: Per Wisconsin Stat. 146.37 Healthcare Services Review; civil immunity and 146.38 Healthcare Services Review; confidentiality of information and Title IV-Health Care Quality Improvement Act 42 U.S.C. sec 11111 et seq) Professional Review.

The Peer Review Committee shall meet as often as needed, but at least semi-annually, and shall report in statistical or summary fashion only to the Medical Staff Executive Committee. All meetings of the Peer Review Committee shall be documented. Records of reviews, inquiries, proceedings and conclusions shall be maintained in accordance with State and Federal laws governing confidentiality of information acquired in connection with the review and evaluation of a healthcare provider. Regular attendance by all members is expected. In the event that a member is unable to or fails to carry out his/her duties, a member may be removed from the committee at the discretion of the Co-chairpersons.
5.4 Committees (Other).

5.4.1 Joint Conference Committee.

The Joint Conference Committee shall consist of not less than two members of the Governing Authority, the Administrator or his/her designee, the Chief Medical Officer and the President of the Medical Staff (or the Vice-President as his/her designee). Additional participants shall be invited, as deemed appropriate.

The purpose of this committee shall be for periodic consultation and discussion of matters related to the quality of medical care provided to patients of the hospital.

This committee shall meet at least semi-annually but may convene more frequently, at the request of the Governing Authority or President of the Medical Staff, when issues of patient safety or quality of care are identified through quality assessment and performance improvement activities, as needing the attention of the Governing Authority in consultation with the Medical Staff. All meetings shall be documented including a list of attendees. [Note: required per CMS 482.32(e)(10)]

5.4.2 Nominating Committee.

The Nominating Committee shall consist of two physician members of the Active Medical Staff and one psychologist member of the Associate Medical Staff, selected by the Medical Staff at large at the May meeting of the Medical Staff Organization in the year when the biennial election of the President is scheduled (even years). The Nominating Committee shall serve as an ad hoc committee for a period of two years and shall reconvene, as necessary during the two year period for all other regularly scheduled elections or if should there be a need for a special election. Should there be a need to replace a member of the nominating committee, a new physician or psychologist, as appropriate, shall be selected by the Medical Staff at large at the next regular meeting of the Medical Staff Organization.

The Nominating Committee shall have the duty of preparing and presenting to the Medical Staff membership a slate of recommended candidates for the office(s) of the Medical Staff and the candidates for Member-At-Large at each meeting when an election is scheduled to take place or for any special election held. The Officers and Members-At-Large shall be nominated by any member of the Active or Associate Medical Staff.

5.4.3 Ad Hoc Committees.

Ad Hoc Committees, as recommended by the Medical Staff Executive Committee, shall be formed through appointment by the President of the Medical Staff to address Medical Staff issues not within the responsibilities of the Medical Staff committees.

5.5 Medical Administrative Organization.

The Medical Administrative Organization shall include the positions of Chief Medical Officer, the Service Medical Directors (Adult Inpatient, Child and Adolescent, Crisis, Community and Physical Care Services) and the Chief Psychologist.
All Medical Directors shall be certified by an appropriate specialty board or affirmatively establish comparable competence through the credentialing process. The Chief Psychologist shall be certified by an appropriate psychology board or affirmatively establish comparable competence through the credentialing process. All Medical Directors and the Chief Psychologist, as applicable to psychological services, shall be responsible or collaboratively responsible with Service Administrator(s) for the following, as appropriate to position and function within his/her MCBHD service:

1. all clinical related activities of his/her department;
2. administratively related activities of the department;
3. continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
4. recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;
5. recommending clinical privileges for each member of the department;
6. assessing and recommending to the Administrator and/or Governing Authority off-site sources for needed patient care, treatment and services not provided by the department or MCBHD;
7. integration of the department into the primary functions of the organization;
8. the coordination and integration of inter-departmental and intra-departmental services;
9. the development and implementation of policies and procedures that guide and support the provision of care, treatment and services;
10. recommending sufficient numbers of qualified and competent persons to provide care, treatment or service;
11. determining qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;
12. the continuous assessment and improvement of the quality of care, treatment and services provided;
13. the maintenance of quality control programs, as appropriate;
14. the orientation and continuing education of all persons in the department; and
15. recommendations for space and other resources needed by the department.

5.5.1 Additional authority and responsibilities to the Medical Staff Organization shall be as follows:
1. serve as a voting member of the Medical Staff Executive Committee;

2. chair and/or serve on other Medical Staff committees, as appointed

3. be responsible for the Medical Staff Organization’s adherence to State and Federal regulations as well as the monitoring and evaluation of required standards and shall work in conjunction with the Medical Staff Organization and MCBHD to facilitate compliance;

4. formulate recommendations for rules, policies and responsibilities reasonably necessary for proper discharge of Medical Staff and service responsibilities, subject to the approval of the Medical Staff Executive Committee and Governing Authority, when appropriate; and

5. request, through the President, that special meetings of the Medical Staff Organization be called, when deemed necessary for the proper clinical functioning of the MCBHD.

6.0 ARTICLE VI – MEETINGS

6.1 Regular Meetings and Agenda.

There shall be general meetings of the full Medical Staff Organization held at least quarterly. The agenda at each of these meetings shall be:

1. call to order;

2. reading of the minutes of the last regular meeting and of any special meetings held during the quarter and approval of said minutes;

3. unfinished business;

4. report from the Medical Staff Executive Committee regarding activities and actions including the results of Medical Staff and hospital quality management monitors and follow-up;

5. reports from chairpersons of other Medical Staff committees;

6. reports from hospital committee chairpersons and by representatives from the various programs and services;

7. reports from the Vice President and Vice-President of Quality

8. reports from the Administrator and Chief Medical Officer;

9. new business; and

10. adjournment.

11. The last meeting of each calendar year shall be designated as the meeting at which election of officers and Members-At-Large shall occur in accordance with the office terms.
defined in section 5.1 of these Bylaws. Newly elected officers and Members-At-Large shall take office as of the first of the New Year after the election. This item will be added to the agenda, as appropriate.

6.2 Special Meetings and Agenda.

Special meetings of the Medical Staff Organization may be called at any time by the President, at the request of the Medical Staff Executive Committee, at the request of the Chief Medical Officer, at the request of the Governing Authority Chair and/or Administrator of MCBHD, or on written request of 25% or more of the voting members of the Medical Staff. Notification of a special meeting shall be published to the entire Medical Staff five days prior to the date set for the meeting.

The agenda at special meetings shall be limited to the reading of the notice calling the meeting, the transaction of only that business for which the meeting was called, and adjournment.

6.3 Attendance at Meetings.

**Active Medical Staff** - All Active Medical Staff are encouraged to attend all regularly scheduled quarterly meetings during each calendar year.

**Associate Medical Staff** - All Associate Medical Staff are encouraged to attend all regularly scheduled quarterly meetings during each calendar year.

**Affiliate Medical Staff** - may, but are not required to, attend meetings.

**Consulting Medical Staff** - may, but are not required to, attend meetings.

**Telemedicine Consulting Medical Staff** – may, but are not required to, attend meetings

**Community Affiliate Medical Staff** – may, but are not required to, attend meetings

**Allied Health Professional Staff** - may, but are not required to, attend meetings.

The Administrator, Chief Nursing Officer and Director of Medical Staff Services shall attend each meeting on an ex-officio basis.

Members of the Medical Staff, Allied Health Professional Staff and ex-officio attendees shall receive minutes from all regular and special meetings held. All Active Medical Staff and Associate Medical Staff shall be required to submit acknowledgement of receipt and review of information within the timeline designated.

6.4 Conduct of Meeting.

All meetings of the Medical Staff Organization and its Medical Staff committees shall be conducted according to the rules contained in "Roberts Rules of Order, Newly Revised" when they are appropriate and consistent with the Bylaws and Rules and Regulations of the Medical Staff.
7.0 ARTICLE VII - CORRECTIVE ACTION AND RIGHT OF APPEAL

7.1 Whenever the professional conduct or other activities of a Medical Staff Member are considered deviant from the standards or are inconsistent with the aims of the Medical Staff, corrective action may be initiated. The manner in which the corrective action shall be initiated, the responsibilities of the Executive Committee and Governing Authority in corrective action, the forms of suspensions, and mechanisms for reduction or termination of Medical Staff appointment and/or privileges are detailed in Appendix I and Appendix II of these Bylaws.

7.2 Whenever the professional conduct or other activities of an Allied Health Professional are considered deviant from the standards or are inconsistent with the aims of the Medical Staff, corrective action may be initiated. The manner in which the corrective action shall be initiated, the responsibilities of the Executive Committee and Governing Authority in corrective action, the forms of suspensions, and mechanisms for reduction or termination of Allied Health Professional appointment and/or privileges are detailed in Appendix I and Appendix III of these Bylaws.

8.0 ARTICLE VIII - HEARING AND APPELLATE REVIEW

8.1 Right to Hearing and to Appellate Review.

Whenever a Medical Staff Member or prospective Medical Staff Member is notified by the Credentialing and Privileging Review Committee of a recommendation that may adversely affect his/her Medical Staff appointment and/or clinical privileges, s/he shall be entitled to a hearing and appellate review, as outlined in Appendix II of these Bylaws.

Allied Health Professionals shall have a right to fair hearing but have no right to formal appellate review.

9.0 ARTICLE IX - RULES AND REGULATIONS

9.1 The Medical Staff Executive Committee shall adopt by a simple majority of quorum vote subject to physician majority of all voting members such Rules and Regulations as may be necessary for the proper conduct of its work. Members may vote by proxy, if not able to be present at a meeting where a vote is to take place. Amendments shall be communicated, considered and acted upon in accordance with Section 5.3.1, subsection 13 of these Bylaws. Amendments so made shall become effective when approved by the Governing Authority.

10.0 ARTICLE X - BYLAWS

10.1 Amendments.

All voting members of the Medical Staff Organization shall be given written notice of any proposed amendment to these Bylaws at least ten days prior to the meeting at which a vote is scheduled to take place. The affirmative vote of two-thirds of the voting membership subject to physician majority shall be required for adoption of the proposed amendment(s). Members may vote by proxy, if not able to be present at a meeting where a vote is to take place. An amendment vote may be held at a regular or special meeting of the Medical Staff Organization or
may be conducted outside of a meeting by ballot, including electronic means, as directed by the President of the Medical Staff. Amendments so made shall become effective when approved by the Governing Authority.

Proposed amendments to these Bylaws may be originated by the Medical Staff Executive Committee or by a petition signed by 25% or more members of the Active and Associate Medical Staff.

10.2 Adoption.

These Bylaws, together with the appended Rules and Regulations, shall replace any previous Bylaws and Rules and Regulations. They shall, when adopted and approved, be equally binding on the Governing Authority, Medical Staff and privileged Allied Health Professional Staff.

11.0 ARTICLE XI - DUES

11.1 Authority.

Dues, as determined by the Executive Committee of the Medical Staff, may be assessed to voting members of the Medical Staff.

11.2 Assessment.

All members of the Medical Staff Organization holding appointment within the Active or Associate Staff Category (voting members) shall be required to pay dues within 45 days of receiving an assessment.

1. All new applicants who apply for and are formally appointed to the Active Staff or Associate Staff on or before July 1 shall be required to pay dues during his/her initial appointment year, unless no dues are assessed for that year.

2. All new applicants who apply for and are formally appointed to the Active Staff or Associate after July 1 shall not be subject to a dues assessment until the following calendar year.

3. If a Medical Staff member is delinquent, payment of any outstanding dues assessment(s) must be made at time of application for reappointment or application shall be deemed incomplete.

11.3 Reporting.

In accordance with 5.0 Article V, Section 5.1.2, the Vice-president of the Medical Staff Organization shall be accountable for all funds of the Medical Staff. S/he shall report on receipts and disbursements of such funds to the Medical Staff Organization, at least annually. Dues accumulated within the treasury fund may be used for, but not limited to, the following purposes:

1. Bereavements
2. Birth/Adoption of child by Medical Staff Member
3. Awards/Recognitions/Appreciations – Individual or Group
4. Scholarships/Education
5. Medical Staff Organization gatherings/functions
6. Other events/circumstances deemed to be appropriate
APPENDIX I

CORRECTIVE ACTION:

Section 1.0 General Procedures:

1.1 Initiation of Corrective Action.

Whenever the activities or professional conduct of a Medical Staff Member or Allied Health Professional deviates from the standards, are inconsistent with the aims of the Medical Staff or are disruptive to the operations of the hospital, corrective action against such Medical Staff Member or Allied Health Professional may be requested by an officer of the Medical Staff, the Chief Medical Officer, a Service Medical Director or the Chief Psychologist, when applicable, or by the Administrator of MCBHD or Governing Authority Chair. Applicants have the burden of producing adequate information for proper evaluation of professional, ethical and other qualifications for membership and/or clinical privileges and for resolving any doubts about such qualifications. If an application is found to contain significant misstatements or omissions following appointment and/or privileging, this shall constitute cause for automatic relinquishment of membership and/or privileges with no right to hearing or appeal. All requests for corrective action shall be in writing, shall be made to the Peer Review Committee or Credentialing and Privileging Review Committee, as appropriate to the matter, and shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request. Appropriate Civil Service procedures shall be followed, when indicated.

1.2 Reduction or Suspension of Clinical Privileges.

Professional Competence. The Peer Review Committee shall conduct a thorough investigation of the charges against the Medical Staff Member or Allied Health Professional. Whenever the corrective action could result in a reduction or suspension of clinical privileges, the Peer Review Committee shall forward its findings and recommendations to the Credentialing and Privileging Review Committee. The Credentialing and Privileging Review Committee shall notify the affected Medical Staff Member or Allied Health Professional, in writing, that charges were filed against him/her.

Professional Conduct. The Credentialing and Privileging Review Committee shall conduct a thorough investigation of the charges against the Medical Staff Member or Allied Health Professional. Whenever the corrective action could result in a reduction or suspension of clinical privileges or appointment, the Credentialing and Privileging Review Committee shall notify the affected Medical Staff Member or Allied Health Professional, in writing, that charges were filed against him/her.
1.3 Credentialing and Privileging Review Committee Interview:

Within ten (10) days after the Credentialing and Privileging Review Committee’s receipt of Peer Review Committee findings or by its own findings, the committee shall present a report to the Medical Staff Executive Committee. Prior to the presentation of such report, the Medical Staff Member or Allied Health Professional against whom corrective action has been requested shall have an opportunity for an interview with the Credentialing and Privileging Review Committee. At such interview, s/he shall be informed of the general nature of the charges against him/her and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing and shall be preliminary in nature. A record of such interview shall be made by the Credentialing and Privileging Review Committee and included with its report to the Executive Committee.

1.4 Withdrawal of Initial Application for Medical Staff Appointment or Clinical Privileges:

A Medical Staff Member or Allied Health Professional may voluntarily withdraw his/her initial application for Medical Staff appointment or clinical privileges prior to a final action. Right to hearing and appellate review shall be forfeited at that time. Such withdrawals are generally not reportable to the National Practitioner Data Bank.

1.5 Withdrawal of Application for Renewal of Medical Staff Appointment or Clinical Privileges While Under Investigation:

A Medical Staff Member or Allied Health Professional who applies for renewal of Medical Staff appointment or clinical privileges and voluntarily withdraws that application while under investigation for possible professional incompetence, improper professional conduct, or in return for not conducting such an investigation or taking a professional review action, must be reported to the National Practitioner Data Bank.

1.6 Resignation While Under or to Avoid Investigation:

A physician Medical Staff Member who resigns his/her Medical Staff appointment and/or clinical privileges while under investigation for possible professional incompetence, improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action, must be reported to the National Practitioner Data Bank regardless of whether the physician was aware that they were under investigation. Non-physician Medical Staff Members and Allied Health Professionals may be reported to the National Practitioner Data Bank under these same circumstances, but it is not required.

1.7 A Medical Staff Member or Allied Health Professional that is reported to the National Practitioner Data Bank under the circumstances described under the aforementioned sections 1.5 or 1.6 has no right to hearing and appellate review procedures, as no professional review action was recommended or taken.
Section 2.0 Medical Staff Executive Committee Authority:

2.1 The action of the Medical Staff Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend: a.) reduction, b.) suspension or c.) revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that a Medical Staff Member's membership be suspended or revoked. Any recommendation by the Executive Committee for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff shall entitle the affected practitioner to the procedural rights provided in Appendix II (Hearing and Appellate Procedure: Medical Staff). Any recommendation by the Executive Committee for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion shall entitle the affected Allied Health Professional to the procedural rights provided in Appendix III (Fair Hearing and Appeal Procedure: Allied Health Professionals).

2.2 Responsibilities.

The President of the Medical Staff shall promptly notify the Administrator of MCBHD. in writing, of all requests for corrective action received by the Medical Staff Executive Committee and shall continue to keep the Administrator of MCBHD fully informed of all action taken. After the Medical Staff Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided in Appendix II or Appendix III of these Bylaws.
Section 3.0 Suspensions:

3.1 Summary.

Any one of the following—the President of the Medical Staff, the Chief Medical Officer, the Chief Psychologist (limited to psychologists), the Administrator, the chairperson of the Credentialing and Privileging Review Committee, or the Governing Authority Chair—shall each have the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition and amendment.

Circumstances which would lead to immediate summary suspensions would include any form of impairment while on duty, sexual misconduct with patients or other caregiver misconduct, conviction of a felony involving violence to others, or any other intentional act performed that endangers patient safety or is considered to be in clear violation of professional ethics.

3.2 Temporary.

A Medical Staff Member whose clinical privileges have been summarily suspended for a period of more than 14 days shall be entitled to request that the Credentialing and Privileging Review Committee of the Medical Staff hold a hearing on the matter. The failure of a Medical Staff Member to request a hearing, from the President of the Medical Staff or designee to which s/he is entitled by these Bylaws, within 30 days shall be deemed a waiver of his/her right to such a hearing and to any appellate review to which s/he might otherwise have been entitled on the matter under Appendix II of these Bylaws. The Credentialing and Privileging Review Committee may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the Credentialing and Privileging Review Committee does not recommend immediate termination of the summary suspension, the affected Medical Staff member shall be entitled to request an appellate review by the Governing Authority. The summary suspension, as sustained or as modified by the Credentialing and Privileging Review Committee, shall remain in effect pending a final decision by the Governing Authority.

An Allied Health Professional whose clinical privileges have been summarily suspended for a period of more than 14 days shall be entitled to request a meeting on the matter before two physicians and one peer, appointed by the President. The failure of an Allied Health Professional to request a meeting from the President to which s/he is entitled by these Bylaws, within (30) days shall be deemed a waiver of his/her right to such a fair hearing and to any appeal to which s/he might otherwise have been entitled on the matter in under Appendix III of these Bylaws.

3.3 Automatic.

A temporary suspension in the form of a withdrawal of a Medical Staff Member's or Allied Health Professional's clinical privileges, effective until medical records are
completed, shall be imposed automatically seventy-two (72) hours after final warning of de inquency for failure to complete medical records within the time allotted by the hospital. Notification of such suspension to the Medical Staff Member or Allied Health Professional and appropriate hospital authorities shall be made by the Chief Medical Officer or designee.

Action by the State Board of Examiners revoking or suspending a Medical Staff Member's or Allied Health Professional's license, or placing him/her on probation, or failure by a Medical Staff Member or Allied Health Professional to maintain current professional licensure shall automatically suspend all of his/her hospital privileges.

Action by the federal Drug Enforcement Administration revoking or suspending a Medical Staff Member's or Allied Health Professional's registration or placing him/her on probation, or failure by a Medical Staff Member or Allied Health Professional to maintain registration, when required, shall automatically suspend his/her prescriptive authority. Automatic suspension of all hospital privileges shall be considered whenever circumstances warrant.

Action by Medicare/Medicaid resulting in exclusion or suspension from participating in these programs or becoming subject to conviction or offense under DHS 12 Wisconsin Caregiver Laws shall automatically suspend all of his/her hospital privileges.

It shall be the duty of the President of the Medical Staff to cooperate with the Administrator of MCBHD in enforcing all automatic suspensions.
APPENDIX II

HEARING AND APPELLATE REVIEW: PROCEDURE (MEDICAL STAFF)

Section 1.0    Right to Hearing and to Appellate Review:

1.1    Whenever a Medical Staff Member or Medical Staff privilege applicant receives a notice of a recommendation by the Credentialing and Privileging Review Committee which, if approved by decisions of the Medical Staff Executive Committee and the Governing Authority, will adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges or is summarily suspended for a period of more than 14 days, s/he shall be entitled to a hearing before the Medical Staff Executive Committee. If the recommendation of the Medical Staff Executive Committee following such hearing is still adverse to the affected practitioner, s/he shall then be entitled to an appellate review by the Governing Authority before s/he makes a final decision on the matter.

Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Appendix II of these Bylaws because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

1.2    When any Medical Staff Member receives notice of a decision by the Governing Authority that will affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges and such decision is not based on a prior adverse recommendation by the Credentialing and Privileging Review Committee of the Medical Staff, s/he shall be entitled to a hearing. Such hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the Active or Associate Medical Staff who are discipline peers appointed by the Chair of the Credentialing and Privileging Review Committee, and one of the members so appointed shall be designated as Chairperson. No Medical Staff Member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee. If such a hearing does not result in a favorable recommendation, s/he shall be entitled to an appellate review by the Governing Authority, before a final decision on the matter is made.

1.3    All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Appendix II to assure that the affected practitioner is accorded all rights to which s/he is entitled.

The notice of hearing shall state in concise language the acts or omissions with which the Medical Staff Member is charged, a list of specific or representative medical records being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.
Section 2.0 Request for Hearing:

2.1 The President of the Medical Staff or his/her designee shall be responsible for giving prompt written notice, by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery, of an adverse recommendation or decision to any affected Medical Staff Member who is entitled to a hearing or to an appellate review.

2.2 The failure of a Medical Staff Member to request a hearing, from the President of the Medical Staff or designee to which s/he is entitled by these Bylaws, within thirty (30) days of receipt of the written notice by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery, shall be deemed a waiver of his/her right to such a hearing and to any appellate review to which s/he might otherwise have been entitled on the matter.

2.3 When the waiver of hearing or appellate review relates to an adverse recommendation of the Credentialing and Privileging Review Committee of the Medical Staff or of a hearing committee appointed by the Medical Staff Executive Committee, the same shall thereupon become and remain effective against the staff member pending decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Governing Authority, the same shall thereupon become and remain effective against the Medical Staff Member in the same manner as a final decision of the Governing Authority, provided for in Section 7.0 of this Appendix II. The President of the Medical Staff shall promptly notify the affected Medical Staff Member of this status by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery.

Section 3.0 Notice of Hearing:

3.1 Within ten (10) days after receipt of a request for hearing from a Medical Staff Member, the Medical Staff Executive Committee or the Credentialing and Privileging Review Committee, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the President of the Medical Staff, notify the Medical Staff Member of the time, place and date so scheduled, by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery. The hearing date shall not be less than fifteen (15) days, nor more than thirty (30) days from the date of receipt of the request for hearing; provided, however, that a hearing for a Medical Staff Member who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, but not later than fifteen (15) days from the date of receipt of such staff member's request for hearing.

3.2 Notice of Hearing and Statement of Reasons

Upon receipt of the practitioner’s timely request for a hearing, the Administrator, in conjunction with the President of the Medical Staff, shall schedule the hearing and shall give written notice to the practitioner who requested the hearing. The notice shall include:
a) The time, place and date of the hearing;

b) A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the Medical Staff Executive Committee, (or Governing Authority), at the hearing;

c) The names of the hearing panel members and presiding officer or hearing officer, if known; and

d) A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to, in writing, by both parties.

Section 4.0 Composition of Hearing Committee:

4.1 When a hearing relates to an adverse recommendation of the Credentialing and Privileging Review Committee, such hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the Active or Associate Medical Staff who are discipline peers appointed by the Chairperson of the Credentialing and Privileging Review Committee, and one of the members so appointed shall be designated as Chairperson. No Medical Staff Member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee.

4.2 When a hearing relates to an adverse decision of the Medical Staff Executive Committee that is contrary to the recommendation of the Credentialing and Privileging Review Committee, the Medical Staff President shall appoint a hearing committee of not less than three (3) individuals to conduct such hearing and shall designate one of the members of said committee as Chairperson. At least one representative from the Medical Staff shall be included on this committee.

Section 5.0 Conduct of Hearing:

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

5.2 An accurate record of the hearing must be kept. The mechanism shall be established by the ad hoc hearing committee and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of minutes.
5.3 The presence of the Medical Staff Member for whom the hearing has been scheduled shall be required. A Medical Staff Member who fails without good cause to appear at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 2.0 of this Appendix II and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Section 2.0 of this Appendix II.

5.4 Postponement of hearing beyond the time set forth in these Bylaws shall be made only with the approval of the ad hoc hearing committee. Granting of such postponement shall only be for cause shown and at the sole discretion of the hearing committee.

5.5 The affected Medical Staff Member shall be entitled to be accompanied by and/or represented at the hearing by an attorney, a member of the Medical Staff in good standing or by a member of his/her local professional association.

5.6 The Chairperson of the hearing committee or his/her designee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.

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

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

5.9 The affected Medical Staff Member shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness or any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the Medical Staff Member does not testify in his/her own behalf, s/he may be called and examined as if under cross-examination.
5.10 The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. Accordingly, both sides shall be entitled to be represented by counsel of their choosing, in connection with preparation for the hearing or for a possible appeal.

5.11 The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon conduct its deliberations outside the presence of the staff member (or whom the hearing was convened).

5.12 Within five (5) days after final adjournment of the hearing, the hearing committee shall make a written report and recommendation and shall forward the same, together with the hearing record and all other documentation, to the Credentialing and Privileging Review Committee or to the Medical Staff Executive Committee, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Credentialing and Privileging Review Committee or decision of the Medical Staff Executive Committee.

Section 6.0 Appeal to the Governing Authority:

6.1 Within seven (7) days after receipt of a notice by an affected Medical Staff Member of an adverse recommendation or decision made or adhered to after a hearing as above provided, s/he may, by

a. written notice to the Governing Authority Chair, then

b. delivered through the President of the Medical Staff by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery

c. request an appellate review by the Governing Authority.

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

6.2 If such appellate review is not requested within seven (7) days, the affected Medical Staff Member shall be deemed to have waived his/her right to the same and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 7.2 of this Appendix II.

6.3 Within ten (10) days after receipt of such notice of request for appellate review, the Governing Authority Chair (or his/her designee) shall schedule a date for such review, including a time and place for oral argument if such has been requested and shall, through the President of the Medical Staff by written notice sent by certified mail
(return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery, notify the affected Medical Staff Member of the same. The date of the appellate review shall not be less than fifteen (15) days nor more than thirty (30) days from the date of receipt of the notice of request for appellate review, except that when the Medical Staff Member requesting the review is under a suspension which is currently in effect, such review shall be scheduled as soon as the arrangements can reasonably be made but not more than ten (10) days from the date of receipt of such notice.

6.4 The appellate review shall be conducted by the Governing Authority or by a duly appointed appellate review committee appointed by the Governing Authority Chair of not less than three (3) members with one designated as Chairperson.

6.5 The affected Medical Staff Member shall have access to the report and record (and transcription, if any) of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. S/he shall have seven (7) days to submit a written statement in his/her own behalf, in which those factual and procedural matters with which s/he disagrees, and his/her reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing Authority Chair through the President of the Medical Staff by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery, at least five (5) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Credentialing and Privileging Review Committee of the Medical Staff. The President of the Medical Staff shall provide a copy thereof to the Medical Staff Member at least five (5) days prior to the date of such appellate review by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery.

6.6 The Governing Authority or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings and shall consider the written statements submitted pursuant to subparagraph 6.5 of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the affected Medical Staff Member was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected Medical Staff Member shall be present at such appellate review, s/he shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him/her by any member of the appellate review body. The Credentialing and Privileging Review Committee or the Medical Staff Executive Committee, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him/her by any member of the appellate review body.

6.7 New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, may be introduced at the appellate review under unusual circumstances, and the Governing Authority or the
committee thereof appointed to conduct the appellate review shall, in its sole discretion, determine whether such new matters shall be accepted.

6.8 If the appellate review is conducted by the Governing Authority, it may affirm, modify or reverse its prior decision, or, in its discretion, refer the matter back to the Credentialing and Privileging Review Committee of the Medical Staff for further review and recommendation within thirty (30) days. Such referral may include a request that the Credentialing and Privileging Review Committee of the Medical Staff arrange for a further hearing to resolve specified disputed issues.

6.9 If the appellate review is conducted by a committee appointed by the Governing Authority Chair, such committee shall, within seven (7) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Governing Authority affirm, modify or reverse its prior decision or refer the matter back to the Credentialing and Privileging Review Committee for further review and recommendation within thirty (30) days. Such referral may include a request that the Credentialing and Privileging Review Committee of the Medical Staff arrange for a further hearing to resolve disputed issues. Within seven (7) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Authority as above provided.

6.10 The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6.0 have been completed or waived.

Section 7.0 Final Decision by the Governing Authority:

7.1 Within ten (10) days after the conclusion of the appellate review, the Governing Authority shall make their final decision in the matter and shall send notice thereof to the Credentialing and Privileging Review Committee and, through the President of the Medical Staff, to the affected Medical Staff Member, by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery. This decision shall be immediately effective and final and shall not be subject to further hearing or appellate review. All final decision adverse actions shall be reported to the National Practitioner Data Bank.

7.2 Notwithstanding any other provision of these Bylaws, no Medical Staff Member shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Credentialing and Privileging Review Committee of the Medical Staff, by the Medical Staff Executive Committee or by the Administrator of MCBHD, or by a duly authorized committee appointed by the Governing Authority Chair.
APPENDIX III

FAIR HEARING AND APPEAL: PROCEDURE (ALLIED HEALTH PROFESSIONALS)

Section 1.0 Right to Fair Hearing:

1.1 Allied Health Professional Staff are not entitled to the hearing and appeals procedures set forth in Appendix II of these Bylaws. In the event an Allied Health Professional receives notice of a recommendation by the Medical Staff Executive Committee that will adversely affect his/her exercise of clinical privileges, the Allied Health Professional and his/her supervising physician shall have the right to meet personally with two physicians and one peer assigned by the President of the Medical Staff to discuss the recommendation.

1.2 The Allied Health Professional and the supervising physician must request such a meeting, in writing, to the Administrator within ten (10) business days from the date of receipt of such notice. At the meeting, the Allied Health Professional and the supervising physician must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing as specified for Medical Staff members and none of the procedural rules set forth in Appendix II of these Bylaws with respect to such hearings shall apply. The meeting shall take place as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the request for meeting unless an earlier date has been specifically agreed to, in writing, by both parties.

1.3 Within five (5) days after the fair hearing meeting, findings from this review body will be forwarded to the affected Allied Health Professional, the Medical Staff Executive Committee and the Governing Authority.

Section 2.0 Right to Appeal:

2.1 The Allied Health Professional and the supervising physician may request an appeal in writing, to the Administrator within ten (10) calendar days of receipt of the findings of the review body. The Administrator shall so notify the Governing Authority Chair of the request.

2.2 Within ten (10) calendar days after receipt of such notice of request for appeal, the Governing Authority shall schedule a date for such review, including a time and place through the Administrator, who shall by written notice sent by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery notify the affected Allied Health Professional and supervising physician of the same. The date of the appeal shall not be less than fifteen (15) days nor more than thirty (30) days from the date of receipt of the notice of request.

2.3 Two members of the Governing Authority assigned by the Governing Authority Chair shall hear the appeal from the Allied Health Professional and the supervising physician. A representative from the Medical Staff leadership (President, Vice-President Chief
Medical Officer or Service Medical Director) may be present. The decision of the appeal body will be forwarded to the Governing Authority for final decision within five (5) days of hearing the appeal.

Section 3.0 Final Decision:

3.1 The Allied Health Professional and the supervising physician will be notified within ten (10) calendar days of the final decision of the Governing Authority.

3.2 Notwithstanding any other provision of these Bylaws, no Allied Health Professional shall be entitled as a right to more than one hearing and one appeal on any matter which shall have been the subject of action by the Credentialing and Privileging Review Committee of the Medical Staff, by the Medical Staff Executive Committee or by the Administrator of MCBHD, or by a duly authorized committee appointed by the Governing Authority Chair.
BYLAWS
OF THE
MEDICAL STAFF ORGANIZATION
OF THE
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION

Approved and Adopted by the Medical Staff Organization
of the Milwaukee County Behavioral Health Division
in accordance with existing Bylaws
August 1, 2018

8/16/18
Clarence P. Chou, MD, President of the Medical Staff
Milwaukee County Behavioral Health Division

And

Approved and Adopted by the Milwaukee County Mental Health Board as Governing Authority
of the Milwaukee County Behavioral Health Division
in accordance with existing Bylaws
August 23, 2018

8/23/18
Thomas Lutzow, Chairperson
Milwaukee County Mental Health Board

Reviewed and Supported by Hospital Administration

8/29/18
John H. Schneider, MD, FAPA, Chief Medical Officer
Milwaukee County Behavioral Health Division

8/30/18
Michael Lappen, MS, LPC, Administrator
Milwaukee County Behavioral Health Division
References: (REGULATORY PUBLICATION DATES BELOW TO BE UPDATED)

- Joint Commission CAMH, Refreshed Core, Effec. July 1, 2018
- CMS Subpart E—Requirements for Specialty Hospitals, Sec 482.60 – 482.62
- Wisconsin State Statutes: 15.195(9); 50.36; 146.37, 146.38
- Title IV-Health Care Quality Improvement Act SEC 411 [42 U.S.C. sec 11111 et seq] Professional Review
- National Practitioner Data Bank Guidebook (rev. 2015)
- "Robert's Rules of Order"
- Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment Medicaid Integrity Group
- Social Security Act, Sec 1128
- Wisconsin Administrative Code, DHS 12 (Caregiver Background Checks) and DHS 124 (Hospitals)
- National Association of Medical Staff Services – Ideal Credentialing Standards: Best Practice Criteria and Protocol for Hospitals, February 2014

DATES REVISED:
(Previous revision dates not kept)

June, 1986
December 1991; Addenda April, 1992 and June, 1993
April 1994
July 1994
September 1994
November 1996
August 1997
November 1998
November 2000
January 2002
September 2002
September 2004
March 2008
October 2010
December 2011
May 2012
February 2013
November 2014
February 2016
August 2016
August 2018