BYLAWS OF THE MEDICAL STAFF OF COMMUNITY HEALTH NETWORK AT BERLIN MEMORIAL HOSPITAL
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BYLAWS OF THE MEDICAL STAFF
OF COMMUNITY HEALTH NETWORK
AT
BERLIN MEMORIAL HOSPITAL

PREAMBLE

WHEREAS, Community Health Network is a non-stock and not-for-profit organization organized under the laws of the State of Wisconsin, and operates the Berlin Memorial Hospital and;

WHEREAS, the general purpose is to serve as a hospital providing patient care, education and research; and

WHEREAS, it is recognized that the medical staff is responsible for the quality of medical care in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the hospital governing body, and that the cooperative efforts of the medical staff, the chief executive officer and the governing body are necessary to fulfill the hospital's obligation to its patients;

WHEREAS, the activities of the members of the medical staff in performing those matters called for in these bylaws, the rules and regulations relating to the medical staff, as well as policies and procedures of the medical staff and the Hospital, are of a nature in which the parties are an Organized Health Care Arrangement (OHCA) as defined and addressed under the federal HIPAA statutes and governing regulations.

THEREFORE, the physicians, dentists, and podiatrists practicing in this hospital hereby organize themselves into a medical staff in conformity with these bylaws.

DEFINITIONS

1. The term "medical staff" means those licensed physicians, dentists and, podiatrists who are appointed by the board of directors of the hospital.

2. The term "governing body" means the board of directors of the hospital.

3. The term "chief executive officer" means the individual appointed by the
governing body to act on its behalf in the overall management of Community Health Network.

4. The term "practitioner" means an appropriately licensed medical physician, osteopathic physician, dentist, or podiatrist.

5. The term "service" means that group of practitioners who have clinical privileges in one of the general areas of medicine, surgery, obstetrics, emergency, ICU, radiology and pathology.

6. The term "chair of care council" means the medical staff member duly appointed or elected in accordance with these bylaws to serve as the head of a care council.

7. The term "chief of staff" means president of the medical staff.

8. The term “medical executive committee” means a standing committee that consists of officers of the medical staff and the care council chairs and the previous chief of staff.

9. "Joint Conference Committee" is a committee composed of an equal number of members of the medical executive committee and governing body as provided for in the corporate bylaws.

10. "Days" when used in these bylaws shall mean calendar days unless stated as business days in these bylaws.

11. The term “telemedicine” is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care treatment, and services.

ARTICLE I: NAME

The name of this organization shall be the Medical Staff of Community Health Network.

ARTICLE II: PURPOSES

The purposes of this organization are to:
1. Provide all patients admitted to or treated in any of the facilities, departments, or services of the hospital with a high level of care consistent with the resources available;

2. Provide a high level of professional performance of all practitioners authorized to practice in the hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the hospital and through programs of ongoing review and evaluation of each practitioner's performance in the hospital;

3. Provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;

4. Initiate and maintain rules and regulations for government and management of the medical staff; and

5. Provide a means whereby issues concerning the medical staff and the hospital may be discussed by the medical staff with the governing body and the chief executive officer.

6. Provide a means of collaboration with other health care providers in evaluation and decision-making regarding services provided in the hospitals.

ARTICLE III: MEDICAL STAFF

SECTION 1. NATURE OF MEDICAL STAFF APPOINTMENT

Appointment to the Medical Staff of Community Health Network is a privilege which shall be extended only to professionally competent physicians, dentists, and podiatrists who continuously meet the qualifications, standards and requirements set forth in these bylaws and associated medical staff policies. Appointment or membership will not be denied due to age, sex, color, creed, sexual orientation, national origin, or physical disabilities which do not impact clinical performance.

SECTION 2. QUALIFICATIONS FOR APPOINTMENT

a. Only physicians, dentists, and podiatrists licensed to practice in the State of Wisconsin, who can document their background, experience, training and demonstrate competence, their adherence to the ethics of their profession, their good health, their ability to practice
efficiently and effectively in the hospital, their good reputation and their ability to work with others, with sufficient adequacy to assure the medical staff and the governing body that any patient treated by them in the hospital will be given a high quality of medical care, shall be qualified for appointment to the medical staff. No physician, dentist or podiatrist shall be entitled to appointment or membership on the medical staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that he/she is duly licensed to practice medicine, dentistry or podiatry in this or any other state, or that he/she is a member of any professional organization, or that he/she had in the past or presently has, such privileges at another hospital. The extension of certain clinical privileges may, pursuant to rules approved by the governing board, require specialty board certification.

b. Qualified telemedicine applicants may be appointed to the Telemedicine Staff whereby they may be granted telemedicine privileges without medical staff membership.

c. Acceptance of appointment to the medical staff shall constitute the practitioner’s agreement that he/she will strictly abide by the Principles of Medical Ethics of the American Medical Association, or American Osteopathic Association, or of the American Dental Association or of the American Podiatric Association.

d. As part of their appointment and reappointment to the medical staff or at any other time upon request of the governing body or the medical executive committee, practitioners must certify to their freedom from physical, mental health, and alcohol or substance abuse problem(s) which would in any way impact negatively on the practitioner’s ability to perform clinical privileges in a competent or safe manner. The chair of care council, chief of staff or delegated physician will to the best of their knowledge confirm there is no existing condition that would affect the applicant or re-applicant’s ability to perform the clinical privileges requested. The governing body or the medical executive committee is authorized to require a practitioner to undergo a health evaluation if deemed appropriate, to be conducted by a health practitioner chosen by or acceptable to the governing body or medical executive committee, as appropriate.

e. All appointees of the Medical Staff will follow an acceptable code of conduct. With appointment the practitioner reads and signs “Disruptive Practitioner” policy #02-031.

f. No appointee of the medical staff will receive from, or pay to, another practitioner, either directly or indirectly, any part of a fee for professional services earned by such practitioner, in return for such other practitioner sending, referring or otherwise inducing a person to communicate with such medical staff member in a professional capacity, or for any professional services not actually rendered by such other practitioner.

SECTION 3. CONDITIONS AND DURATION OF APPOINTMENT

a. All initial appointments to the medical staff shall be made by the governing body after recommendation by the medical executive committee and shall be for a period of one (1)
year, or a lesser period if so specified by the governing body. The governing body shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the medical executive committee as provided in these bylaws unless the medical staff declines to make a recommendation.

b. In no case shall the governing body refuse to renew an appointment, or terminate an appointment previously made without a conference with the medical executive committee. However, in the event of unwarranted delay or a failure to act on the part of the medical executive committee, the governing body may without the previous recommendation of the medical executive committee take action on the basis of documented evidence of the applicant's professional and ethical qualifications obtained from reliable sources. Unwarranted delay means one hundred calendar days from the date that the fully completed application has been received by the medical executive committee.

c. All subsequent reappointments to the medical staff shall be for no more than 24 calendar months, renewable by the governing body with formal reapplication.

d. Any conclusions which result in a determination not to appoint a practitioner based upon hospital resources or community needs must be made by the governing board following consultation with the medical executive committee.

SECTION 4. MEMBERSHIP DUES

All members of the Community Health Network Medical Staff will pay annual dues in the amount of $100 or as established by the medical executive committee.

SECTION 5. RESPONSIBILITIES OF MEMBERSHIP

Each staff member will:

a. Direct the care of his or her patients and supervise the work of any allied health professionals under his / her direction.

b. Assist the hospital in fulfilling responsibilities for providing emergency and charitable care.

c. Assist other physicians in the care of their patients when asked or consultation is requested.

d. Act in an ethical and professional manner.

e. Treat employees, patients, visitors, and other physicians in a dignified and courteous manner.

f. Establish and maintain patient care standards and oversight of the quality of care, treatment and services provided to patients.

g. Participates with Peer Review Policy #02-024 when indicated.
ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

SECTION 1. THE HONORARY MEDICAL STAFF

The honorary medical staff shall consist of physicians, dentists, and podiatrists who are honored by emeritus positions. These may be physicians, dentists, and podiatrists who have retired from active hospital practice or who are of outstanding reputation, not necessarily residing in the community. Honorary staff members shall not be eligible to admit patients, to vote, hold office, or unless some special expertise is possessed by the member to serve on the standing medical staff committees.

SECTION 2. THE ACTIVE MEDICAL STAFF

The active medical staff shall consist of practitioners who regularly admit to or treat patients in the hospital. Active staff members assume all the functions and responsibilities of membership on the active medical staff including, where appropriate, emergency service care, consultation assignments, and committee appointments. Members of the active medical staff shall be eligible to vote, to hold office and to serve on medical staff committees and shall be encouraged to attend medical staff meetings.

SECTION 3. THE COURTESY MEDICAL STAFF

The courtesy medical staff shall consist of physicians qualified for staff membership, but who admit twenty (20) or fewer patients per year to the hospital. Courtesy staff members do not vote, hold office or chair committees or care councils. They may and are encouraged to attend staff meetings and may be appointed to serve on staff committees. Courtesy staff members with the exception of Emergency Department physicians must be a member of the active staff of another hospital, which may be waived by the governing board following consultation with the medical executive committee.

SECTION 4. THE CONSULTING MEDICAL STAFF

The consulting medical staff shall consist of physicians, dentists, and podiatrists qualified for staff membership but who act only as consultants and not as primary physicians. Consulting medical staff members shall not be eligible to vote or hold office in this medical staff organization. Consulting medical staff cannot admit.

SECTION 5. TELEMEDICINE
Applicants for telemedicine privileges will be processed in accordance with provisions in the Telemedicine Policy #02-030. Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

**SECTION 6. ADVANCED PRACTICE PROFESSIONAL STAFF**

The advanced practice professional staff shall include those members of the professional health care team, qualified by academic and clinical training, including but may not be limited to certified physician assistants, nurse practitioners, certified nurse anesthetists. Advanced Practice Professionals work under the direction, supervision, and responsibility of a physician. A collaboration / supervision agreement with a Physician member of the medical staff shall be maintained for the purpose of traceability. Only those members of the Advanced Practice Professional staff who maintain a collaborating or supervising agreement with an ACTIVE member of the Medical Staff will be allowed the following:

- One seat on the Medical Executive Committee with vote; recommended by peers to and appointed by the MEC; cannot hold office.
- Hospital Committee and Patient Care Council membership with vote; cannot hold office.
- Attend medical staff meetings without vote.
- Attend continuing medical education programs.

The procedure for appointment and reappointment of the Advanced Practice Professionals shall be in accordance with Article V of these Medical Staff Bylaws, Rules & and Regulations.

Advanced practice professionals may attend medical staff meetings, and as a condition of continued privileges, may be required to attend meetings involving the clinical review of patient care in which they participated.

The hospital retains the right, either through the administration or upon recommendation of the medical executive committee, to suspend or terminate any or all of the privileges or functions of member of the Advanced Practice Professional staff without recourse on the part of such person or others to the review and appeal procedures of these bylaws.

Advanced practice professional staff members whose membership or privileges are terminated or curtailed shall be told the reasons for such action, and if they so request, shall be entitled to have such action reviewed by the physician council or a committee duly appointed by said Medical Executive Committee. At any review meeting, the individual shall be present and allowed to fully participate.

The training, experience, and demonstrated current competence of individuals in this category shall be sufficient to permit their performing the following:

- Seeing patients referred by physician members of the medical staff;
(2) Exercising judgment within their areas of competence, provided that a physician member of the medical staff (or certified registered nurse anesthetist while performing within prescribed scope of practice) shall be ultimately responsible for patient care:
   a) In accordance with the Nurse Practice Act, Chapter 441, Administrative Rule N8, the Certified Registered Nurse Anesthetist (CRNA) may provide anesthesia services without direct supervision or control. However, each CRNA shall work in collaboration with their contracted anesthesia services MD/DO, choosing the most appropriate anesthetic(s) or anesthesia-related procedure for the patient’s medical indication, given the patient’s pre-procedure medical condition.

(3) Practice within the limits established by the medical staff, and consistent with the Wisconsin State Board of Medical Examiners, the Wisconsin Medical Practice Acts or other Wisconsin licensing statutes, including the writing of orders and recording of reports and progress notes in patients' medical records. Advanced Practice Professionals shall carry out their activities subject to and in conformity with the applicable provisions of the Medical Staff Bylaws, Rules & and Regulations, and, Policies & Procedures.

(4) An APNP or PA can admit or discharge an inpatient or outpatient only under a verbal / telephone order from the admitting or discharging physician.

ARTICLE V: APPOINTMENT AND REAPPOINTMENT

SECTION 1. APPLICATION FOR APPOINTMENT

All applications for appointment to the medical staff shall be in writing, shall be signed by the applicant and shall be submitted on a form prescribed by the governing body after consultation with the medical staff. The chief executive officer or designee shall transmit the fully completed application and all supporting materials to the medical executive committee for evaluation. The fully completed application form shall include a statement that the applicant has received and has had an opportunity to read the bylaws of the hospital governing body and the bylaws, rules and regulations and policy, procedures of the medical staff and that he/she agrees to be bound by the terms thereof.

A. Application of Appointment

1. All applications for appointment to the medical staff shall be in writing, shall be signed by the applicant and shall be submitted on a form prescribed by the governing body after consultation with the medical staff. The application shall require detailed information confirming the applicant’s professional qualifications,
and shall include three (3) letters of reference from persons who have had extensive experience in observing and working with the applicant and who can provide adequate reference pertaining to the applicant’s professional competence and ethical character, and shall include information as to whether the applicant’s membership status and/or clinical privileges and/or license to practice any profession in any jurisdiction or DEA prescribing authority have ever been revoked, suspended, reduced, voluntarily or involuntarily surrendered, withdrawn or not renewed in local, state, or national medical societies or other hospitals, or whether his/her license to practice any profession in any jurisdiction or DEA prescribing authority is currently being challenged. In addition, the applicant must state why he / she has been involved in any malpractice event during their career prior to application and provide information on said malpractice action as outlined in the application packet, including final judgments and settlements. Additionally, the applicant shall submit a copy of a current professional license; evidence of professional liability insurance by an insurance company licensed to do business by the Wisconsin Insurance Commissioner’s office at or in excess of the state mandated minimum limits and a report of claims experience. Each year thereafter, staff members must supply a certificate of insurance. Minimum amounts of coverage for persons covered by the Patient’s Compensation Fund shall be the starting coverage of the Fund. Those persons exercising privileges who are not covered by the Fund must have minimum professional liability coverage of $1,000,000 - $3,000,000 per event.

2. The applicant must attest to his/her good health status or any health problems, which may affect his/her ability to exercise privileging in a competent or safe manner and have verification by another independent physician. The Medical Executive Committee has the right to ask for verification of an individual’s health status by a physician of their choosing, when such is deemed appropriate pursuant to the review process. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. The fully completed application shall be submitted to the chief executive officer or his/her designee. After collection of the references, as well as verification of competency by either residency training director or by chiefs of services in other hospitals or their designee, where applicant has received training or been granted privileges, and other materials deemed pertinent, the chief executive officer or his/her designee shall transmit the fully completed application and all supporting materials to the Medical Executive Committee for evaluation.

3. By applying for appointment to the medical staff, each applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application, authorizes the hospital to consult with members of medical staffs of other hospitals with which the applicant has been associated with and others who may have information bearing on his/her competence, character, and ethical qualification; and consents to the hospital’s inspection of all records and documents that may be material to an
evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, as well as of his/her moral and ethical qualifications for staff membership. By applying, the applicant further releases from any liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating the applicants and his/her credentials, and releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant’s competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

4. The fully completed application form shall include a statement that the applicant has received and has had an opportunity to read the bylaws of the hospital governing body and the bylaws, rules and regulations and policy / procedures of the medical staff and that he/she agrees to be bound by the terms thereof without regard to whether or not he/she is granted membership and/or clinical privileges and to be bound by the terms there of without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of his/her application.

5. A fully completed application consists of the following:
   a. Completed application form with general biographical information
   b. Completed privilege delineation form with defined competency levels
   c. Evidence of current licensure with verification information
   d. Evidence of current DEA numbers
   e. Documented verification of professional liability coverage
   f. Documentation of continuing medical education programs attended during the past two (2) years
   g. Demonstration and verification of Board Certification, if applicable
   h. Evidence of relevant training with verification
   i. Evidence of current competence for each privilege requested and verification either by residency training director or by chiefs of services or other designees in other hospitals where the applicant is privileged or by submitting a number of cases with patient outcomes, complications and indications for each privilege requested. The number of cases to be submitted may vary by procedure or privilege requested and technical skills needed to perform said procedure
   j. Evidence of health status by applicant and verifying physician of choice
   k. Documentation of vaccination or confirmed immunity against measles, mumps & rubella
   l. Recent (within one year) documentation of Tuberculosis PPD skin testing results
   m. National Practitioner Data Bank Profile and Office of Inspector General (OIG)
   n. Signed statement from applicant pledging to provide for continuous care for his/her patients; seek consultation when necessary, appropriate or required;
agree to abide by generally recognized ethical principles and agree to accept committee assignments and other duties assigned by the Medical Executive Committee

o. Caregiver background check with the Department of Health and Family Services and the Wisconsin Department of Justice Criminal History

B. Appointment Process

1. Within sixty (60) days after receipt of the fully completed application for membership, Medical Executive Committee shall make a written report of its investigation to the governing body, including its recommendation that the practitioner be provisionally appointed to the medical staff, that he/she be rejected for medical staff membership, or that his/her application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted which may, where appropriate, be qualified by probationary status.

2. Prior to making this report and recommendation, the Medical Executive Committee shall interview or arrange for some of its members to interview the applicant, shall examine evidence of the character, professional competence, qualifications and ethical standing of the practitioner and shall determine, through information contained in references given by the practitioner and from other sources available to the committee including an appraisal from the clinical service in which privileges are sought, whether the practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by him/her. Every service in which the practitioner seeks clinical privileges shall provide the Medical Executive Committee with specific, written recommendations, which shall be made a part of the report. Together with its report, the Medical Executive Committee shall transmit to the CEO or his / her designee who will then present to the governing body the fully completed application and all other documentation considered in arriving at its recommendation.

3. Credentialing decisions are not based solely on an applicant’s race, ethnic / national identity, gender, age, sexual orientation or the types of procedures or patients in which the practitioner specializes. The Executive Director of Provider Services will provide oversight and identify any potential issues during the routine review of the newly credentialed provider files prior to being presented to the Medical Executive Committee. This does not preclude CHN from including in the CHN Medical Group, practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members.

4. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within thirty (30) days
with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection for staff membership.

5. When the recommendation of the Medical Executive Committee is favorable to the practitioner, the chief executive officer or his/her designee shall promptly forward it, together with all supporting documentation, to the governing body.

6. When the recommendation of the Medical Executive Committee is adverse to the practitioner, either in respect to appointment or clinical privileges, the chief executive officer or his / her designee shall promptly so notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the governing body until after the practitioner has exercised or has been deemed to have waived his/her right to a fair hearing as provided in the bylaws.

7. If, after the Medical Executive Committee has considered the report and recommendation of a Hearing Committee and reviewing the record, the Medical Executive Committee’s reconsidered recommendation is favorable to the practitioner, it shall be processed in accordance with subparagraph 4 of this Section 2. If such recommendation continues to be adverse, the chief executive officer or his/her designee shall promptly so notify the practitioner, by certified mail, return receipt requested. The chief executive officer or his/her designee shall also forward such recommendation and documentation to the governing body, but the governing body shall not take any action thereon until after the practitioner has exercised or has been deemed to have waived his/her right to appellate review as provided in Article VII of the bylaws.

8. At its next regular meeting after receipt of a favorable recommendation, the governing body or its Executive Committee shall act in the matter. If the governing body’s decision is adverse to the practitioner in respect to either appointment or clinical privileges, the chief executive officer or his / her designee shall promptly notify him/her of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived his/her rights under Article VII of the bylaws and until there has been compliance with subparagraph 9 of this Section 2. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

9. At its next regular meeting after all of the practitioner’s rights under Article VII have been exhausted or waived, the governing body or its duly authorized committee shall act in the matter. The governing body’s decision shall be conclusive, except that the governing body may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent
recommendation to the governing body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, and new evidence in the matter, if any, the governing body shall make a decision either to provisionally appoint the practitioner to the staff or to reject him/her for a staff membership. All decisions to appoint shall include a delineation of the clinical privileges, which the practitioner may exercise.

10. Whenever the governing body’s decision will be contrary to the recommendation of the Medical Executive Committee, the governing body shall submit the matter to the Joint Conference Committee for review and recommendation and shall consider such recommendation before making its decision final.

11. When the governing body’s decision is final, it shall send notice of such decision through the chief executive officer or his/her designee to the president of the medical staff and to the practitioner.

12. Once the applicant has been accepted to the Medical Staff, he/she will undergo an orientation as outlined in the Orientation – Medical Staff Provider policy # 02-035 of the medical staff.

C. Appointments Provisional

1. Each initial appointment for active or courtesy categories shall be provisional for twelve (12) months, as specified in Section 3. A practitioner may be reappointed to provisional membership for an additional twelve-month period. A practitioner who does not qualify for promotion to the regular medical staff with two (2) full calendar years should be scheduled for a personal interview with the Medical Executive Committee to discuss the status of his/her continued interest in membership on the medical staff of the hospitals. The Medical Executive Committee will recommend continuation on the active or courtesy staff, or denial of reappointment to the medical staff. In the latter case, the practitioner shall be entitled to the procedural rights set forth in the bylaws.

2. During the first six months of the provisional period, it will be the responsibility of the medical staff to orient the practitioner and establish and oversee a monitoring protocol also known as the Focused Professional Practice Evaluation. Monitoring for this purpose should be determined by the medical staff’s capacity to perform a monitoring program and the experience and scope of practice of the new practitioner. The degree of monitoring may range from periodic case review, to full case review, to the need for admission/treatment consultation or the required presence of a medical staff member. In establishing a monitoring protocol, the staff may also establish guidelines regarding the termination or extension of the monitoring. The appropriate
chair of patient care council shall provide reports and recommendations to the medical staff regarding ongoing monitoring.

3. During the interim monitoring period, an initial number of cases (which may vary dependent upon technical skills required) in which the practitioner admits and treats, or participates as a non-admitting practitioner, shall be reviewed by means of the monitoring protocol. At the conclusion of the initial monitoring period as set forth in (2) above, or upon completion of the review and satisfactory evaluation of the initial cases, the medical staff shall recommend that the interim monitoring process be terminated or that an additional interim period of monitoring be established. Should the Medical Executive Committee determine to extend six months, such may be done with no further action being required by the governing body. Further, the practitioner shall not be entitled to a hearing or review on such a decision in accord with the Fair Hearing Plan. Any decisions to extend such monitoring protocol beyond two initial periods must be ratified by the governing body, and such decision is subject to review in accord with the Fair Hearing Plan in bylaws.

4. During the interim period, the monitoring protocol shall afford the hospitals and practitioner the following:
   The ability to establish pretreatment consultation requirements
   a. A current review of the clinical abilities of a practitioner
   b. A resource person or committee to whom the practitioner can or must seek voluntary or required consultation
   d. A resource in the form of the monitor or monitoring committee with whom other staff members of hospital personnel may confer concerning the practitioner on interim status
   e. A basis for recommending privileges at the completion of the interim status

D. Reappointment Process

1. Within sixty (60) days prior to the final scheduled governing body meeting in the medical staff year of October 1st, the Medical Executive Committee shall review all pertinent information available on each practitioner scheduled for periodic appraisal, for the purpose of determining its recommendations for reappointments to the medical staff and for the granting of clinical privileges for the ensuing period, and shall transmit its recommendations, in writing, to the governing body. When reappointment or a change in clinical privileges is recommended, the reason for such recommendations shall be stated and documented.

2. In arriving at recommendations for reappointment of each medical staff member and the assignment of privileges, specific consideration shall be given to the practitioner’s professional competency and clinical judgment in the treatment of patients; ethics and conduct; physical and mental capabilities relating to his/her ability to exercise privileging in a competent or safe manner; attendance at medical staff meetings and
participation in staff affairs; compliance with the hospital Bylaws, Medical Staff Bylaws, Rules and Regulations (including timeliness of medical record completion) and policy / procedures; cooperation with hospital personnel; efficient and economic use of the hospitals’ facilities for patients; relations with other staff members; general attitude toward patients, the hospitals and the public, termination of employment as a practitioner and/or the investigation or filing of complaints by the Health Care Financing Administration or other third party payment organizations. Reappointment includes the periodic appraisal of the professional activities of each member of the medical staff and of all other practitioners with clinical privileges in the hospitals, as well as periodic appraisal of physical and mental capabilities and that they show evidence of successful completion of at least the state’s required number of CME credits. Additionally, practitioners shall, as a part of the reappointment process, provide evidence of good health with verification by a licensed physician of his/her choice, notify the Medical Executive Committee regarding any of the following actions that may have occurred since the practitioner’s last application: any malpractice claims or judgments, whether pending or finally determined or settlements reached; revocation, suspension, reduction or non-renewal of medical staff membership or clinical privileges, whether voluntary or involuntary, at any hospital or institution or DEA prescribing authority; suspension or revocation of licensure or registration of membership in local, state or national medical societies; and refusal or cancellation of liability insurance. A written report of all matters considered in each practitioner’s periodic reappointment appraisal must be made part of the permanent files and the confidentiality of the files maintained. The Medical Executive Committee shall notify the members of the medical staff when review for reappointment commences and solicit the views and recommendations of the medical staff regarding the reappointment of members of the medical staff, including evidence of current competence in delineated clinical areas.

3. Thereafter, the procedure provided in B of this policy relating to recommendations on applications for initial appointment shall be followed.

4. A fully completed application for reappointment is the same as that defined in A. 4 and 5 of this policy for initial appointments.

5. The re-application process will begin each calendar year in April and completed in September.

6. Failure to return a reappointment application in a timely manner (90 days) will result in suspension of privileges until the reapplication process is completed.

7. All reappointments to the Medical Staff are for no more than 24 calendar months. During this reappointment process, the Medical Executive Committee reserves the right to request documentation of additional training or CME courses in privileges in
which the physician has had limited experience in the preceding privileged time period. This will be a procedure-specific request for documentation.

8. Telemedicine privileges, if granted, will be for a period of not more than 24 calendar months.

E. Modification of Membership Status or Privileges

1. A member of the medical staff may, either in connection with the reappointment process or at any other time, request modification of his/her staff category or clinical privileges by submitting a written application to the chief executive officer or his/her designee in writing provided the modification requested has not previously been the subject of a final adverse action. Such application shall be processed in the same manner as provided in C. above for reappointment.

2. Because it is inevitable that from time to time, some practitioners will develop physical or mental disabilities that may limit their ability to exercise the clinical privileges granted them, it shall be the responsibility of all members of the medical staff to bring such disabilities to the attention of the president of the medical staff or the chief executive officer or his/her designee. A review of the individual’s status by the medical executive committee shall follow, and the medical executive committee may require the individual to submit any required evidence of his/her current physical and/or mental status, as determined by a physician acceptable to the medical executive committee. Refer to the Physician Health & Welfare Program Policy # 02-001.

2. If as a result of the practitioner’s self-reporting of a disability, the medical executive committee submits a recommendation for modification of membership status or privileges. The affected practitioner shall be notified in writing of the recommendation. The recommendation shall be considered a professional review action, and thus subject to hearing and review under the Fair Hearing Plan, if the practitioner chooses to exercise the rights available under the Fair Hearing Plan. If the medical executive committee recommends modification of membership status or privileges due to a practitioner’s disability initially discovered by means other than self-reporting, such recommendation shall constitute a peer review action without regard to whether or not the practitioner exercises the review rights available under the Fair Hearing Plan.

F. Leave of Absence and Reappointment

1. Any member of the active or courtesy staff may obtain a leave of absence from the medical staff for a period not to exceed his/her present term of appointment by submitting a written request to the Medical Executive Committee and the chief
executive officer or his/her designee. Failure of the practitioner to return or make an
application extension of leave shall constitute a resignation from the medical staff,
and shall not be subjected to any hearings or appellate review. A request for medical
staff membership subsequently received from a staff member so terminated shall be
submitted and processed in the manner specified in the policy for applications for
initial appointments.

2. Upon return from leave of absence, the practitioner may be required to submit a
request in writing to the Medical Executive Committee which will review the request
and make any recommendations to the governing body regarding privileges or staff
status subsequent to the termination of the leave of absence.

G. Reapplication After Adverse Action

1. An applicant who has received a final adverse action regarding appointment or
clinical privileges or both and who did not exercise any of the hearing and appeal
rights provided in the Fair Hearing Plan shall not be eligible to reapply for the
membership status or privileges that were the subject of the adverse action for a
period of six (6) months after the date of final adverse action.

2. An applicant who has received a final adverse action regarding appointment or
clinical privileges or both and who exercised some or all of the hearing and
appeal rights provided in the Fair Hearing Plan shall not be eligible to reapply for the
membership status 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. Any reapplication under this Section I shall be processed as an initial application, but
the applicant shall submit such additional information as the medical executive
committee or governing body may require in demonstration that the basis for the
earlier adverse action no longer exits.

4. If the recommendation of the medical executive committee or the action proposed by
the governing body upon a reapplication under subsection (2) continues to be adverse,
the scope of the hearing and review to which the practitioner is entitled shall be
limited to consideration of the sufficiency of the additional information submitted in
demonstration that the basis for the earlier adverse action no longer exists.

H. Continuing Reporting Requirements

1. Each medical staff member, as a condition of medical staff membership and the
exercise of clinical privileges shall promptly notify the chief executive officer or
his/her designee of any of the following:
a. The revocation, limitation or suspension of his/her professional license or DEA registration, or the imposition of terms of probation or limitation of practice by the state
b. Loss of staff membership or privileges at any hospital or other health care institution
c. The cancellation of professional liability insurance coverage
d. The receipt of an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation, or the filing of charges, by a Medicare peer review organization, the Department of Health and Human Services, or any law enforcement agency of health regulatory agency of the United States or the State of Wisconsin
e. Receipt of notice of the filing of any suit against the practitioner alleging professional liability in connection with the treatment of any patient in or at the hospital.

ARTICLE VI: CLINICAL PRIVILEGES

SECTION 1. CLINICAL PRIVILEGES DEFINED

a. Every practitioner practicing at this hospital by virtue of medical staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the governing body. In unusual situations on recommendation of the medical executive committee, the board of directors may grant special privileges to practitioners who are not and do not intend to seek membership on the medical staff. These can include, but are not limited to practitioners in a setting remote from the hospital who provide professional clinical services by electronic or telehealth means. The medical executive committee and hospital management shall have in place, a policy providing that any practitioner who provides professional services by means of telehealth shall have his or her credentials and professional liability insurance coverage verified by hospital staff so as to provide assurances to the board of directors that such individuals are professionally qualified to provide the clinical services necessary for patient care needs of the hospital.

SECTION 2. PROFESSIONAL PRACTICE EVALUATION

a. The Medical Staff conducts ongoing professional practice evaluation to assess practitioner’s clinical competency and professional behavior, to ensure quality of care, patient safety and to identify areas for performance improvement. The activities of the ongoing professional practice evaluation are considered privileged and confidential. Refer to Ongoing Professional Practice Evaluation policy #02-007.
b. The Berlin Memorial Hospital Medical Staff may utilize proctoring as a method to provide focused professional practice evaluation of specific practitioners in three key areas: assessing the competence of a practitioner at initial appointment for requested privileges; practitioner granted new privileges; evaluating the performance of practitioners when issues affecting the provision of safe, high-quality patient care are identified. Refer to Proctoring – Focused Professional Practice Evaluation policy #02-014.

SECTION 3. TEMPORARY PRIVILEGES

a. The CEO or designee may grant temporary privileges for a limited period of time, not to exceed 120 days, on the recommendation of the applicable chair of care council, or the chief of the medical staff.

b. Temporary privileges are granted when an applicant with a complete application is awaiting review and approval of the medical staff executive committee and the governing body.

c. Temporary privileges are intended to help Community Health Network meet urgent and important patient care needs as defined by the medical executive committee.

d. Granting of temporary privileges will not be routinely used for administrative purposes, such as when a member of the medical staff fails to provide all information necessary for the processing of his/her reappointment in a timely manner. In this specific situation the member of the medical staff would be required to cease providing care in the facility until the reappointment process is completed, unless ceasing the medical staff member’s privileges would result in a significant patient care problem.

e. Types of temporary privileges recognized by the medical staff are:

• Emergency / Disaster Privileges – medical staff who have clinical privileges regardless of their staff status or clinical privileges, can provide any type of patient care that is necessary to save a life or prevent serious harm as long as the care provided is within the scope of their license and/or in any officially declared emergency, whether local, state or national. Refer to Emergency-Disaster Privileges Policy #02-023.

• Special Training and Experience – Physicians with specialized training or experience not available on the medical staff may be granted temporary privileges to provide a consultation. Refer to Transitory Privileges Policy #02-020.

• Locum Tenens – a physician is recruited to provide necessary patient care services for a specified time period until the medical staff member returns to resume their practice. Refer to Locum Tenens Policy #02-021
ARTICLE VII: CORRECTIVE ACTION

SECTION 1. HEARING RIGHTS

Whenever privileges are denied, suspended, reduced or terminated; staff membership denied, suspended, or revoked; admitting prerogatives limited; consultation required; terms of probation / preceptorship imposed which limit a practitioner's practice; or staff category denied or reduced, the practitioner affected shall have the right to have a hearing in the manner and according to the limits set forth in the Fair Hearing Plan.

SECTION 2. CORRECTIVE ACTION

All members shall be subject to corrective action. The grounds for requesting corrective action, actions that may be taken in response to the request, when the action is deemed adverse and when the practitioner is entitled to a fair hearing, are set forth in the Fair Hearing Plan. The Medical Executive Committee of the medical staff is the disciplinary body and all requests for corrective action shall be directed to that body in the manner and according to the limits set forth in the Fair Hearing Plan.

SECTION 3. EXCEPTIONS

Neither the issuance of a warning, a letter of admonition, or a letter of reprimand, nor the denial, termination or reduction of temporary privileges, or any other action except those specified in the Fair Hearing Plan shall give rise to any right to a hearing or appellate review.

SECTION 4. REMOVAL OF HOSPITAL EMPLOYED PHYSICIAN

Removal of a hospital-employed or contracted practitioner may be accomplished in accordance with the terms of such individual's contractual agreement. If such individual maintains medical staff membership and privileges, termination of the contract shall not terminate such privileges and staff membership unless provision to the contrary is made in such individual's contractual relationship with the hospital.

ARTICLE VIII: OFFICERS
SECTION 1. OFFICERS OF THE MEDICAL STAFF

a. The officers of the medical staff shall be:

1. President
2. Vice-President
3. Secretary-Treasurer

SECTION 2. QUALIFICATIONS OF OFFICERS

Officers must be members of the active medical staff at the time of nomination and election and for a minimum of two years prior, except at the discretion of the Medical Executive Committee, and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The officers shall be physicians with demonstrated competence in their fields of practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of hospital and medical staff activities.

SECTION 3. ELECTION OF OFFICERS - BALLOTING

a. Officers shall be elected at the last meeting of the year of the medical staff. Only members of the active medical staff shall be eligible to vote.

b. The Nominating Committee shall consist of three (3) members of the active medical staff appointed by the president of the medical staff. This committee shall offer one (1) or more nominee(s) for the office of president, vice-president and secretary-treasurer.

c. Nominations may also be made from the floor for any officer at the regular medical staff meeting the month prior to election. Such nominations must include an assurance from the candidate of a willingness to accept the nomination.

d. Elections shall be by secret written ballot if more than one (1) physician is nominated for any of the offices.

e. The election of all officers must be approved by the Governing Board.

f. Any officer of the medical staff is subject to recall by a two-thirds (2/3) vote of the medical staff. No such removal is effective unless ratified by the governing body.

g. Any officer of the medical staff who does not remain in good standing during the term of office or who does not abide by generally accepted ethical standards or has his/her medical
license revoked by the licensing board or whose conduct results in corrective action as outlined in the Fair Hearing Plan, Article I, is subject to immediate removal from office, by the board of directors after consultation with the medical executive committee.

SECTION 4. TENURE OF OFFICE

All officers shall serve a two (2) year term from their election date or until a successor is elected. Officers shall take office on the first day of the medical staff year.

SECTION 5. MEDICAL STAFF YEAR

The medical staff year shall commence January 1st and run through December 31st.

SECTION 6. VACANCIES IN OFFICE

Vacancies in office during the medical staff year, except for the presidency, shall be appointed by the medical executive committee of the medical staff. If there is a vacancy in the office of president, the vice-president shall serve out the remaining term, subject to Governing Board approval.

SECTION 7. RESPONSIBILITIES OF OFFICERS

a. President:
The president shall serve as the chief administrative officer of the medical staff to:

1. Act in coordination and cooperation with the chief executive officer in all matters of mutual concern within the hospital.

2. Call, preside at, and be responsible for the agenda of all general meetings of the medical staff.

3. Preside at and set agenda for the Medical Executive Committee.

4. Serve as ex officio member of all other Patient Care Councils without vote.

5. Be responsible for the enforcement of medical staff bylaws, rules and regulations, and policies / procedures; for implementation of sanctions where these are indicated; and for the medical staff's compliance with procedural safeguards in all instances where reactive action has been requested against a practitioner.

6. Appoint committee members to all standing, special and multidisciplinary medical staff committees except the Medical Executive Committee.
7. Represent the views, policies, needs and grievances of the medical staff to the governing body and to the chief executive officer.

8. Receive and interpret the policies of the governing body to the medical staff and report to the governing body on the performance and maintenance of quality with respect to the medical staff's delegated responsibility to provide medical care.

9. Act as a spokesperson for the medical staff in its external professional and public relations.

10. Nominate all care council chairs and committee chairs prior to the first meeting of the medical executive committee of the medical staff year unless otherwise provided in these bylaws. These nominations are subject to ratification by the medical executive committee.

11. Select medical staff representation for the patient care councils.


13. Assign medical executive committee members to review and update the bylaws and rules and regulations every two years and policies / procedures every year in conjunction with the Director of Quality / Risk Management and Executive Director of Provider Services to maintain The Joint Commission compliance.

b. Vice-President:

The vice-president will take over for the president in his/her absence or resignation. He/She shall be a member of the medical executive committee of the medical staff and of the joint conference committee.

c. Secretary-Treasurer:

He/She shall be a member of the medical executive committee. The secretary-treasurer shall keep accurate and complete minutes of all medical staff meetings, call medical staff meetings on order of the president, attend to all correspondence, and perform such other duties as ordinarily pertain to his/her office.

ARTICLE IX: CARE COUNCILS

SECTION 1. ORGANIZATION OF CARE COUNCILS

There shall be care councils as outlined below. Each care council shall be headed by a chair,
appointed by the president of the medical staff and approved by the medical executive committee. The chairs of care councils will be on the medical executive committee.

a. Medical Patient Care Council includes general medicine, intensive care, emergency department and pediatrics.
b. Surgical Patient Care Council includes general surgery, surgical subspecialties, dentistry, podiatry, and anesthesia.
c. OB Patient Care Council includes obstetrics and newborn nursery (up to one (1) month of age).
d. Diagnostic Service Patient Care Council includes emergency service as relates to diagnostic services, radiology service, pathology, laboratory, and cardiopulmonary services.

SECTION 2. STAFF FUNCTIONS

Medical staff, care councils and other committees approved by the medical executive committee, and governing board will be formed to effectively perform the following medical staff functions:

a. Monitor, evaluate, and improve care provided in and develop clinical policy for special care areas, such as, intensive care, patient care support services, such as respiratory therapy, anesthesia, emergency, outpatient, and ambulatory care.
b. Conduct or coordinate quality, appropriateness, and improvement activities, including invasive procedures, blood usage, drug usage reviews, medical records, and other reviews.
c. Conduct or coordinate utilization management activities.
d. Conduct or coordinate credentials investigations of staff membership and recommend hospital privileges.
e. Provide continuing education opportunities responsive to quality assessment / improvement activities, new state-of-the-art developments, and other perceived needs, and supervise the professional medical library.
f. Develop and maintain surveillance over drug utilization policies and practices.
g. Investigate and control health care associated infections and monitor the hospital’s infection prevention control program.
h. Plan for response to fire and other emergencies, for hospital growth and development, and for the provision of services required to meet the needs of the community.
i. Direct staff organization activities, including review and revisions of medical staff bylaws, staff officer and committee nominations, liaison with the governing board and hospital administration, and review and maintenance of hospital accreditation.
j. Coordinate the care provided by members of the medical staff with the care provided by the nursing service and with the activities of other hospital patient care and administrative services; and
k. Engage in other functions reasonably requested by the medical executive committee and governing board.
l. Assure appropriate management, coordination and communication of patient’s care, treatment and services.
SECTION 3. QUALIFICATIONS, SELECTION & TENURE OF CARE COUNCIL CHAIRS

a. Each care council chair shall serve for a period of two (2) years, and is eligible for reappointment.

b. Removal of a chair during his/her term of office may be initiated by a two-thirds (2/3) majority vote of all active staff members of the care council, but no such removal shall be effective unless and until it has been ratified by the medical executive committee and by the governing body.

c. The chairs of care councils must be members of the active medical staff for a minimum of two (2) years prior to their appointment, and must remain members in good standing during the term of office. Failure to maintain such standing shall immediately create a vacancy in the office. The chairs of care councils shall be board certified in one of the areas of service and/or have demonstrated proficiency and have privileges in that area of service without restrictions for a minimum of two (2) years prior to appointment.

SECTION 4. FUNCTIONS OF CARE COUNCIL CHAIRS

A care council chair is accountable for all clinical and administrative activities within the care council. He/she is responsible for:

a. Periodic review of the professional performance of all practitioners within clinical privileges in the designated care council area. Such review includes drawing conclusions and initiating actions as necessary.

b. Assuring the quality of the care rendered in the services, including but not limited to:
   1. Regular patient care review.
   2. Selection of appropriate indicators to monitor the quality of care.
   3. Continuous surveillance of the professional performance of all individuals with clinical privileges in the services.
   4. Providing for appropriate orientation and continuing education of all persons in the services.

c. Enforcement of hospital and medical staff bylaws, rules and regulations and policies / procedures.

d. Assuring the appropriateness of clinical privileges as they relate to the services. This includes:
   1. Recommendations to the medical executive committee concerning criteria for clinical privileges.
   2. Recommendations to the medical executive committee concerning clinical privileges to be granted to each new applicant or member of the department.
e. Implementation of actions taken by the medical executive committee as they relate to the services.

f. Participation in every phase of administration of the services in cooperation with other members and hospital staff. This participation includes but is not limited to:
   1. Development and implementation of services.
   2. Personnel selection and development.
   3. Technical considerations such as supplies, techniques, policies and procedures.
   4. Establishment of pre-printed orders as applicable to the services.
   5. Provision for regulatory compliance.
   6. Determination of departmental or service-related space requirements.
   7. Recommendations concerning off-site services needed for patient care.
   8. Preparation of annual budgets or other reports as may be required.
   9. Leadership role in performance improvement activities.

   g. Implementation of any corrective action necessary involving members of the service.

SECTION 5. FUNCTIONS OF CARE COUNCILS

a. Each clinical care council shall establish criteria for clinical privilege recommendations within its own service areas. These criteria must be consistent with the policies of the medical staff and governing body.

b. Each clinical care council shall regularly review patient care within the services. Such reviews shall include:
   1. All deaths.
   2. Infections.
   3. Hospitalized patients with unsolved clinical problems.
   4. Appropriateness of utilization of hospital facilities and services.
   5. Other significant patient care matters.
   6. Procedure appropriateness.
   7. Pre-operative and pathological diagnosis comparisons.

Refer to Committees – BMH Medical Staff Policy #02-022.

c. Institute peer review process when indicated. Refer to Peer Review Policy - #02-024.

ARTICLE X: MEDICAL EXECUTIVE COMMITTEE

SECTION 1. Medical Executive Committee

a. Medical Executive Committee shall be a standing council that consists of officers of the medical staff, the care council chairs, one advanced practice professional and the previous
chief of staff. The Chief Executive Officer of the hospital or his/her designated delegate and the President of the CHN Medical Group also attends each meeting on an ex-officio basis, without a vote. The Medical Executive Committee shall act as the Credentials Committee for the purpose of reviewing credentials and making recommendations for staff membership and/or privileging.

b. **Duties:** The duties of the Medical Executive Committee shall be:

1. To review and act on reports and recommendations from patient care councils, clinical departments and services and assigned activity groups.
2. To represent and to act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws.
3. To coordinate the activities and general policies of the various services;
4. To implement policies of the medical staff not otherwise the responsibility of the services;
5. To recommend action to the chief executive officer on matters of a medico-administrative nature;
6. To fulfill the medical staff’s accountability to the governing body for the medical care rendered to patients in the hospital;
7. To review the credentials of all applicants and to make recommendations for staff membership and delineation of clinical privileges as well as make recommendations regarding further or continued CME training on a procedure-specific basis.
8. To review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges, and as a result of such reviews, to make recommendations for reappointments and renewal or changes in clinical privileges;
9. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the medical staff, including the initiation of and/or participation in medical staff corrective or review measures when warranted;
10. To report at each medical staff meeting.
11. To act for the medical staff in intervals between medical staff meetings.
12. To provide direction and facilitate conflict resolution between patient care councils.

c. **Confidentiality:** The members of the Medical Executive Committee will at all times adhere to the confidentiality policy of the organization and a signed acknowledgement of that agreement will be kept on file indefinitely.

d. **Meetings:** The Medical Executive Committee shall meet monthly.

e. **Minutes:** Minutes of each regular and special meeting of the committee shall be prepared per policy.
ARTICLE XI: MEDICAL STAFF MEETINGS

SECTION 1. REGULAR MEETINGS

a. Staff meetings shall be held regularly. Elect officers every two years.

SECTION 2. SPECIAL MEETINGS

a. The president of the medical staff, the medical executive committee, or not less than one-fourth (1/4) of the members of the active medical staff may at any time file a written request with the president that within ten (10) days of the filing of such request, a special meeting of the medical staff be called. The medical executive committee shall designate the time and place of any such special meetings.

b. Written or printed notice stating the place, day and hour of any special meeting of the medical staff shall be delivered, either personally or by mail, to each member of the active staff not less than three (3) nor more than ten (10) days before the date of such meeting, by or at the direction of the president or other persons authorized to call the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his/her address as it appears on the records of the hospital. Notice may also be sent to members of other medical staff groups who have so requested. The attendance of a member of the medical staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

SECTION 3. QUORUM

Presence of thirty-three percent (33%) of the active medical staff shall constitute a quorum for the following purposes:

a. Election of officers
b. Amendment of bylaws
c. Amendment of the rules and regulations

At any other regular or special meeting of the medical staff, a quorum shall consist of those present but not less than 2 medical staff members.

SECTION 4. ATTENDANCE REQUIREMENTS

Attendance requirement: Each member of the active medical staff shall be required to attend 50% the regular medical staff meetings. Failure to attend number of required meetings shall result in a
letter from the CEO advising of delinquency. If attendance requirements are not met over the next six (6) months the provider will be referred to the Medical Executive Committee for corrective action and possible suspension of privileges.

ARTICLE XII. PHYSICIAN HEALTH & WELFARE PROGRAM

Section I. Composition

In order to improve the quality of care and promote the competence of the medical staff, medical executive committee shall establish a physician’s health and welfare program.

Section II. Duties

The medical executive committee shall receive reports related to the health, well being, or impairment of medical staff members and, as it deems appropriate, investigate such reports. With respect to matters involving individual medical staff members the medical executive committee may provide peer counseling, or referrals as appropriate. Such activities shall be confidential; however, in the event information received by the medical executive committee clearly demonstrates that the health or known impairment of a medical staff member poses a risk of harm to patients or staff that information shall be considered for corrective action. The medical executive committee shall also consider general matters related to the health and well being of the medical staff and develop educational programs or related activities.

Section III. Meetings

The medical executive committee agenda will maintain a standing agenda item – physician health and welfare. It shall maintain only such records of its proceedings as it deems advisable. Refer to Physician Health & Welfare Program Policy #02-001, and Chemical Dependency or Other Illnesses Policy #02-002.

ARTICLE XIII: MEDICAL HISTORY AND PHYSICAL EXAMINATION

A. A medical history and physical examination (H & P) may be performed by active medical staff doctor of medicine or osteopathy, or, for patients admitted only for oral and
maxillofacial surgery, by an oral and maxillofacial surgeon who has been granted such privileges by the medical staff.

B. An Advanced Practice Nurse Prescriber (APNP) or Physician Assistant (PA) if privileged may perform and document an H & P’s under the supervision / collaboration of the admitting physician or surgeon. A physician or surgeon must sign the H & P and assume full responsibility for the H & P.

C. Each dental / podiatry case admitted to the hospital for dental or podiatry surgery shall have an admission H & P by a physician, APNP or PA in addition to the specific dental or podiatry history and oral examination supplied by the attending dentist or podiatrist.

D. A complete H & P shall, in all cases, be written or dictated within twenty-four (24) hours of admission of the patient. A copy must be on the chart.

E. An H & P must be updated at the time of admission when using an H & P that was performed before admission. No updates can be done on an H & P that is older than 30 days.

F. H & P’s must include at a minimum the following:

1. Medical History
   - Chief complaint / indications and symptoms for present illness
   - Relevant past medical, social and family history and surgical history
   - Existing co-morbid condition, if any
   - Any known allergies, including medication reactions
   - Current list of medications and dosages

2. Physical Examination
   - Heart
   - Lungs
   - Appropriate inventory of systems
   - Vital signs

3. In regards to services for children and adolescents, the following shall be included:
   - Evaluation of the patient’s development age, length / height, head circumference, and weight.
   - Consideration of educational needs and daily activities, as appropriate.
   - Parent’s report or other documentation of the patient’s immunization status.
   - The families / guardian’s expectation for, and involvement in, the assessment, treatment, and continuous care of the patient.

G. Observation patient: the physician, APNP or PA will record a brief note, including the need for observation, relevant history, physical exam, plan for patient care and discharge status and diagnoses. A full H & P as detailed above in # E. above is not required but should be complete enough to understand the events surrounding the observation.

H. Obstetric patient: the physician will submit a copy of the prenatal record.

1. The prenatal record shall be updated at the time of admission covering the interval between the last prenatal visit and the admission date.
2. Cesarean birth records should contain an admission H & P.
3. An Emergency Cesarean, if feasible, will have an H & P documented in the progress notes, to include at least the cardiopulmonary system.
I. Surgical patient: A patient needing surgery will require an H & P exam regardless of the type of anesthesia planned and/or given. The H & P must be current within 30 days of the procedure and updated the day of the procedure. The H & P shall include specific elements; refer to the Preoperative Requirements Policy #02-004 and follow any guidelines as outlined in Medical Coverage for Orthopedic and Sub-specialty In-Patients Policy #02-028.
   1. A surgical patient’s H & P must be updated the day of the procedure.
   2. In an emergency situation, a brief note including the pre-operative diagnosis must be recorded prior to surgery.
   3. A CRNA can perform and update the patient’s condition (H & P) in conjunction with the pre-anesthetic assessment prior to the patient going to surgery, per delegation by the surgeon and/or anesthesiologist. Any changes in the patient’s condition from the initial medical history and physical examination will be communicated to the surgeon and/or anesthesiologist.

ARTICLE XIV: IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at the hospitals.

1. Any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

2. Such privilege shall extend to members of the hospital's medical staff and of its governing body, its other practitioner, its chief executive officer and his representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XIV, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the governing body or of the medical staff.

3. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, or disclosure, even where the information involved would otherwise be deemed privileged.

4. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any health care institution's activities related, but not limited to:
   a. Applications for appointment or clinical privileges;
b. Periodic reappraisals for reappointment or clinical privileges;

c. Corrective action, including summary suspension;

d. Hearings and appellate reviews;

e. Medical care evaluations;

f. Utilization reviews; and

g. Other hospital, service or committee activities related to quality patient care and inter-professional conduction.

5. The acts, communications, reports, recommendations and disclosures referred to in this Article XIII may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

6. In furtherance of the foregoing, each practitioner shall, upon request of the hospital, execute releases in accordance with the tenor and import of this Article XIII in favor of the individuals and organizations specified in Paragraph Second, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state.

7. The consents, authorizations, releases, rights, privileges and immunities provided by Article V of these bylaws for the protection of this hospital's practitioners, and other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XIII.

ARTICLE XV: RULES AND REGULATIONS

The medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found with these bylaws, subject to the approval of the governing body. They shall not conflict with the bylaws. These shall relate to the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required of each practitioner at Community Health Network. Such rules and regulations shall be a part of these bylaws, except that they may be amended or revised after approval by the medical staff and become effective when approved by the governing body.
ARTICLE XVI: POLICIES AND PROCEDURES

Policies and procedures related to the bylaws and rules & regulations shall outline and describe specific mechanisms used to carry out processes. The policies and procedures shall not conflict with the bylaws or rules and regulations. Policies and procedures are amended or revised after approval by the medical executive committee and forwarded as applicable to the Board of Directors.

ARTICLE XVII: ADOPTION AND AMENDMENT OF BYLAWS

SECTION 1. MEDICAL STAFF RESPONSIBILITY

The medical staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the governing body, medical staff bylaws, rules and regulations, policies and procedures, and amendments thereto, which shall be effective when approved by the governing body.

Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, so as to have bylaws, rules and regulations, and policies and procedures to provide a basis for acceptance by accreditation agencies, to comply with supervising licensing authorities, and to provide a system of ongoing effective professional review.

SECTION 2. METHODOLOGY

Medical Staff bylaws may be adopted, amended, or repealed by the following combined action:

(a) Submission of the proposed amendment at any regular or special meeting of the medical staff and referral to a special committee, which shall report on it at the next regular meeting of the medical staff or at a special meeting called for such purpose; and

(b) A simple majority vote of the active staff eligible to vote on this matter who are present at a meeting at which a quorum is present and at which the special committee makes its report on the proposed amendment; and

(c) The affirmative vote of a majority of the governing body.

The governing body may not adopt a bylaw amendment by unilateral action. Unilateral action for these purposes would be the adoption of a proposed amendment without notice to the medical staff and further without providing a reasonable time for response and recommendation. If the medical staff fails to exercise its responsibility and authority as
required by Section 1 of this ARTICLE, and after notice from the governing body to such effect, including a reasonable period of time for response, the governing body may, upon its own initiative, formulate or amend these bylaws. In such event medical staff recommendations and views shall be carefully considered by the governing body during its deliberations and in its actions. Updated bylaws, rules and regulations, policies and procedures will be distributed to all medical staff at the time of appointment/reappointment processing.

SECTION 3. EFFECTIVE DATE

These bylaws, together with the appended rules and regulations, shall be adopted at any regular meeting of the active medical staff, shall replace any previous bylaws, rules and regulations, and shall become effective when approved by the governing body of the hospital. They shall, when adopted and approved, be equally binding on the governing body and the medical staff.

SECTION 4. REVIEW AND REVISION

The medical staff bylaws and rules and regulations shall be reviewed at least every two years and revised as necessary. The review shall be undertaken by a committee appointed by the president of the medical staff and chaired by the secretary-treasurer. Any proposed amendments and revisions shall be adopted by the medical staff and governing body as provided herein.

ARTICLE XVIII: ADOPTION

These bylaws, together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the active medical staff, shall replace any previous bylaws, rules and regulations, and shall become effective when approved by the governing body of the hospital.

ADOPTED by the Medical Staff on October 24, 2014.

________________________________________
President of the Medical Staff

________________________________________
President / Chief Executive Officer
Community Health Network, Inc.
APPROVED by the Governing Body on January 27, 2015.

__________________________________________
Chairperson of the Board
Community Health Network, Inc.
RULES AND REGULATIONS OF

COMMUNITY HEALTH CHN MEDICAL STAFF

A. General

1. Except in an emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated and the consent of the patient or guardian secured. In the case of an emergency, the provisional diagnosis shall be stated as soon as possible after admission. Physicians admitting private patients shall be held responsible for giving such information as may be necessary to secure protection of other patients from those who are a source of danger from any cause whatsoever or to assure protection of the patient from self harm.

2. Active medical staff that provide primary medical or surgical care to patients at the hospital should be able to be on site within thirty (30) minutes. Refer to Emergency Department On-Call Policy #02-036.

3. Admission
An inpatient or outpatient may be admitted or discharged from the Critical Access Hospital only by the order of an active or courtesy (twenty or fewer admission per year) physician, dentist or podiatrist. An APNP or PA can admit or discharge an inpatient or outpatient only under the supervision or collaboration with a physician. The APNP or PA may receive and enter a verbal / telephone order from the admitting physician. An attending physician must be designated to be responsible for the medical aspect of care.

4. Rounding
Physicians or their designated coverage shall make daily rounds on their patients and write appropriate progress notes. A designated APNP or PA may conduct daily rounds on the physician’s patients and document a daily progress note, but the APNP or PA must communicate verbally (i.e., by telephone) with the respectful physician or surgeon regarding the patient’s status.

5. Discharge
A discharge summary including the final diagnosis, the reason for hospitalization, the significant findings, the procedures performed, the condition of the patient on discharge and any specific instructions given the patient or family or both the patient and the family. The attending physician can delegate the discharge summary to another qualified health care provider, such as, an APNP, PA, Certified Surgical Technician or a physician who is familiar with the patient. Refer to Delinquent Medical Record / Suspension of Medical Staff Privileges Policy #13-055.
6. Dental / Podiatric Staff  
   a. Privileges granted to dentists and podiatrists shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist and podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the chair of surgery.
   
   b. Each case admitted to the hospital for dental or podiatric surgery shall first have an admission history and physical examination by a physician on the active or courtesy medical staff in addition to the specific dental or podiatric history and oral examination supplied by the attending dentist or podiatric.
   
   c. Patients admitted for dental or podiatric services shall be the responsibility of the attending physician.
   
   d. Rules and regulations of the dental or podiatric staff or department shall be regulated by the surgery department.
   
   e. Members of the dental or podiatric staff shall be responsible to the chair of the surgical care council.
   
   f. Dentists and podiatrists are invited to attend medical staff meetings.
   
   g. Dentists or podiatrists may, within the scope of their license, convey written orders relating to the dental or podiatrist aspects of the patient’s treatment.

7. Every member of the Medical Staff shall attempt to secure an autopsy when the case so warrants. No autopsy shall be performed without proper written consent. All autopsies shall be performed by the hospital pathologist or his designated pathologist. Refer to Autopsy, Indications For A Policy #10-137.

8. It is the responsibility of the attending physician to provide coverage during his/her absence and to inform the hospital switchboard accordingly.

9. Physicians or their designated coverage shall see patients on a daily basis and write appropriate progress notes.

10. Physician orders and progress notes shall be dated, timed and authenticated.

11. After consultation with the patient and/or family, physicians shall clearly outline and communicate the plan of care in advance for terminal patients in the event of cardiopulmonary arrest.

B. Medical Records

1. All members of the staff and consultant physicians will be required to see that a permanent record of the case is on file in the hospital when the patient leaves. This record is to include chief complaint, personal history, history of present illness,
physical examination, special reports such as: consultations, clinical lab, x-ray, and others, provisional diagnosis, medical or surgical treatment, operative report (where appropriate), progress notes, final diagnosis, condition on discharge, summary or discharge note and an autopsy report when available. No medical record should be filed until it is complete except on the order of the Medical Executive Committee.

2. All original medical records are the property of Berlin Memorial Hospital and no medical record shall leave the hospital except in a duces tecum subpoena. In case of readmission of a patient, all previous records shall be available for use by the attending physician. This shall apply whether the patient is being attended by the same physician or by another on the active medical staff.

3. Subject to the discretion of the Chief Executive Officer or designee, former members of the medical staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

4. Implemented pre-printed orders shall be signed, dated and timed by the practitioner. Pre-printed orders may be formulated by individual physicians subject to the approval of the medical executive committee.

5. Patients shall be admitted or discharged only on the order of a physician.

6. All records are to be completed within thirty (30) days after the patient has been discharged. If a physician is on vacation, medical leave, or away for other approved medical activities, the days of absence will not count but on return, the physician will be given seven days to complete any delinquent charts. Failure to complete the charts in 30 days results in immediate referral to the Medical Executive Committee for suspension of all privileges other than on currently hospitalized patients until such records are completed. Refer to Delinquent Medical Record / Suspension of Medical Staff Privilege Policy #13-055.

7. Any Suspension lasting greater than thirty (30) days will be referred to the Medical Executive Committee for review as it relates to the Disruptive Physician Policy.

8. Approved Symbols and Abbreviations -- Refer to Abbreviations & Symbols List Policy #13-044.

9. The medical executive committee reserves the right to establish a mechanism of notification to physicians of any delinquent records. Refer to Delinquent Medical Record / Suspension of Medical Staff Privileges Policy #13-055.

10. Discipline-specific verbal / telephone orders relative to their department may be accepted by the following personnel: registered nurses, physical therapist, respiratory
therapy technician, medical technologist, radiology technologist, pharmacist, social service worker, occupational therapist, dietitian, diet technician, physician assistants, and advance practice nurses. Refer to Physician Orders Policy #03-002.

11. Verbal or telephone orders will be signed, dated, and timed by the prescribing practitioner within 48 hours.

12. When a physician is not immediately available to issue an order for restraints, qualified staff may initiate the intervention by using the least restrictive, effective, alternative available. The physician’s order (written or verbal) is obtained immediately for 4-point Velcro restraints. Orders are countersigned or authenticated within 24 hours. All restraints orders will specify a time limit of no longer than 24 hours use. A new order for restraints needs to be written for each 24 hour time period of use. PRN orders for restraints are not acceptable. Refer to Restraints Policy #30-401.

13. A physician Assistant may write orders for labs, x-rays, EKG’s, Rehab Services, and Respiratory Therapy Services in the area of their competence, education, training and experience without a co-signature of a supervising physician. They must work under the supervision of their assigned medical staff member.

14. A Physician Assistant may write medication orders according to the Prescriptive Practice – Physician Assistant policy / procedures #02-025.

15. An Advanced Practice Nurse Practitioner may write orders for labs, X-rays, EKG’s, Rehab Services, Respiratory Therapy Services and prescribe and administer medications in the area of their competence, education, training and experience without the co-signature of the collaborating licensed physician. They must work in collaboration with their assigned medical staff member.

C. Surgery

1. No surgical procedure will be done until an H & P is on the medical record, either handwritten or transcription except in emergencies. Refer to Preoperative Requirements Policy #02-004.

2. A surgical operation shall be performed only on informed consent of the patient or his/her legal representative, except in emergencies.

3. The operative report shall be written or dictated immediately by the operating surgeon.

4. The operative progress note shall be written immediately following surgery. The operative progress note shall contain at a minimum these elements: the name of the
primary surgeon and assistants; procedures performed and description of each procedure; findings; estimated blood loss; specimens removed and post operative diagnosis.

5. All tissues and materials removed by an operative procedure is the property of the hospital laboratory for a sufficient time to allow the pathologist to make an examination necessary to arrive at a pathology diagnosis. The pathologist shall sign a report of the diagnosis unless the removed specimen can be verified by x-ray. Examinations which cannot be made in the hospital shall be referred to an outside approved laboratory for the pathological diagnosis.

6. The physician who is performing the procedures will obtain the informed consent. Legal requirements for informed consent must be given in lay language, nature of procedures and benefits must be explained, must tell patient his/her chance of mortality, and must inform of alternative methods of treatment when available as well as indications for said procedure. The nurse may get the consent form signed, but he/she is only a witness to the signature. The nurse should chart in the nurse’s notes and inform the physician of any questions raised by the patient in regard to the consent or proposed procedure. Refer to Consents, Informed Policy #30-115. All procedures must have a consent signed.

7. Administration of anesthesia can be undertaken by a CRNA in collaboration with a duly licensed anesthesiologist or surgeon / physician. Preoperative anesthetic evaluation shall be performed by the CRNA with assessment of the patient’s health status as it relates to the relative risk involved with anesthetic management of the patient during the performance of an operative procedure.

CRNA’s can perform and update the patient’s condition (history and physical) in conjunction with the pre-anesthetic assessment prior to the patient going to surgery, per delegation by the surgeon and / or anesthesiologist. Any changes in the patient’s condition from the initial history and physical assessment will be communicated to the surgeon and / or anesthesiologist.

The CRNA shall develop a plan of anesthesia with the concurrence of the surgeon and/or anesthesiologist and shall implement appropriate anesthetic plan. The CRNA shall take corrective action to counteract problems that may develop during the implementation of the anesthesia plan. The surgeon and/or anesthesiologist shall be responsible for the anesthesia plan. The surgeon and/or anesthesiologist shall be responsible for diagnosing new medical problems associated with the patient’s care. The anesthetist shall inform and consult with the surgeon and/or anesthesiologist regarding medical complications during implementation of the patient’s surgery or anesthesia plan. The CRNA shall provide necessary post-anesthesia care and shall discuss potential complications or conditions requiring further treatment with the surgeon and/or anesthesiologist.
8. A Wisconsin licensed nurse anesthetist who is certified as an advanced practice nurse prescriber can prescribe oxygen in a hospital without physician supervision director, or a physician order.

9. A pre-anesthesia evaluation, intra-operative record and a post-evaluation within 48 hours shall be conducted by an individual qualified to administer anesthesia. Refer to policy Anesthesia Quality of Care #19-803.

10. A patient needing surgery will require a history and physical exam regardless of the type of anesthesia planned and / or given. The history and physical must be current with 30 days of the procedure and updated the day of the procedure. The history and physical exam shall include specific elements; refer to the Preoperative Requirements Policy #02-004.

D. Emergency Department

1. All patients entering the Emergency Department will receive a medical screen, performed by an Emergency Department physician. All patients will be triaged by an Emergency Department registered nurse.

2. Orders provided by the Emergency Department physician are to be carried out until the attending physician assumes responsibility for care of the patient. If the patient is admitted, the attending physician shall be notified to assume responsibility for the care of the patient. The Emergency Department physician shall ask the patient or guardian who he/she wants to care for them, and if no attending physician is named, the patient will be assigned a physician according to the unassigned patient list.

3. If, during an emergency with an in-house patient, the attending physician cannot be located, then it is the responsibility of the nurse to contact another physician, with first priority given to the Emergency Department physician.

4. All obstetrical patients presenting to the Berlin Memorial Hospital Emergency Department or Family Birth Center seeking obstetrical care shall receive a medical screening exam by a registered nurse trained in obstetrical care or a physician.

5. When a sexual assault victim presents to the Emergency Department, a qualified Sexual Assault Nurse Examiner (SANE) has the ability to conduct a Medical Screening Exam (MSE) within the International Association of Forensic Nurses (IAFN) standards. Events that fall out of these standards or outside of the nursing scope of practice are referred to the Emergency Department Physician for further evaluation and treatment.

“Qualified” is defined as a Registered Nurse who has completed the required didactic
training and competency based on the Wisconsin Chapter of the IAFN and the Wisconsin Coalition Against Sexual Assault (WCASA) to practice independently as a SANE.

RULES & REGULATIONS OF
COMMUNITY HEALTH NETWORK
MEDICAL STAFF

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PRESIDENT OF THE MEDICAL STAFF

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DATE

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PRESIDENT / CHIEF EXECUTIVE OFFICER
COMMUNITY HEALTH NETWORK, INC.

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DATE

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CHAIRPERSON OF THE BOARD
COMMUNITY HEALTH NETWORK, INC.

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DATE