Joint Meeting - UWHCA and UWMF Board of Directors

September 23, 2020, 3:00 - 5:00 PM

Via WebEx: https://uwhealth.webex.com/uwhealth/onstage/g.php?
MTID=e6944ccb0955c3fe742cf8e314ae90724
Meeting number: 120 600 9556 // Password: 092320

**ADVANCE MEETING MATERIALS ARE POSTED FOR REFERENCE. OCCASIONALLY, THE POSTED MATERIALS DO NOT REFLECT CHANGES MADE SHORTLY BEFORE OR DURING BOARD MEETINGS. THE FULL BOARD MINUTES ARE THE OFFICIAL RECORD OF FINAL BOARD ACTION**
## Agenda

### 3:00 PM

**I. Call to Order of the Joint Board Meeting**

Dean Robert Golden

### 3:03 PM

**II. Welcome - Dr. Meghan Lubner (UWHC Medical Board Liaison)**

Dean Robert Golden

Attachment - Biography Dr. Meghan Lubner Page 5

### 3:05 PM

**III. UWMF Consent Agenda**

Dean Robert Golden

UWMF Open Session Minutes from July 22, 2020

2021 and 2022 UWMF Board, Council and Committee Meeting Schedules

Attachment - 2021 and 2022 UWMF Board, Council and Committee Meeting Schedules Page 7

Department of Anesthesiology, Addendum for Chronic Pain Management

Clinical Compensation Plan

Attachment - Executive Summary - Department of Anesthesiology – Addendum for Chronic Pain Management Clinical Compensation Plan Page 12

Attachment - Department of Anesthesiology Chronic Pain Compensation Report Page 14

Resolution - UWMF Resolution of Approval of Department Anesthesiology Chronic Pain Plan Page 26

### 3:07 PM

**IV. UWHCA Consent Agenda**

Dean Robert Golden

UWHCA Approval

2021 and 2022 UWHCA Board and Committee Meeting Schedules

Attachment - 2021 and 2022 UWHCA Board and Committee Meeting Schedules Page 28

Medical Staff Membership and Clinical Privileges

Attachment - Medical Staff Membership and Clinical Privileges August 2020 Page 37

Attachment - Medical Staff Membership and Clinical Privileges September 2020 Page 52
UWHC Medical Staff Bylaws

Attachment - UWHC Medical Staff Bylaws Executive Summary Page 61

Adoption of Amended and Restated Bylaws of UWHC Medical Staff

Resolution - Adoption of Amended and Restated Bylaws of UWHC Medical Staff Page 72

Attachment - Amended and Restated Bylaws of UWHC Medical Staff (Redlined Copy) Page 74

Attachment - Fair Hearing and Appellate Review Plan (Redlined Copy) Page 105

Isthmus Project, Inc. Bylaws Revisions

Attachment - Executive Summary - Isthmus Project, Inc. Bylaws Revisions Page 130

Attachment - Isthmus Project, Inc. Bylaws (Red-lined) Page 134

Attachment - Isthmus Project, Inc. Bylaws (Clean) Page 143

Attachment - Isthmus Project, Inc. Investment Guidelines (Red-lined) Page 152

Attachment - Isthmus Project, Inc. Investment Guidelines (Clean) Page 157

UWMF Board of Directors - Faculty Director Candidates

Attachment - UWMF Proposed Candidates for UWMF Board Faculty Director Seat as Selected by the UW Health Council of Faculty Page 161

UW Health ACO, Inc. Shared Savings Distribution Methodology

Resolution - UW Health ACO, Inc. Shared Savings Distribution Methodology Page 174

Department of Anesthesiology, Addendum for Chronic Pain Management Clinical Compensation Plan

Attachment - Executive Summary - Department of Anesthesiology – Addendum for Chronic Pain Management Clinical Compensation Plan Page 177

Attachment - Department of Anesthesiology Chronic Pain Compensation Report Page 179

Resolution - UWHCA Resolution of Approval of Department Anesthesiology Chronic Pain Plan Page 191
Motion W Industrial, LLC Warehouse Lease

Attachment - Executive Summary - Motion W Industrial, LLC Warehouse Lease

Resolution - Motion W Industrial, LLC Warehouse Lease

3:10 PM V. UW Health Diversity, Equity, Inclusion and Anti-Racism at UW Health - Retreat Preparation
Ms. Shiva Bidar-Sielaff

Presentation - Weaving Equity in the Board Retreat

3:20 PM VI. UW Health Financial Report
Mr. Robert Flannery

Presentation - UW Health Consolidated Financials Preliminary August 31, 2020

3:30 PM VII. UW Health Office of Business Integrity
Mr. Troy Lepien

Presentation - UW Health Office of Business Integrity

Attachment - UW Health Office of Business Integrity - FY21 Work Plan

3:40 PM VIII. Closed Session

Motion to enter into closed session pursuant to Wisconsin Statutes sections 146.38 and 19.85(1)(e), for the discussion of the following confidential strategic matters, which for competitive reasons require a closed session: review and approval of closed session minutes, strategic board education, and FY20 annual corporate compliance report; pursuant to Wisconsin Statutes section 19.85(1)(e) and 19.85(1)(c), for discussion of workforce planning update; and, pursuant to Wisconsin Statutes section 19.85(1)(g), to confer with legal counsel regarding these and other matters.

4:59 PM IX. Return To Open Session
Dean Robert Golden

4:59 PM X. ACTION: UW Health Annual Corporate Compliance Report – FY20
Dean Robert Golden
Motion to approve UW Health Annual Corporate Compliance Report – FY20 as discussed in closed session.

5:00 PM XI. Adjourn
Attachment

Biography

Dr. Meghan Lubner
We are pleased to welcome D. Meghan Lubner to the UWHCA Board of Directors

Dr. Meghan Lubner is a professor of radiology in the Abdominal Imaging and Intervention section at the University of Wisconsin. She completed her medical degree at the University of Wisconsin, then completed internship and diagnostic radiology residency at Washington University in St. Louis, MO. She then returned to University of Wisconsin where she completed a fellowship in abdominal imaging and intervention and subsequently joined the UW faculty in 2009. She is currently serving as the Modality Director of Clinical Computed Tomography, co-director of the CT research program, associate section chief of abdominal imaging and intervention and president of the UWHC Medical Board. She has an active diagnostic and interventional radiology clinical practice and won a Clinical Physician Excellence award from UWHC in 2012. She is also an active, funded clinical researcher and has published over 150 manuscripts and given numerous invited national and international presentations. Her clinical and research interests include oncologic imaging, advanced CT applications, quantitative CT imaging biomarkers, and image guided interventions. She is a member of several national radiologic societies including Radiologic Society of North America, American Roentgen Ray Society, the American College of Radiology and she is a fellow of the Society of Abdominal Radiology. She and her husband Dr. Sam Lubner, a GI oncologist at UW, live in Madison with 3 children and a quarantine dog.
Attachment

2021 and 2022
UWMF Board, Council and Committee
Meeting Schedules
<table>
<thead>
<tr>
<th>Board of Directors</th>
<th>Executive/Governance Committee</th>
<th>Council of Chairs</th>
<th>Finance Committee</th>
<th>Retirement Plan Committee</th>
<th>Compensation Development Committee</th>
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<tbody>
<tr>
<td>4:00 - 6:00 PM</td>
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<td>Fourth Wednesday of the Month</td>
<td>Second Wednesday Of Months Listed Below (Number of meetings will be reduced as applicable)</td>
<td>2nd Tuesday &amp; 4th Tuesday Monthly</td>
<td>3rd Tuesday &amp; Additional Meeting Monthly</td>
<td>1st or 3rd Thursday Of Months Listed Below Except for Sep 9 *</td>
<td>1st Tuesday Monthly</td>
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<td>Jan No Meeting Jan No Meeting</td>
<td>Jan 12 Jan 26</td>
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<td>Aug No Meeting Aug No Meeting</td>
<td>Aug 10 Aug 24</td>
<td>Aug No Meeting Aug 5</td>
<td>Aug No Meeting Aug 3</td>
<td>Sep 22 TBD UWMF &amp; UWHCA Joint Board Meeting 3:00-5:00 PM</td>
<td>Sep No Meeting Sep 14 Sep 28 Sep 21 Sep 9 * Sep 7</td>
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<td>Sep 22 TBD UWH Strategic Retreat 5:00 - 8:30 PM</td>
<td>Sep 23 TBD UWH Strategic Retreat All Day</td>
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Locations TBD or Virtual
## 2021 Committee Meeting Schedule

**Revised 09/15/20**

*Blue Indicates a Schedule or Location Change*

### Locations TBD or Virtual

<table>
<thead>
<tr>
<th>Council of Faculty</th>
<th>Pre-Board Meeting</th>
<th>Compensation Review Committee (CRC)</th>
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<tbody>
<tr>
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*Due to Strategic Retreat*
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<th>Board of Directors</th>
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<td>Third Wednesday if there is a Holiday</td>
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**Locations TBD or Virtual**

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## Locations TBD or Virtual

| Council of Faculty 4:30 – 6:00 PM  
2nd Wednesday Monthly | Pre-Board Meeting 3:30 - 4:00 PM  
Of Months Listed Below | Compensation Review Committee (CRC) 2:30 - 4:00 PM  
Of Months Listed Below |
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<td>Aug 10</td>
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<td>No Meeting</td>
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</table>
| Sep 14 | Sep | No Meeting  
Due to Strategic Retreat |
| Oct 12 | Oct 26 | UWMF Pre-Board 3:30 - 4:00 PM |
| Nov 9 | Nov | No Meeting |
| Dec 14 | Dec 21* | UWMF Pre-Board 3:30 - 4:00 PM |

*Note: Dates marked with an asterisk (*) indicate a schedule or location change.*
The Department of Anesthesia presented a report to the UWMF Compensations Development Committee (CDC) on July 7, 2020. From feedback received at the July 7, 2020 CDC meeting, the Department of Anesthesiology prepared an addendum to the compensation plan that implements a chronic pain management clinical compensation plan. Attached, for your reference, is the Department of Anesthesiology Chronic Pain Clinical Compensation Report (presented to CDC on July 7, 2020) and the CDC Sub-Group Committee’s Executive Summary/Review.

The Department of Anesthesiology, Addendum for Chronic Pain Management Clinical Compensation Plan was submitted to CDC via written and majority endorsed on September 15, 2020. On September 23, 2020, the UWHCA and UWMF Board of Directors will approve the Department of Anesthesiology, Addendum for Chronic Pain Management Clinical Compensation Plan.
Department of Anesthesiology Chronic Pain Clinical Compensation

Situation

The Department of Anesthesiology lacks a clinical compensation plan designed specifically for the practice of chronic pain management. Currently, faculty practicing chronic pain management are compensated similar to faculty in the OR void of any internal (points) or external (wRVU) production expectation. Specifically, chronic pain management is rooted in a salary-based compensation model. Total compensation is comprised of a clinical salary that is aligned with OR faculty (respective of track), academic salary (respective of track and rank) and merit. Given the lack of a production expectation, the current model does not include a formal year-end true-up process.

Department of Anesthesiology leadership believes that the creation of a chronic pain management clinical compensation plan it is integral to the sustainability, growth and development of the program.

Background

In order to implement a chronic pain management clinical compensation plan, department faculty must submit a two-thirds majority vote in favor of the proposal, followed by review and approval of the Compensation Development Committee (CDC), UWMF Board, UWMSMPH Dean and the Compensation Review Committee (CRC). A previous attempt to implement a production/collections-based chronic pain management compensation plan in 2016 plan was not approved by the faculty.
Overview of multiple peer organizations within the Morton group, in addition to the UWSMPH Department of Orthopedics and Rehab in order to understand their chronic pain management compensation models. The department has observed a spectrum of compensation models amongst these various institutions and departments, ranging from salary-based to collections-based with multiple hybrid models in between. Figure 1 provides a basic overview of pros and cons associated with both ends of the spectrum.

<table>
<thead>
<tr>
<th>Pros (+)</th>
<th>Salary-Based</th>
<th>Production/Collections-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain uniformity in clinical base salary across the department</td>
<td>Encourages and rewards extra work effort</td>
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<tr>
<td>“Worry free”; therefore sense of security in knowing your salary</td>
<td>Aligns with a chronic pain practice where an anesthesiologist can/does have control over their assignments and workloads (contrary to the OR, where an internal work unit/point is more applicable)</td>
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<td></td>
<td>Institutional precedence and support in the Dept. of Orth/Rehab, Ophthalmology and Urology</td>
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<tr>
<td>Cons (-)</td>
<td>Lacks a financial and production incentive</td>
<td>Potential to foster unhealthy intra-specialty competition amongst physicians</td>
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<td>Potential to discourage growth and may support minimum work effort standards</td>
<td><em>Potential to foster unethical practices (over-production)</em></td>
</tr>
</tbody>
</table>

Figure 1.*The department understands institutional policies and procedures are in place in order to safeguard and protect providers and patients from excessive or inappropriate production, treatment and billing (e.g. prior-authorizations, compliance and coding review, fair-market compensation analysis, etc.).

By way of the institution’s Compensation Development Committee (CDC), department administration has been directly involved in the review of various UWSMPH academic clinical department compensation plans. Institutional precedence and support exists for production-based compensation models in similar ambulatory/procedural practices (i.e. Ortho/Rehab pain management, Ophthalmology and Urology). In such instances, the CDC has shown support for, and fostered adoption of, production-based clinical compensation that is allocated on 50/50 wRVU/collections (professional revenue) basis; the intent of which is to address discrepancies in payor mix and practice. Recent information from UW Health Practice Plan indicates that production-based clinical compensation should be allocated on a 100% wRVU basis; thus removing any allocation based on payments.
UW Health Practice Plan supports clinical compensation at the benchmark rate given production at the benchmark level "benchmark pay for benchmark work". The benchmark is a blend of academic and private practices on the national level. Specifically, this benchmark references the weighted, median compensation and production from the MGMA, Sullivan Cotter and AMGA surveys on a specialty basis.

The Department of Anesthesiology Compensation Plan considers a full-time clinical CHS faculty physician as working 4 clinical days and 1 academic day per week. The plan also provides a mechanism in which faculty physicians can earn merit compensation based on their academic and clinical accomplishments. On average, for a CHS Assistant Professor, the combined annual academic salary and merit compensation is approximately $85,000 ($60,000 merit and $25,000 academic salary); which can be attributed to their 1 academic day per week.

The blended benchmark clinical compensation is based on a full time clinical physician working 5 days per week. Therefore, a full time clinical CHS physician in the Department of Anesthesiology would be measured against 80% of benchmark clinical compensation and production (i.e. 4/5 clinical days = 80%). Considering the current Anesthesiology Pain Management compensation and production benchmarks of $437,709 and 6,621 wRVU respectively, a chronic pain management physician in the department would be measured against a clinical compensation of $350,167 (80%) and production of 5,297 wRVUs (80%) for 4 days of clinic per week. Total annual compensation for the physician in this scenario, assuming benchmark production and considering an average academic/merit salary of $85,000 for the 5th day of the week, would equal $435,125 or ($435,167 / $437,709 = 99%) of the blended benchmark. In essence, there is alignment with “benchmark pay for benchmark work”.

Building from the foundation outlined above, department administration sought counsel from the UWSMPH Departments of Ophthalmology and Urology to understand their practice of budgeting and allocating clinical compensation; such that there was alignment with the benchmark, as well as, accordance with institutional funds flow.

What follows are two scenarios of a production-based clinical compensation plan taking into account the blended benchmark and allocation of clinical compensation based solely on wRVU production. These scenarios are based on the following key elements:

- The benchmark chronic pain clinical compensation pool is calculated by multiplying the provider’s chronic pain clinical FTE by the benchmark compensation pool (e.g. $437,709 * 0.8 = $350,167).
- The benchmark chronic pain clinical compensation pool is allocated to the individual physician on a wRVU basis; which results in their clinical incentive (or clinical compensation)
  - A chronic pain physician’s clinical compensation percent of benchmark is equal to their chronic pain clinical percent FTE assuming a proportionate level of production (e.g. 60% clinical FTE results in a clinical compensation that is 60% of the benchmark as long as the physician produced wRVUs at 60% of the benchmark)
- Compensation from other sources (e.g. academic salary, merit, admin, etc.) are added to the clinical compensation to arrive at the Total Compensation.
  - In theory, a full time clinical (80% in the case of DoA, 4/5 clinical days) CHS Associate Professor should realize a total compensation equal to 100% of the benchmark considering a clinical compensation of approximately $350,000 (based on wRVU production at 80% of benchmark), an academic salary of approximately $29,000 and an average merit compensation of $60,000.
Scenario 1 is a representation of a new, full time clinical CHS Assistant Professor assuming FY20 benchmarks, an Academic salary of $22,500 aligned with our compensation plan, and funding for new hires of $32,500.

### Scenario 1: Assistant Prof CHS Year 1

<table>
<thead>
<tr>
<th>1.0 Total FTE</th>
<th>FY20 Benchmark’s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full time is 4 days per week CHS Track</td>
</tr>
<tr>
<td></td>
<td>FY2020 Blended Benchmark wRVU</td>
</tr>
<tr>
<td></td>
<td>FY2020 Blended Benchmark Comp</td>
</tr>
<tr>
<td></td>
<td>% Pain Clinical FTE</td>
</tr>
<tr>
<td></td>
<td>Benchmark Chronic Pain Comp Pool (Pain FTE % x Benchmark Comp)</td>
</tr>
</tbody>
</table>

| Chronic Pain Clinical FTE | 0.8 |
| wRVU Target | 5,297 |
| WRVU % of Benchmark | 80% |

| Clinical Incentive Allocation based on wRVU | 350,167 |
| Total Clinical Incentive | 350,167 |
| Total Clinical Incentive % of Benchmark | 80% |

| Total Chronic Pain Comp | 350,167 |
| Comp From Other Sources | |
| Clinical OR Comp | 0 |
| Academic Salary | 22,500 |
| Academic & Clinical Merit/New Hire Funding | 32,500 |
| Regional Services Per Diem | 0 |
| Admin (Med. Dir, SMPH-Teaching, DYAD) | 0 |
| Total Comp from Other Sources | 55,000 |

| Total Comp (Clinical Incentive + Non-Pain Comp) | 405,167 |
| Total Comp % of Benchmark | 93% |

| Salary Guarantee | 382,700 |

| Salary Guarantee % of Benchmark | 87% |
Scenario 1 highlights the following key points:

- If the new physician produced at 80% of benchmark (5,297/6,621) level in FY20, the physician’s clinical compensation would equal 80% of benchmark ($350,167/$437,709)
  - 4 clinical days = 80% of the benchmark. (4/5 days)

- Total compensation is projected to be 93% of benchmark ($405,167/$437,709).
  - Assuming an academic salary of $22,500 for a CHS Assistant Professor with 1 year of service and funding for new hires of $32,500 (not yet merit eligible).
  - $55,000 academic salary and funding for new hires for the 5th day of the week.

- Given the current initialization rate of $382,700 is 87% of benchmark, and the likelihood that a new physician will not produce at benchmark levels for the first years, continuing the practice of initializing new faculty with a minimum guarantee of $382,700 for three years seems appropriate.
**Scenario 2** is a representation of full time clinical CHS Associate Professor assuming FY20 benchmarks, an Academic salary of $29,375 aligned with our compensation plan, and an average merit of $60,000.

<table>
<thead>
<tr>
<th>Scenario 2: Associate Prof CHS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.0 Total FTE</strong></td>
</tr>
<tr>
<td><strong>FY20 Benchmark’s</strong></td>
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<tr>
<td>Full time is 4 days per week CHS Track</td>
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<td>FY2020 Blended Benchmark Comp</td>
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<td>% Pain Clinical FTE</td>
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<tr>
<td>Benchmark Chronic Pain Comp Pool (Pain FTE x Benchmark Comp)</td>
</tr>
<tr>
<td><strong>Chronic Pain Clinical FTE</strong></td>
</tr>
<tr>
<td>wRVU Target</td>
</tr>
<tr>
<td>WRVU % of Benchmark</td>
</tr>
<tr>
<td>Clinical Incentive Allocation based on wRVU</td>
</tr>
<tr>
<td><strong>Total Clinical Incentive</strong></td>
</tr>
<tr>
<td><strong>Total Clinical Incentive % of Benchmark</strong></td>
</tr>
<tr>
<td><strong>Total Chronic Pain Comp</strong></td>
</tr>
<tr>
<td>Comp From Other Sources</td>
</tr>
<tr>
<td>Clinical OR Comp</td>
</tr>
<tr>
<td>Academic Salary</td>
</tr>
<tr>
<td>Academic &amp; Clinical Merit/New Hire Funding</td>
</tr>
<tr>
<td>Regional Services Per Diem</td>
</tr>
<tr>
<td>Admin (Med. Dir, SMPH -Teaching, DYAD)</td>
</tr>
<tr>
<td>Total Comp from Other Sources</td>
</tr>
<tr>
<td><strong>Total Comp (Clinical Incentive + Non-Pain Comp)</strong></td>
</tr>
<tr>
<td><strong>Total Comp % of Benchmark</strong></td>
</tr>
</tbody>
</table>
**Scenario 2 highlights the following key points:**

- Production at 80% of benchmark (5,297/6,621) level in FY20 results in the physician’s clinical compensation equaling 80% of benchmark ($350,167/$437,709)
  - 4 clinical days = 80% of the benchmark. (4/5 days)

- Total compensation is projected to be 100% of benchmark ($439,542/$437,709)
  - Assuming an academic salary of $29,375 for a CHS Associate Professor who earned and average merit amount of $60,000.
  - $89,375 academic salary and merit for the 5th day of the week.

---

**Recommendation**

The current Department of Anesthesiology Compensation Plan is a production (shifts) and merit based plan. The department recognizes that the operating room and intensive care unit represent different clinical settings in which anesthesiologists do not control their own case assignments or daily workload. Therefore, an internal measure (i.e. a work unit or a point) was developed to estimate the relative value of the numerous clinical assignments according to a common work expectation, a day in the operating room – which is valued at 1.0 point.

In a chronic pain practice, an anesthesiologist can/does have more control of their assignments and workloads. In these environments a clinical performance benchmark is an appropriate measure to utilize in the calculation of clinical compensation. The institution supports benchmark clinical compensation for benchmark work, in this case production of wRVUs.

In an effort to implement a chronic pain management clinical compensation plan that incentivizes appropriate production; fosters the growth and development of this critical service; and enhances retention and recruitment of pain management physicians; department leadership recommends the implementation of a production-based clinical compensation model for chronic pain management. This model should align clinical compensation with the benchmark rate and be driven by production of wRVUs at the benchmark level. Existing compensation mechanisms for academic salary and merit would remain in place for chronic pain management.

To this end, it is recommended that the department present the model outlined above at the November 21, 2019 faculty meeting and cast a subsequent vote for implementation effective the start of the next fiscal year, July 1, 2020.
Attachment

Compensation Development Committee
Sub-Group Committee Report

Department of Anesthesiology
(Chronic Pain Addendum)
COMPENSATION DEVELOPMENT COMMITTEE REPORT

DATE: JULY 29, 2020

ACADEMIC DEPARTMENT: ANESTHESIOLOGY (CHRONIC PAIN ADDENDUM)

Committee Executive Summary:

The Chronic Pain addendum to the Department of Anesthesiology Physician Compensation Plan pays for clinical work based on Work RVU’s. Because this compensation is completely tied to productivity, it will be important for the department to closely monitor these faculty and ensure they have equal opportunity to generate Work RVU’s. Clinical Compensation Guidelines that are currently under development for UW Health may require the Department to revise this addendum in the future.

SUB-GROUP COMMITTEE REVIEW:

Reviewed by Dr. Bennett, Dr. Giles, Dr. Meyer, Steve Hall, Kelsie Doty, Lisa Kurth, Daniel Rhiner

The Department of Anesthesiology Physician Compensation Plan pays for clinical work using a shift model. Chronic Pain doctors have a different type of practice – scheduled office visits that generate hospital/ASC procedures. Department leadership felt a productivity model would be more appropriate for these doctors. The Department developed and voted on an addendum for Clinical FTE devoted to Chronic Pain. This impacts three physicians, only for their clinical time devoted to Chronic Pain.

Plan Overview

The Chronic Pain addendum only impacts clinical pay, for Chronic Pain work. All other compensation elements follow the overall department plan reviewed previously by CDC (Clinical OR Comp, Academic Salary, Academic Merit, Clinical Merit, Regional Services Per Diem, Administrative Comp). We noted that Clinical Merit is not based on productivity, so is not redundant.

The Clinical Compensation for Chronic Pain is calculated as:

- Individual Work RVU’s divided by UWMF Blended WRVU Benchmark (median) multiplied by UWMF Blended Compensation Benchmark (median)

The benchmarks are specific to the Chronic Pain subspecialty. A 10% withhold is applied to expected compensation and “trued-up” at the end of the fiscal year.

Strengths

- Clear
- Rewards clinical productivity
- Correlation with revenue
• Market-based pay
• Withhold

**Opportunities (weaknesses)**

• This compensation is 100% variable
• No ceiling or floor
• May create competition among Chronic Pain faculty

**Recommendations**

• Monitor individual productivity for unexpected fluctuations
• Consider ways to introduce more stability or shared goals into future iterations
RESOLUTION OF
THE BOARD OF DIRECTORS OF
UNIVERSITY OF WISCONSIN MEDICAL FOUNDATION, INC.

Approval of Department of Anesthesiology – Addendum for Chronic Pain Management Clinical Compensation Plan

September 23, 2020

WHEREAS, the University of Wisconsin Hospitals and Clinics Authority (“UWHCA”) is the sole corporate member of University of Wisconsin Medical Foundation, Inc. (“UWMF”), with such powers over the governance of UWMF as are provided in the bylaws of the University of Wisconsin Medical Foundation, Inc., as amended and restated effective July 1, 2015, and as further amended effective July 1, 2020 (“UWMF Bylaws”); and

WHEREAS, UWMF is in the process of updating and reviewing each University of Wisconsin School of Medicine and Public Health (“UWSMPH”) clinical department compensation plan (the “Plan” or “Plans”) in accordance with Exhibit A, the UWMF “Compensation Principles & Procedures Policy” (“Policy”) of the UWMF Bylaws. The Policy requires that each Plan be reviewed and approved by the UWMF Compensation Development Committee (“CDC”), the UWMF Board of Directors (“UWMF Board”), the Dean of UWSMPH (“Dean”), and the UWMF Compensation Review Committee (“CRC”);

WHEREAS, on September 15, 2020 the UWMF Compensation Development Committee endorsed the Department of Anesthesiology – Addendum for Chronic Pain Management Clinical Compensation Plan; and

WHEREAS, the Plan has been presented to the UWMF Board for approval, and the UWMF Board has determined that the Plan is in the best interest of UWMF;

NOW, THEREFORE, BE IT RESOLVED, that the Plan is hereby approved by UWMF, and is authorized and empowered to seek such further approvals as required by the UWMF Bylaws and to take all other actions necessary or appropriate to effectuate the Plan.
Attachment

2021 and 2022
UWHCA Board and Committee
Meeting Schedules
UNIVERSITY of WISCONSIN HOSPITAL AND CLINIC AUTHORITY
2021 MEETING SCHEDULE

Effective 09/15/20

Location TBD or Virtual

BOARD of DIRECTORS
(4th Thursday of the month – 1:30-4:30 PM)
January 28
February 25
March 25
(April – No Meeting)
May 27
June 24
July 22
(August – No Meeting)
September 22 (3:00-5:00PM) Joint Meeting – UWHCA and UWMF Boards, Location TBD
September 22 (5:00-8:30PM) & September 23 (all day) UW Health Strategic Retreat, Location TBD
October 28
(November – No Meeting)
December 16 (3rd Thursday of month due to Holiday)

EXECUTIVE COMMITTEE
January 28, 11:45 AM – 1:15 PM
February 25, 11:45 AM – 1:15 PM
March 25, 11:45 AM – 1:15 PM
(April – No Meeting)
May 27, 12:30 PM – 1:15 PM
June 24, 12:15 PM – 1:15 PM
July 22, 11:45 AM – 1:15 PM
(August – No Meeting)
(September – No Meeting due to UW Health Retreat)
October 28, 12:15 PM – 1:15 PM
(November – No Meeting)
December 16 (3rd Thursday of the month due to Holiday), 11:45 AM – 1:15 PM

➢ If you have any questions regarding the UWHCA 2021 Meeting Schedule, please contact Ms. Patti Meyer at pmeyer2@uwhealth.org or 608.821.4224. Thank you.
UW Health AUDIT COMMITTEE  
(Thursday [Quarterly] – Note time below)

(February – No Meeting)  
February 25 (8:30-10:00 AM)  
(March – No Meeting)  
(April – No Meeting)  

May 6 – Special Audit Committee – (9:00-10:00 AM)  
May 27 (9:00-10:00 AM)  
(June – No Meeting)  
July 22 (9:00-10:30 AM)  
(August – No Meeting)  
(September – No Meeting)  
(October – No Meeting)  
November 4 (9:00-10:00 AM)  
(December – No Meeting)

FINANCE COMMITTEE  
(Thursday – Note time below)

(February – No Meeting)  
February 25 (10:00-11:30 AM)  
March 25 (10:00-11:30 AM)  
(April – No Meeting)  

May 6 – Special Finance Committee (10:00-11:30 AM)  
May 27 (10:00-11:30 AM)  
June 24 (9:00-10:00 AM)  
(July – No Meeting)  
August 26 (10:00-11:30 AM)  
(September – No Meeting)  
October 28 (10:00-11:30 AM)  
November 18 (10:00-11:30 AM)  
December 16 (10:00-11:30 AM)

➢ If you have any questions regarding the UWHCA 2021 Meeting Schedule, please contact Ms. Patti Meyer at pmever2@uwhealth.org or 608.821.4224. Thank you.
PATIENT SAFETY AND QUALITY COMMITTEE
(3rd Thursday of the month – 10:30-1:00 PM)
Except for September 9 *

(January – No Meeting)
February 18
March 18

(April – No Meeting)
May 20
June 17
July 15

(August – No Meeting)
September 9 *
October 21

(November – No Meeting)
December 9 (2nd Thursday of Month)

INVESTMENT SUBCOMMITTEE

(January – No Meeting)
February 18 (4:00 – 5:30 PM)

(March – No Meeting)

(April – No Meeting)
May 19 (4:00 – 5:30 PM)

(June – No Meeting)

(July – No Meeting)
August 26 (4:00 – 5:30 PM)

(September – No Meeting)

(October – No Meeting)

(November – No Meeting)
December 1 (4:00 – 5:30 PM)

If you have any questions regarding the UWHCA 2021 Meeting Schedule, please contact Ms. Patti Meyer at pmeyer2@uwhealth.org or 608.821.4224. Thank you.
COMPLIANCE COMMITTEE
(1st Thursday of months listed below)

(January – No Meeting)
February 4, 5:00-6:30 PM
(March – No Meeting)
(April – No Meeting)
May 6, 5:00-6:30 PM
(June – No Meeting)
July 1, 5:00-6:30 PM
(August – No Meeting)
(September – No Meeting)
(October – No Meeting)
November 4, 5:00-6:30 PM
(December – No Meeting)

EXECUTIVE COMPENSATION COMMITTEE

(January – No Meeting)
(February – No Meeting)
(March – No Meeting)
(April – No Meeting)
May 27, 11:45 AM – 1:30 PM
June 24, 11:45 – 12:15 PM
(July – No Meeting)
(August – No Meeting)
September 9, 4:00 – 5:30 PM
October 28, 11:45 – 12:15 PM
(December – No Meeting)

WORKFORCE COMMITTEE
TBD

➢ If you have any questions regarding the UWHCA 2021 Meeting Schedule, please contact Ms. Patti Meyer at pmeyer2@uwhealth.org or 608.821.4224. Thank you.
UNIVERSITY of WISCONSIN HOSPITAL AND CLINIC AUTHORITY
2022 MEETING SCHEDULE

Effective 09/15/20

Location TBD or Virtual

BOARD of DIRECTORS
(4th Thursday of the month – 1:30-4:30 PM)
January 27
February 24
March 24
(April – No Meeting)
May 26
June 23
July 28
(August – No Meeting)
September 21 (3:00-5:00PM) Joint Meeting – UWHCA and UWMF Boards, Location TBD
September 22 (5:00-8:30PM) & September 22 (all day) UW Health Strategic Retreat, Location TBD
October 27
(November – No Meeting)
December 22

EXECUTIVE COMMITTEE

January 27, 11:45 AM – 1:15 PM
February 24, 11:45 AM – 1:15 PM
March 24, 11:45 AM – 1:15 PM
(April – No Meeting)
May 26, 12:30 PM – 1:15 PM
June 23, 12:15 PM – 1:15 PM
July 28, 11:45 AM – 1:15 PM
(August – No Meeting)
(September – No Meeting due to UW Health Retreat)
October 27, 12:15 PM – 1:15 PM
(November – No Meeting)
December 22

➢ If you have any questions regarding the UWHCA 2022 Meeting Schedule, please contact Ms. Patti Meyer at pmeyer2@uwhealth.org or 608.821.4224. Thank you.
UW Health AUDIT COMMITTEE
(Thursday [Quarterly] – Note time below)

(February 24 (8:30-10:00 AM)
(March – No Meeting)
(April – No Meeting)
(May 5 – Special Audit Committee – (9:00-10:00 AM)
(May 26 (9:00-10:00 AM)
(June – No Meeting)
(July 28 (9:00-10:30 AM)
(August – No Meeting)
(September – No Meeting)
(October – No Meeting)
(November 3 (9:00-10:00 AM)
(December – No Meeting)

FINANCE COMMITTEE
(Thursday – Note time below)

(February 24 (10:00-11:30 AM)
(March 24 (10:00-11:30 AM)
(April – No Meeting)
(May 5 – Special Finance Committee (10:00-11:30 AM)
(May 26 (10:00-11:30 AM)
(June 23 (9:00-11:00 AM)
(July – No Meeting)
(August 25 (10:00-11:30 AM)
(September – No Meeting)
(October 27 (10:00-11:30 AM)
(November 17 (10:00-11:30 AM) (Due to Holiday)
(December 22 (10:00-11:30 AM)

➢ If you have any questions regarding the UWHCA 2022 Meeting Schedule, please contact Ms. Patti Meyer at pmeyer2@uwhealth.org or 608.821.4224. Thank you.
PATIENT SAFETY AND QUALITY COMMITTEE  
(3rd Thursday of the month – 10:30-1:00 PM)

(January – No Meeting)  
February 17  
March 17  
(April – No Meeting)  
May 19  
June 16  
July 21  
(August – No Meeting)  
September 15  
October 20  
(November – No Meeting)  
December 15

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INVESTMENT SUBCOMMITTEE  
(4:00-5:30 PM)

(January – No Meeting)  
February 17 (4:00 – 5:30 PM), (3rd Thursday of the month)  
(March – No Meeting)  
(April – No Meeting)  
May 18 (4:00 – 5:30 PM), (3rd Wednesday of the month)  
(June – No Meeting)  
(July – No Meeting)  
August 25 (4:00 – 5:30 PM), (4th Thursday of the month)  
(September – No Meeting)  
(October – No Meeting)  
(November – No Meeting)  
December 7 (4:00 – 5:30 PM), (1st Wednesday of the month)

______________________________________________________________________________

➢ If you have any questions regarding the UWHCA 2022 Meeting Schedule, please contact Ms. Patti Meyer at pmeyer2@uwhealth.org or 608.821.4224. Thank you.
COMPLIANCE COMMITTEE
(1st Thursday of the month – 5:00-6:30 PM)

(January – No Meeting)
February 3, 5:00-6:30 PM
(March – No Meeting)
(April – No Meeting)
May 5, 5:00-6:30 PM
(June – No Meeting)
July 7, 5:00-6:30 PM
(August – No Meeting)
September 1, 5:00-6:30 PM
(October – No Meeting)
November 3, 5:00-6:30 PM
(December – No Meeting)

EXECUTIVE COMPENSATION COMMITTEE
(2nd and 4th Thursday of the month – Times Listed Below)

(January – No Meeting)
(February – No Meeting)
(March – No Meeting)
(April – No Meeting)
May 26, 11:45 AM – 12:30 PM
June 23, 11:45 – 12:15 PM
(July – No Meeting)
(August – No Meeting)
September 8, 4:00 – 5:30 PM
October 27, 11:45 – 12:15 PM
(November – No Meeting)
(December – No Meeting)

WORKFORCE COMMITTEE
TBD

➢ If you have any questions regarding the UWHCA 2022 Meeting Schedule, please contact Ms. Patti Meyer at pmeyer2@uwhealth.org or 608.821.4224. Thank you.
The Medical Board, upon the recommendation of the Credentials committee, recommends approval of the following new applications, additional privileges, biennial reappointments and status changes for the medical staff and other providers requesting professional privileges for practice at UWHC. All of the recommended actions have been reviewed in accordance with the Medical Staff Bylaws. The credentials of all new applicants have been verified. All persons listed below meet the standards of the medical staff for the membership and privileges recommended.

Credentials Committee: July 20 & August 3, 2020
Medical Board: August 13, 2020

Thomas Brazelton MD.
Chair of Medical Board & President of Medical Staff

The following actions were endorsed by the UWHC Credentials Committee and are recommended to the Medical Board for approval/action.

**July 20, 2020**

**New Applications**

**Ruben A. Alexanian, MD, Active Staff**
**Department of Medicine/Cardiovascular Medicine**

- Internal Medicine/Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture, thoracentesis, paracentesis, arterial line insertion, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods and supervision of residents, fellows, and others in training.
- Cardiovascular Medicine Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with diseases of the heart and blood vessels. These privileges include, but are not limited to, cardioversion; insertion and management of central venous and pulmonary artery catheters; use of thrombolytic agents; pericardiocentesis; Holter scan interpretation; treadmill testing; temporary transvenous pacemaker placement; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.
- Cardiac Imaging: Nuclear Cardiology
- Peripheral Vascular Interventions: Diagnostic percutaneous peripheral vascular interventions including renal, femoral and brachiocephalic.
- Peripheral Vascular Interventions: Therapeutic percutaneous peripheral vascular interventions including renal, femoral and brachiocephalic.
- Peripheral Vascular Interventions: Diagnostic percutaneous peripheral vascular interventions of the extracranial carotid
- Peripheral Vascular Interventions: Therapeutic percutaneous peripheral vascular interventions of the extracranial carotid
- Percutaneous interventions (primary operator): atherectomy, angioplasty and stent placement
- Percutaneous interventions: Intra-aortic balloon pump placement
- Diagnostic Cardiac Catheterization: Coronary Angiography
- Diagnostic Cardiac Catheterization: Endomyocardial biopsy
- Management of implanted VAD devices
- Percutaneous VAD implant and management(This includes ECMO cannulation as part of this procedure)
- Adult Moderate Sedation-- All locations - includes UH, TAC, DHC, and UWHC Clinics
Mariam N. Ali-Mucheru, MD, Active Staff
Department of Surgery/Fellow

- General Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with disorders, illnesses or injuries of the alimentary tract, the abdomen and its contents, breast, skin, soft tissue, head and neck, endocrine system and minor extremity surgery. These privileges include, but are not limited to, laparoscopic surgery, upper gastrointestinal endoscopy, colonoscopy, insertion and management of arterial catheter, insertion and management of chest tubes, insertion and management of central venous catheters, lumbar puncture, pericardiocentesis, tracheostomy, paracentesis, management of trauma, and complete care of critically ill patients with underlying surgical conditions; performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training. These privileges include care of patients via telemedicine.

Alexandra C. Bolognese, MD, Active Staff
Department of Surgery/Fellow

- General Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with disorders, illnesses or injuries of the alimentary tract, the abdomen and its contents, breast, skin, soft tissue, head and neck, endocrine system and minor extremity surgery. These privileges include, but are not limited to, laparoscopic surgery, upper gastrointestinal endoscopy, colonoscopy, insertion and management of arterial catheter, insertion and management of chest tubes, insertion and management of central venous catheters, lumbar puncture, pericardiocentesis, tracheostomy, paracentesis, management of trauma, and complete care of critically ill patients with underlying surgical conditions; performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training. These privileges include care of patients via telemedicine.

Swaroop R. Bommareddi, MD, Active Staff
Department of Surgery/Fellow

- Cardiothoracic Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and surgically treat patients presenting with illnesses, injuries, and disorders of the chest and abdomen, including the support structures and vascular supply to the extremities and brain. These privileges include transplantation of the heart and/or lung; ventricular assist devices; ECMO cannulation; management of ECMO; pediatric cases within scope of training; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training. These privileges include care of patients via telemedicine.

- Organ Procurement

Kelly W. Capel, MD, Active Staff
Department of Radiology/Neuroradiology

- Radiology Core Privileges: Performance and interpretation of all radiologic tests and procedures including radiographs, ultrasound, CT, MRI, diagnostic (non-therapeutic) nuclear medicine in adults and children. These privileges include, but are not limited to, Doppler vascular imaging, transcranial Doppler, arthograms and joint aspirations, venography of major vessels, lumbar puncture, mammography, supervision of physician assistants with prescriptive authority, and supervision of residents, fellows and other trainees. These privileges include care of patients via telemedicine.

- Fluoroscopy

- Neuroradiology (Diagnostic): Including but not limited to Myelography and diagnostic fluoroscopy-guided spinal puncture; percutaneous diagnostic angiography (without intervention) of the extracranial carotid arteries.

Alex Cruz, MD, Active Staff
Department of Orthopedics and Rehabilitation/Fellow

- Orthopedic Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with illnesses, injuries and disorders of the musculoskeletal system; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; and supervision of residents, fellows and others in training. supervision of physician assistants with prescriptive authority

- Fluoroscopy
Lucia Diaz Garcia, MD, Active Staff
Department of Surgery/Fellow
- Otolaryngology Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with illnesses, injuries and disorders of the head and neck affecting the ears, facial skeleton, and respiratory and upper alimentary system. These privileges include, but are not limited to, surgical procedures involving the temporal bone, nasal and paranasal sinuses, the skull-base, the thyroid, parathyroid, salivary glands, and lymphatic tissue of the head and neck, maxillofacial plastic and reconstructive procedures; sinus endoscopy; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training. These privileges include care of patients via telemedicine.
- Use of surgical laser

Chad M. Ennis, MD, Active Staff
Department of Surgery/Otolaryngology
- Otolaryngology Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with illnesses, injuries and disorders of the head and neck affecting the ears, facial skeleton, and respiratory and upper alimentary system. These privileges include, but are not limited to, surgical procedures involving the temporal bone, nasal and paranasal sinuses, the skull-base, the thyroid, parathyroid, salivary glands, and lymphatic tissue of the head and neck, maxillofacial plastic and reconstructive procedures; sinus endoscopy; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training. These privileges include care of patients via telemedicine.
- Use of surgical laser

Cesar F. Hernandez Arroyo, MD, Active Staff
Department of Medicine/Fellow
- Internal Medicine/Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture, thoracentesis, paracentesis, arterial line insertion, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods and supervision of residents, fellows, and others in training.
- Nephrology Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with illnesses, injuries, and disorders of the kidneys. These privileges include, but are not limited to, placement of temporary vascular access for hemodialysis; management of acute and chronic hemodialysis; placement of (temporary and permanent) catheter for peritoneal dialysis; management of peritoneal dialysis; continuous renal replacement therapy; initiation and supervision of continuous ultrafiltration/dialysis; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.
- Central venous catheter insertion for access
- Percutaneous needle biopsy of the kidney
- Fluoroscopy

Rajbir S. Hundal, MD, Active Staff
Department of Orthopedics and Rehabilitation/Fellow
- Orthopedic Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with illnesses, injuries and disorders of the musculoskeletal system; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; and supervision of residents, fellows and others in training. Supervision of physician assistants with prescriptive authority.
- Fluoroscopy

Barrett P. Kenny, MD, Active Staff
Department of Medicine/Cardiovascular Medicine
- Internal Medicine/Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture, thoracentesis, paracentesis, arterial line insertion, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a
breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods and supervision of residents, fellows, and others in training.

- Cardiovascular Medicine Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with diseases of the heart and blood vessels. These privileges include, but are not limited to, cardioversion; insertion and management of central venous and pulmonary artery catheters; use of thrombolytic agents; pericardiocentesis; Holter scan interpretation; treadmill testing; temporary transvenous pacemaker placement; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.
- Cardiovascular Imaging: Transthoracic echocardiography
- Cardiovascular Imaging: Transesophageal echocardiography
- Cardiovascular Imaging: Stress echocardiography
- Cardiovascular Imaging: Nuclear Cardiology
- Reading Cardiac Studies for Radiology

Michael A. Kessler, MD, Active Staff
Department of Medicine/Infectious Disease
- Infectious Diseases Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with infectious or immunologic diseases. These privileges include supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and other persons in training.

Steven C. Kim, MD, Active Staff
Department of Surgery/Fellow
- General Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with disorders, illnesses or injuries of the alimentary tract, the abdomen and its contents, breast, skin, soft tissue, head and neck, endocrine system and minor extremity surgery. These privileges include, but are not limited to, laparoscopic surgery, upper gastrointestinal endoscopy, colonoscopy, insertion and management of arterial catheter, insertion and management of chest tubes, insertion and management of central venous catheters, lumbar puncture, pericardiocentesis, tracheostomy, paracentesis, management of trauma, and complete care of critically ill patients with underlying surgical conditions; performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training. These privileges include care of patients via telemedicine.
- Adult Moderate Sedation-- ONLY within University Hospital or UW Health at The American Center

Evan C. Klein, MD, Active Staff
Department of Medicine/Cardiovascular Medicine
- Internal Medicine/Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture, thoracentesis, paracentesis, arterial line insertion, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods and supervision of residents, fellows, and others in training.
- Cardiovascular Medicine Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with diseases of the heart and blood vessels. These privileges include, but are not limited to, cardioversion; insertion and management of central venous and pulmonary artery catheters; use of thrombolytic agents; pericardiocentesis; Holter scan interpretation; treadmill testing; temporary transvenous pacemaker placement; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.
- Cardiovascular Imaging: Transthoracic echocardiography
- Cardiovascular Imaging: Transesophageal echocardiography
- Cardiovascular Imaging: Stress echocardiography
- Cardiovascular Imaging: Nuclear Cardiology
- Diagnostic Cardiac Catheterization: Coronary Angiography
- Diagnostic Cardiac Catheterization: Endomyocardial biopsy
- Management of implanted VAD devices
- Percutaneous VAD implant and management(This includes ECMO cannulation as part of this procedure)
- Fluoroscopy

Mark A. Oyer, MD, Active Staff
Department of Orthopedics and Rehabilitation/Fellow

- Orthopedic Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with illnesses, injuries and disorders of the musculoskeletal system; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; and supervision of residents, fellows and others in training. Supervision of physician assistants with prescriptive authority.

Matthew T. Perkovich, MD, Active Staff

Department of Medicine/Hospital Medicine

- Internal Medicine/Hospital Medicine Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges include, but are not limited to, providing care via inpatient service and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.
  - Central venous catheter insertion for access
  - Paracentesis
  - Thoracentesis

Ashley N. Privalle, MD, Active Staff

Department of Dermatology

- Dermatology Core Privileges: Privileges to admit, evaluate, diagnose, consult, and treat patients presenting with illnesses and or injuries of the integumentary system. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, excision or other means of removal (including by liposuction) of benign and malignant lesions; curettage; electro surgery; liquid nitrogen cryosurgery of the skin and other appropriate lesions; nail surgery; acti ther apy treatments ( photother apy - e.g. PUVA); collagen implantation; injectable fillers; Botox injections; dermabrasion; chemical peels; laser treatments; sclerotherapy; dermatopathology; flaps and grafts; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

Benjamin E. Rosenstein, MD, Active Staff

Department of Medicine/General Internal Medicine

- Internal Medicine/Intermediate Care Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses in the outpatient setting (General Internal Medicine clinic). Includes lumbar puncture, thoracentesis, paracentesis, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, supervision of physician assistants with prescriptive authority, and supervision of residents, fellows, and others in training.

Timothy M. Schmidt, MD, Active Staff

Department of Medicine/Hematology/Oncology

- Internal Medicine/Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture, thoracentesis, paracentesis, arterial line insertion, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.
- Hematology Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with diseases and disorders of the blood and blood-forming tissues. These privileges include, but are not limited to, bone marrow aspiration and biopsy; administration of chemotherapy; the management and care of indwelling venous access catheters; plasmapheresis; therapeutic phlebotomy; lymph node aspiration; bone marrow harvest; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.
- Medical Oncology Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with malignancies. These privileges include, but are not limited to, administration of chemotherapeutic agents and biological response modifiers through all therapeutic routes; management and maintenance of indwelling venous access catheters; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.
Hematopoietic progenitor cell component infusion
Adult Moderate Sedation-- All locations - includes UH, TAC, DHC, and UWHC Clinics

Alexandra M. Schultz, MD, Active Staff
Department of Pediatrics
- Pediatric Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult and provide care for infants, children and adolescents with complex problems or severe illnesses, including those that are potentially life-threatening. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture; peripheral arterial puncture; peripheral venous puncture; neonatal circumcision; intubation; suprapubic bladder tap in the care of newborn infants greater than 2000 grams; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training.

Bridget E. Shields, MD, Active Staff
Department of Dermatology
- Dermatology Core Privileges: Privileges to admit, evaluate, diagnose, consult, and treat patients presenting with illnesses and or injuries of the integumentary system. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, excision or other means of removal (including by liposuction) of benign and malignant lesions; curettage; electrosurgery; liquid nitrogen cryosurgery of the skin and other appropriate lesions; nail surgery; actinotherapy treatments (phototherapy - e.g. PUVA); collagen implantation; injectable fillers; Botox injections; dermabrasion; chemical peels; laser treatments; sclerotherapy; dermatopathology; flaps and grafts; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

Lindsay M. Stratchko, DO, Active Staff
Department of Radiology/Musculoskeletal Imaging
- Radiology Core Privileges: Performance and interpretation of all radiologic tests and procedures including radiographs, ultrasound, CT, MRI, diagnostic (non-therapeutic) nuclear medicine in adults and children. These privileges include, but are not limited to, Doppler vascular imaging, transcranial Doppler, arthograms and joint aspirations, venography of major vessels, lumbar puncture, mammography, supervision of physician assistants with prescriptive authority, and supervision of residents, fellows and other trainees. These privileges include care of patients via telemedicine.
- Fluoroscopy
- Musculoskeletal Imaging and Intervention: Including but not limited to Imaged guided, extracranial injection, biopsy, ablation, drainage or aspiration.
- Vascular-Interventional: Including but not limited to Imaged guided catheter placement, TIPs procedure, Transjugular liver biopsy, Image guided caval filter, Therapeutic percutaneous peripheral arterial or venous angioplasty or stenting, Tunneled catheter and port placement, Image guided percutaneous biliary dilatation, drainage, ballooning, stenting or biopsy, Image guided urological dilatation, drainage, ballooning, stenting or biopsy, Image guided embolotherapy, Image guided ablation and/or operative imaging of thoracolumbar or pelvic neoplasms, Imaged guided needle, biopsy, ablation, drainage or aspiration, Image guided analysis for surgery, biopsy or treatment planning using any imaging modality.
- Adult Moderate Sedation-- ONLY within University Hospital or UW Health at The American Center

Jessica S. Tischendorf, MD, Active Staff
Department of Medicine/Infectious Disease
- Infectious Diseases Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with infectious or immunologic diseases. These privileges include supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and other persons in training.

Meaghan E. Trainor, MD, Active Staff
Department of Medicine/Hematology/Oncology (50% Hospital Medicine)
- Internal Medicine/Hospital Medicine Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges include, but are not limited to, providing care via inpatient service and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.
- Arterial Line Insertion
- Central venous catheter insertion for access
Paracentesis
Palliative Care

Brenda M. Zosa, MD, Active Staff
Department of Surgery/Fellow
- General Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with disorders, illnesses or injuries of the alimentary tract, the abdomen and its contents, breast, skin, soft tissue, head and neck, endocrine system and minor extremity surgery. These privileges include, but are not limited to, laparoscopic surgery, upper gastrointestinal endoscopy, colonoscopy, insertion and management of arterial catheter, insertion and management of chest tubes, insertion and management of central venous catheters, lumbar puncture, pericardiocentesis, tracheostomy, paracentesis, management of trauma, and complete care of critically ill patients with underlying surgical conditions; performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training. These privileges include care of patients via telemedicine.

Additional Privileges

Majid Afshar, MD, Active Staff
Department of Medicine/Allergy, Pulmonary & Critical Care
- Adult Moderate Sedation--ONLY within University Hospital or UW Health at The American Center

Michael J. Beninati, MD
Status change from Affiliate Staff to Active Staff
Department of Obstetrics and Gynecology/Maternal Fetal Medicine (90%), Surgery (10%)
- Obstetrics Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and medically treat pregnant patients. These privileges include, but are not limited to, ultrasound; fetal monitoring; amniocentesis; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of residents, fellows and others in training.
- Emergency Obstetrics Core Privileges: Privileges to evaluate including performance of H&P, diagnose, manage, and surgically treat pregnant and post-partum patients admitted to UWHC. This does not permit admission for the primary purpose of obstetrical services, except when such admission is required by law in emergencies. These privileges include, but are not limited to, vaginal delivery; outlet forceps delivery; cesarean section; electronic fetal monitoring; D&C and/or uterine exploration and exploratory laparotomy for post-partum hemorrhage and supervision of residents, fellows and others in training.
- Medical Gynecology Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and medically treat patients presenting with disorders of the female urogenital tract. These privileges include, but are not limited to, evaluation for gynecologic disease, screening for gynecologic cancers (including breast cancer), family planning and contraception, evaluation and treatment of endocrine dysfunction and infertility, termination pregnancy, colposcopy and cervical biopsy, endometrial biopsy, gynecologic ultrasound, evaluation and treatment of incontinence; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training.
- Surgical Gynecology Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and surgically treat patients presenting with benign and pre-malignant disorders of the female urogenital tract. These privileges include, but are not limited to, pelvic endoscopic procedures; dilatation & curettage of the uterus; surgical termination pregnancy; surgical exploration of abdomen, major and minor abdominal and vaginal surgical procedures, repair of simple injuries to the bladder or bowel, appendectomy, evaluation and treatment of incontinence; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.
- General Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with disorders, illnesses or injuries of the alimentary tract, the abdomen and its contents, breast, skin, soft tissue, head and neck, endocrine system and minor extremity surgery. These privileges include, but are not limited to, laparoscopic surgery, upper gastrointestinal endoscopy, colonoscopy, insertion and management of arterial catheter, insertion and management of chest tubes, insertion and management of central venous catheters, lumbar puncture, pericardiocentesis, tracheostomy, paracentesis, management of trauma, and complete care of critically ill patients with underlying surgical conditions; performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training. These privileges include care of patients via telemedicine.
- Critical Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat as an attending physician adult patients in need of critical care within an ICU type setting. These privileges include, but are not limited to, Swan Ganz catheter insertion and management; endotracheal intubation; management of mechanical ventilation; management of noninvasive ventilation; fiberoptic bronchoscopy; direct laryngoscopy; chest tube placement; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

**August 3, 2020**

**New Applications**

**William S. Bradham, MD, Active Staff**  
**Department of Medicine/Cardiovascular Medicine**

- Internal Medicine/Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture, thoracentesis, paracentesis, arterial line insertion, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods and supervision of residents, fellows, and others in training.

- Cardiovascular Medicine Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with diseases of the heart and blood vessels. These privileges include, but are not limited to, cardioversion; insertion and management of central venous and pulmonary artery catheters; use of thrombolytic agents; pericardiocentesis; Holter scan interpretation; treadmill testing; temporary transvenous pacemaker placement; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

**Melissa B. Carroll, MD, Active Staff**  
**Department of Radiology/Fellow**

- Radiology Core Privileges: Performance and interpretation of all radiologic tests and procedures including radiographs, ultrasound, CT, MRI, diagnostic (non-therapeutic) nuclear medicine in adults and children. These privileges include, but are not limited to, Doppler vascular imaging, transcranial Doppler, arthrograms and joint aspirations, venography of major vessels, lumbar puncture, mammography, supervision of physician assistants with prescriptive authority, and supervision of residents, fellows and other trainees. These privileges include care of patients via telemedicine.

**Melinda E. Chen, MD, Active Staff**  
**Department of Pediatrics/Endocrinology**

- Pediatric Endocrinology Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult and treat infants, children, and adolescents with documented or possible disorders of the endocrine system. These privileges include, but are not limited to, endocrine tolerance and provocative tests; provision of immediate and longitudinal care for adults previously treated for pediatric endocrine system disorders; and supervision of residents, fellows and others in training.

**Whitney Fallahian, MD, Active Staff**  
**Department of Anesthesiology/Fellow**

- Anesthesiology Core Privileges: Privileges to evaluate including performance of H&P, consult and administer anesthesia to patients for relief and prevention of pain during and following surgical, therapeutic and diagnostic procedures, including the monitoring and maintenance of normal physiology during the perioperative period and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods. Supervision of Anesthesiologist Assistants is included in these privileges. These privileges include supervision of residents, fellows, and other persons in training.

**Blair P. Golden, MD, Active Staff**  
**Department of Medicine/Hospital Medicine**

- Internal Medicine/Hospital Medicine Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges include, but are not limited to,
providing care via inpatient service and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

**Luke C. Hillman, MD, Active Staff**
Department of Medicine/Gastroenterology & Hepatology
- Internal Medicine/Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture, thoracentesis, paracentesis, arterial line insertion, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods and supervision of residents, fellows, and others in training.
- Gastroenterology and Hepatology Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with diseases of the alimentary tract and associated organs. These privileges include, but are not limited to, diagnostic upper gastrointestinal endoscopy; therapeutic upper gastrointestinal endoscopy (treatment of bleeding lesions, sclerotherapy or banding of esophageal or proximal gastric varices, removal of foreign bodies, removal of polypoid lesions, dilation of stenotic lesions with transendoscopic balloon dilators or dilating systems with guidewires, palliative treatment of stenosing neoplasms); colonoscopy with polypectomy; liver biopsy; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.
- Upper Gastrointestinal and Enteric: Endoscopic injection of botulism toxin for achalasia
- Upper Gastrointestinal and Enteric: Percutaneous endoscopic gastrostomy (PEG) or jejunostomy (JEG) placement
- Manometry: Esophageal motility testing
- Adult Moderate Sedation-- All locations - includes UH, TAC, DHC, and UWHC Clinics

**Suhaib Kazmouz, MD, Active Staff**
Department of Pediatrics/Cardiology
- Pediatric Cardiology Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult and treat fetuses, infants, children and adolescents with cardiac disease or possible cardiac disease. These privileges include, but are not limited to, electrocardiography performance and interpretation; echocardiography; exercise testing; cardioversion/defibrillation; central venous/pulmonary artery catheterization; temporary transvenous pacemaker placement; pacemaker interrogation and programming; balloon atrial septostomy; pericardiocentesis; provision of immediate and longitudinal care for adults with congenital heart disease and adult patients with pediatric acquired heart disease and arrhythmias; and supervision of residents, fellows and others in training.

**Frederick B. Ketchum, MD, Active Staff**
Department of Neurology/General
- Neurology Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and provide medical treatment to patients presenting with illnesses or injuries of the neurological system. These privileges include, but are not limited to, lumbar puncture; EEG interpretation and operative monitoring; EMG and nerve conduction studies; muscle and nerve biopsy; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training. These privileges also include care of patients via telemedicine.
- Neurocritical Care Core Privileges: Privileges to admit, evaluate (including H&P), diagnose, consult and provide medical treatment to patients with critical illnesses or injuries of the brain, spinal cord, nerves, vessels, and their supporting structures with associated medical problems complicating their care.

**Alexandra M. Lacey, MD, Active Staff**
Department of Surgery/Acute Care and Regional General
- General Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with disorders, illnesses or injuries of the alimentary tract, the abdomen and its contents, breast, skin, soft tissue, head and neck, endocrine system and minor extremity surgery. These privileges include, but are not limited to, laparoscopic surgery, upper gastrointestinal endoscopy, colonoscopy, insertion and management of arterial catheter, insertion and management of chest tubes, insertion and management of central venous catheters, lumbar puncture, pericardiocentesis, tracheostomy, paracentesis, management of trauma, and complete care of critically ill patients with underlying surgical conditions; performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in
training. These privileges include care of patients via telemedicine.

- Critical Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat as an attending physician adult patients in need of critical care within an ICU type setting. These privileges include, but are not limited to, Swan Ganz catheter insertion and management; endotracheal intubation; management of mechanical ventilation; management of noninvasive ventilation; fiberoptic bronchoscopy; direct laryngoscopy; chest tube placement; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

- Use of surgical laser
- Adult Moderate Sedation-- ONLY within University Hospital or UW Health at The American Center

James R. Lehman, MD, Active Staff
Department of Psychiatry

- Adult Psychiatry Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult and treat patients, above the age of 15, who suffer from mental, behavioral, or emotional disorders. These privileges also include care of patients via telemedicine. These privileges include supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training.

Allison L. Lindell, MD, Active Staff
Department of Pediatrics/General

- Pediatric Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult and provide care for infants, children and adolescents with complex problems or severe illnesses, including those that are potentially life-threatening. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture; peripheral arterial puncture; peripheral venous puncture; neonatal circumcision; intubation; suprapubic bladder tap in the care of newborn infants greater than 2000 grams; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training.

Syed A. Masood, MD, Active Staff
Department of Pediatrics/Cardiology

- Pediatric Cardiology Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult and treat fetuses, infants, children and adolescents with cardiac disease or possible cardiac disease. These privileges include, but are not limited to, electrocardiography performance and interpretation; echocardiography; exercise testing; cardioversion/defibrillation; central venous/pulmonary artery catheterization; temporary transvenous pacemaker placement; pacemaker interrogation and programming; balloon atrial septostomy; pericardiocentesis; provision of immediate and longitudinal care for adults with congenital heart disease and adult patients with pediatric acquired heart disease and arrhythmias; and supervision of residents, fellows and others in training.

Meisam H. Moghbelli, MD, Active Staff
Department of Medicine/Cardiovascular Medicine

- Internal Medicine/Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture, thoracentesis, paracentesis, arterial line insertion, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods and supervision of residents, fellows, and others in training.

- Cardiovascular Medicine Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with diseases of the heart and blood vessels. These privileges include, but are not limited to, cardioversion; insertion and management of central venous and pulmonary artery catheters; use of thrombolytic agents; pericardiocentesis; Holter scan interpretation; treadmill testing; temporary transvenous pacemaker placement; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

- Cardiac Imaging: Transthoracic echocardiography
- Cardiac Imaging: Transesophageal echocardiography

Srinivas N. Naidu, MD, Active Staff
Department of Anesthesiology

- Anesthesiology Core Privileges: Privileges to evaluate including performance of H&P, consult and administer
anesthesia to patients for relief and prevention of pain during and following surgical, therapeutic and diagnostic procedures, including the monitoring and maintenance of normal physiology during the perioperative period and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods. Supervision of Anesthesiologist Assistants is included in these privileges. These privileges include supervision of residents, and other persons in training.

- **Pain Management Core Privileges:** Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with acute or chronic pain. These privileges include, but are not limited to, anesthetic nerve block; arthrocentesis; injection of neuromuscular block; neurolytic nerve block; botulism toxin injection; epidural steroid injections/selective nerve root block; facet joint injections/medial and lateral branch blocks; major joints blocks/steroid injection; radiofrequency neurolysis; sympathetic ganglion blocks; trigger point injection; soft tissue injection; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

- **Fluoroscopy**

**Andrew R. Spiel, MD, Active Staff**
**Department of Medicine/Gastroenterology & Hepatology**
- Internal Medicine/Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture, thoracentesis, paracentesis, arterial line insertion, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods and supervision of residents, fellows, and others in training.

- **Gastroenterology and Hepatology Core Privileges:** Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with diseases of the alimentary tract and associated organs. These privileges include, but are not limited to, diagnostic upper gastrointestinal endoscopy; therapeutic upper gastrointestinal endoscopy (treatment of bleeding lesions, sclerotherapy or banding of esophageal or proximal gastric varices, removal of foreign bodies, removal of polypoid lesions, dilation of stenotic lesions with transendoscopic balloon dilators or dilating systems with guidewires, palliative treatment of stenosing neoplasms); colonoscopy with polypectomy; liver biopsy; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

- **Upper Gastrointestinal and Enteric:** Endoscopic injection of botulism toxin for achalasia
- **Upper Gastrointestinal and Enteric:** Percutaneous endoscopic gastrostomy (PEG) or jejunostomy (JEG) placement
- **Adult Moderate Sedation--All locations - includes UH, TAC, DHC, and UWHC Clini**

**Jessica L. Vaughan, MD, Active Staff**
**Department of Pediatrics/General**
- Pediatric Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult and provide care for infants, children and adolescents with complex problems or severe illnesses, including those that are potentially life-threatening. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture; peripheral arterial puncture; peripheral venous puncture; neonatal circumcision; intubation; suprapubic bladder tap in the care of newborn infants greater than 2000 grams; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

**Tyler D. Will, MD, Active Staff**
**Department of Medicine/Hospital Medicine**
- Internal Medicine/Hospital Medicine Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges include, but are not limited to, providing care via inpatient service and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

- **Lumbar Puncture**
- **Paracentesis**
- **Thoracentesis**

**Shuang Zhao, MD, Active Staff**
**Department of Human Oncology**
• Radiation Oncology Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat patients of all ages, with malignant and benign tumors, as well as other conditions where radiotherapy has a role. These privileges include, but are not limited to, administration of external beam radiation therapy, brachytherapy, naked or tagged radioisotopes (including intrallesional, intracavitary, intracystic, intravenous, intra-articular or other routes of administration), radiosensitizers, radioprotectors and other therapeutic drugs required in the routine management of these patients; management and maintenance of indwelling brachytherapy catheters and other devices for delivery of brachytherapy or other forms of radiation; performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and other persons in training.

Additional Privileges/Status Changes

Julia R. Berian, MD
Department of Surgery/Colorectal
• Adult Moderate Sedation: All locations - includes UH, TAC, DHC, and UWHC Clinics

Evan T. Nolander, DO
Department of Family Medicine and Community Health
Includes change of status from Affiliate to Active effective 10/5/2020
• Family Medicine Adult Core Privileges: Physicians granted these privileges shall be able to care for patients with more complicated medical problems. If a diagnosis cannot be established after reasonable investigation, or if there is a serious threat to a patient’s life, consultation shall be obtained. Privileges to admit, evaluate including performance of H&P, diagnose, consult and provide treatment to adult patients with general medical problems. These privileges include, but are not limited to, suturing of uncomplicated lacerations; arthrocentesis; I&D of abscess; simple skin biopsy or excision; removal of nonpenetrating corneal foreign body; uncomplicated minor closed fractures (not involving traction or major manipulation); uncomplicated dislocations; diagnostic endometrial sampling; peripheral intravenous cannulation; peripheral arterial puncture; lumbar puncture; preoperative care of surgical patients; postoperative medical care of surgical patients; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

• Family Medicine Pediatric Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult and provide non-surgical treatment to pediatric patients without major complications or serious life threatening disease. These privileges include, but are not limited to, the care of normal newborn as well as the uncomplicated premature infant equal to or greater than 36 weeks gestation; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

Samir Sultan, DO
Department of Medicine/Allergy, Pulmonary & Critical Care
• ECMO Management

Focused Professional Practice Evaluation Review
The following focused review applications have been endorsed by the UWHC Credentials Committee and are recommended to the Medical Board for approval/action:

<table>
<thead>
<tr>
<th>Name</th>
<th>Department/Section</th>
<th>Staff Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achufusi, Uzoamaka E., MD</td>
<td>Medicine/Nephrology</td>
<td>Active Staff</td>
</tr>
<tr>
<td>Bhagavath, Bala, MD</td>
<td>Ob Gyny/Reproductive Endocrinology</td>
<td>Active Staff</td>
</tr>
<tr>
<td>Cole, James P., Jr., DO</td>
<td>Surgery/Acute Care and Regional General</td>
<td>Active Staff</td>
</tr>
<tr>
<td>Ferguson, Sancia, MD</td>
<td>Medicine/Rheumatology</td>
<td>Active Staff</td>
</tr>
<tr>
<td>Hunter, Paul H., MD</td>
<td>Family Medicine and Community Health</td>
<td>Active Staff</td>
</tr>
<tr>
<td>Kurtz, R Compton, II, MD</td>
<td>Surgery/Minimally Invasive</td>
<td>Active Staff</td>
</tr>
<tr>
<td>Laferriere, James R., MD</td>
<td>Pediatrics/General</td>
<td>Active Staff</td>
</tr>
<tr>
<td>Polyak, Sarah E., PsyD</td>
<td>Family Medicine and Community Health</td>
<td>Clin Psych</td>
</tr>
<tr>
<td>Sisk, Elizabeth A., MD</td>
<td>Surgery/Otolaryngology</td>
<td>Active Staff</td>
</tr>
</tbody>
</table>

Focused Professional Practice Evaluation Review- Additional Privileges
The following focused review applications have been endorsed by the UWHC Credentials Committee and are recommended to the Medical Board for approval/action:
Advanced Practice Provider Privileges—New Applications

Rebecca R. Atkins, NP, UW Advance Practice Nurse

Department of Medicine/Cardiovascular Medicine
- Adult NP Core Privileges: Privileges to assess/evaluate, perform history and physical, diagnose, consult, manage, prevent disease and promote the health of adolescent and adult patients in any setting. Treatment of these patients includes the following, but not limited to, ordering and performing diagnostic studies, performing routine therapeutic procedures, injections, and ordering respiratory therapy and blood products.
- NP Cardiovascular Medicine Core Privileges: Privileges to manage and treat patients with cardiovascular disease.
- Prescriptive Authority

Advanced Practice Provider Privileges—Additional Privileges

Kristin E. Friedl, NP (Adult Gerontology Acute Care NP)
Department of Surgery/Acute Care and Regional General
- RN First Assist

Andrea L. Gilbertson, PA
Department of Medicine/Cardiovascular Medicine
- Central line/electrophysiology catheter insertion

Chad E. Hermsdorf, PA
Department of Surgery/Cardiothoracic
- Harvest arterial and/or venous conduit for bypass grafting

Barbara J. Koschak, NP (Family Nurse Practitioner)
Department of Anesthesiology
- Removal of neuraxial catheter and manipulation of neuraxial catheter

Jennifer L. Trott, NP (Adult Gerontology Primary Care NP)
Department of Medicine/Hematology/Oncology
- Lumbar Puncture

Shelly J. Weisheipl, CNM (Certified Nurse Midwife)
Department of Obstetrics and Gynecology/Nurse Midwife
Includes status change from APP Affiliate to UW Advanced Practice Nurse
- Nurse Midwife Core Privileges: Privilege as a Certified Nurse Midwife, as defined by the Wisconsin State Statutes, includes the management of women’s health care, pregnancy, childbirth, family planning, and gynecological services. These privileges include, but are not limited to, endometrial biopsy; I&D of abscess; Implanon/Nexplanon insertion; IUD insertion and removal; skin tag and wart removal; suturing; vulvar biopsy; wound debridement. It also includes health maintenance, episodic care, urgent care and ongoing monitoring and management of chronic health problems. These privileges also include prescriptive authority, ordering respiratory therapy and blood product ordering.
- Adult NP Core Privileges: Privileges to assess/evaluate, perform history and physical, diagnose, consult, manage, prevent disease and promote the health of adolescent and adult patients in any setting. Treatment of these patients includes the following, but not limited to, ordering and performing diagnostic studies, performing routine therapeutic procedures, injections, and ordering respiratory therapy and blood products.
- NP Gynecology Core Privileges: Privileges to manage and treat patients with acute and chronic gynecologic conditions and related issues.
- NP Obstetrics Core Privileges: Privileges to manage and treat patients during antepartum, pregnancy, and postpartum.
- Prescriptive Authority
Focused Professional Practice Evaluation Review

The following focused review applications have been endorsed by the UWHC Credentials Committee after review by their applicable sub-committees (if appropriate) and are recommended to the Medical Board for approval/action:

<table>
<thead>
<tr>
<th>Name</th>
<th>Department/Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bergman, Claire E., NP</td>
<td>Surgery/Plastic</td>
</tr>
<tr>
<td>Hughes, Sarah A., NP</td>
<td>Radiology/Interventional Radiology</td>
</tr>
<tr>
<td>Macy, Ashley A., NP</td>
<td>Medicine/Cardiovascular Medicine</td>
</tr>
<tr>
<td>Mullan-Towns, Erin M., PA</td>
<td>Medicine/Allergy, Pulmonary &amp; Critical Care</td>
</tr>
<tr>
<td>Piechowski, Dena L., NP</td>
<td>Medicine/General Internal Medicine</td>
</tr>
<tr>
<td>Rider, Kristen L., PA</td>
<td>Surgery/Acute Care and Regional General</td>
</tr>
</tbody>
</table>

Focused Professional Practice Evaluation Review- Additional Privileges

The following focused review applications have been endorsed by the UWHC Credentials Committee and are recommended to the Medical Board for approval/action:

<table>
<thead>
<tr>
<th>Name</th>
<th>Department/Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conway, Camille E., NP</td>
<td>Medicine/Clinical Research Unit</td>
</tr>
<tr>
<td>Gilbertson, Andrea L., PA</td>
<td>Medicine/Cardiovascular Medicine</td>
</tr>
<tr>
<td>Schuett, Ryan R., PA</td>
<td>Radiology/Abdominal Imaging</td>
</tr>
<tr>
<td>Shapiro, Nicole T., NP</td>
<td>Obstetrics and Gynecology/General Ob &amp; Gyn</td>
</tr>
</tbody>
</table>
Attachment

Medical Staff Membership
and
Clinical Privileges
September 2020
The Medical Board, upon the recommendation of the Credentials committee, recommends approval of the following new applications, additional privileges, biennial reappointments and status changes for the medical staff and other providers requesting professional privileges for practice at UWHC. All of the recommended actions have been reviewed in accordance with the Medical Staff Bylaws. The credentials of all new applicants have been verified. All persons listed below meet the standards of the medical staff for the membership and privileges recommended.

Credentials Committee: August 28, 2020
Medical Board: September 10, 2020

The following actions were endorsed by the UWHC Credentials Committee and are recommended to the Medical Board for approval/action.

New Applications

Sandip Biswas, MD, Active Staff
Department of Medicine/Hospital Medicine

- Internal Medicine/Hospital Medicine Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges include, but are not limited to, providing care via inpatient service and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

Roomasa Channa, MD, Active Staff
Department of Ophthalmology

- Ophthalmology Medical and Minor Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with illnesses, injuries, and disorders of the eye, including its related structures and visual pathways*; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training. These privileges also include care of patients via telemedicine.

- Ophthalmology Surgical Core Privileges: Privileges to perform basic surgical procedures considered a result of a residency training program including removal of radioactive plaque, corneal micropuncture and debridement, astigmatic keratotomy, cataract surgery with or without IOL placement, glaucoma filtration surgery with or without antimetabolite, combined cataract and filtering surgery, strabismus surgery on horizontal muscles, enucleation, cryotherapy, primary repair of entropion, ectropion, eyelid injury, tarsorrhaphy, blepharoplasty, lacrimal intubation and irrigation; supervision of physician assistants with prescriptive authority; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods. These privileges also include supervision of residents, fellows, and others in training.

- Special Competence Surgical Retina: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients of all ages, presenting with complicated illnesses, injuries, and disorders of the retina, vitreous and choroids. These privileges include, but are not limited to, posterior vitrectomy; intraocular foreign body removal; scleral buckling; placement of radioactive plaques for tumors, vitreous implants and injections.

- Special Competence Medical Retina: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients of all ages, presenting with complicated illnesses, injuries, and disorders of the retina. These privileges include, but are not limited to management of macular disease; written interpretation of ICG angiography, OCT, ERG, ultrasound of the globe.

- Use of surgical laser - Argon and Diode for panretinal laser.
- Use of surgical laser - YAG capsulotomy, iridotomy, cyclophotocoagulation.
Andreas R. De Biasi, MD, Active Staff
Department of Surgery/Cardiothoracic

- Cardiothoracic Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and surgically treat patients presenting with illnesses, injuries, and disorders of the chest and abdomen, including the support structures and vascular supply to the extremities and brain. These privileges include transplantation of the heart and/or lung; ventricular assist devices; ECMO cannulation; management of ECMO; pediatric cases within scope of training; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training. These privileges include care of patients via telemedicine.

- Organ Procurement

Gina M. Forte, DO, Active Staff
Department of Psychiatry/Child

- Adult Psychiatry Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult and treat patients, above the age of 15, who suffer from mental, behavioral, or emotional disorders. These privileges also include care of patients via telemedicine. These privileges include supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training.

- Child Psychiatry Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult and treat children and adolescents who suffer from mental, behavioral, or emotional disorders. These privileges also include care of patients via telemedicine. These privileges include supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and other trainees. These privileges include care of patients via telemedicine.

Mehreen T. Kisat, MD, Active Staff
Department of Surgery/Acute Care and Regional General

- General Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with disorders, illnesses or injuries of the alimentary tract, the abdomen and its contents, breast, skin, soft tissue, head and neck, endocrine system and minor extremity surgery. These privileges include, but are not limited to, laparoscopic surgery, upper gastrointestinal endoscopy, colonoscopy, insertion and management of arterial catheter, insertion and management of chest tubes, insertion and management of central venous catheters, lumbar puncture, pericardiocentesis, tracheostomy, paracentesis, management of trauma, and complete care of critically ill patients with underlying surgical conditions; performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training. These privileges include care of patients via telemedicine.

- Critical Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat as an attending physician adult patients in need of critical care within an ICU type setting. These privileges include, but are not limited to, Swan Ganz catheter insertion and management; endotracheal intubation; management of mechanical ventilation; management of noninvasive ventilation; fiberoptic bronchoscopy; direct laryngoscopy; chest tube placement; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

Indraneel Gowdar, MD, Active Staff
Department of Surgery/Cardiothoracic

- Cardiothoracic Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and surgically treat patients presenting with illnesses, injuries, and disorders of the chest and abdomen, including the support structures and vascular supply to the extremities and brain. These privileges include transplantation of the heart and/or lung; ventricular assist devices; ECMO cannulation; management of ECMO; pediatric cases within scope of training; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training. These privileges include care of patients via telemedicine.

- Organ Procurement

Camille S. Ladanyi, MD, Active Staff
Department of Obstetrics and Gynecology/Gynecology

- Medical Gynecology Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and medically treat patients presenting with disorders of the female urogenital tract. These privileges include, but are not limited to, evaluation for gynecologic disease, screening for gynecologic cancers (including breast cancer), family planning and contraception, evaluation and treatment of endocrine dysfunction and infertility, termination pregnancy, colposcopy and cervical biopsy, endometrial biopsy, gynecologic ultrasound, evaluation and treatment of incontinence; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training.

- Surgical Gynecology Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and surgically treat patients presenting with benign and pre-malignant disorders of the female urogenital tract. These privileges include, but are not limited to, pelvic endoscopic procedures; dilatation & curettage of the uterus; surgical termination pregnancy; surgical exploration of abdomen, major and minor abdominal and vaginal
surgical procedures, repair of simple injuries to the bladder or bowel, appendectomy, evaluation and treatment of incontinence; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

- Use of surgical robot for procedures otherwise privileged to perform.

Frank C. Lin, MD, Active Staff  
Department of Urology
- Urology Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and surgically treat patients presenting with illnesses or injuries of the genitourinary system; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and vaginal pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training. These privileges include care of patients via telemedicine.
- Use of surgical laser
- Laparoscopic urologic procedures
- Use of surgical robot for procedures otherwise privileged to perform.
- Fluoroscopy

Vishnu Manoranjan, MD, Active Staff  
Department of Medicine/General Internal Medicine
- Internal Medicine/Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges include, but are not limited to, lumbar puncture, thoracentesis, paracentesis, arterial line insertion, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods, supervision of physician assistants with prescriptive authority, and supervision of residents, fellows, and others in training.
- Internal Medicine/Intermediate Care Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses in the outpatient setting (General Internal Medicine clinic). Includes lumbar puncture, thoracentesis, paracentesis, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, supervision of physician assistants with prescriptive authority, and supervision of residents, fellows, and others in training.

Sarah J. Maudlin, MD, Active Staff  
Department of Psychiatry
- Adult Psychiatry Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult and treat patients, above the age of 15, who suffer from mental, behavioral, or emotional disorders. These privileges also include care of patients via telemedicine. These privileges include supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training.

Andrew S. McClintock, PhD, Clinical Psychology  
Department of Psychiatry
- Psychological testing: adolescents
- Psychological testing: adults
- Individual psychotherapy: adolescents
- Individual psychotherapy: adult
- Behavior modification
- Group therapy
- Psychoeducational counseling
- Psychoeducational testing
- Psychological consultation

Jonathan Mietichen, PhD, Clinical Psychology  
Department of Neurology
- Psychological testing: children (under 12)
- Psychological testing: adolescents
- Psychological testing: adults
- Individual psychotherapy: children (play)
- Individual psychotherapy: adolescents
- Individual psychotherapy: adult
- Behavior modification
- Neuropsychology
- Psychoeducational counseling
- Psychoeducational testing
Thoracentesis
Paracentesis
Lumbar Puncture

consult, and treat adult patients presenting with diseases of the alimentary tract and associated organs. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture; thoracentesis, paracentesis, arterial line insertion, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

Monica A. Patel, MD, Active Staff
Department of Medicine/Hematology/Oncology

- Internal Medicine/Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture, thoracentesis, paracentesis, arterial line insertion, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

- Medical Oncology Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with malignancies. These privileges include, but are not limited to, administration of chemotherapeutic agents and biological response modifiers through all therapeutic routes; management and maintenance of indwelling venous access catheters; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

Vinay L. Patel, MD, Active Staff
Department of Medicine/Gastroenterology & Hepatology

- Internal Medicine/Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture, thoracentesis, paracentesis, arterial line insertion, diagnostic or therapeutic joint aspiration/injection, endometrial biopsy, endocervical polyp removal/biopsy, intrauterine device (IUD) insertion, punch biopsy of the skin, percutaneous needle biopsy of a breast mass or skin lesion, soft tissue injection, liquid nitrogen cryosurgery of the skin or other appropriate lesion, and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

- Gastroenterology and Hepatology Core Privileges: Privileges to evaluate including performance of H&P, diagnose, consult, and treat adult patients presenting with diseases of the alimentary tract and associated organs. These privileges include, but are not limited to, diagnostic upper gastrointestinal endoscopy; therapeutic upper gastrointestinal endoscopy (treatment of bleeding lesions, sclerotherapy or banding of esophageal or proximal gastric varices, removal of foreign bodies, removal of polyloid lesions, dilation of stenotic lesions with transendoscopic balloon dilators or dilating systems with guidewires, palliative treatment of stenosing neoplasms); colonoscopy with polypectomy; liver biopsy; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

- Upper Gastrointestinal and Enteric: Endoscopic injection of botulism toxin for achalasia
- Upper Gastrointestinal and Enteric: Percutaneous endoscopic gastrostomy (PEG) or jejunostomy (JEG) placement
- Manometry: Esophageal motility testing
- Manometry: Anorectal manometry
- Adult Moderate Sedation-- All locations - includes UH, TAC, DHC, and UWHC Clinics

Kyle Z. Schmidt, MD, Active Staff
Department of Medicine/Hospital Medicine

- Internal Medicine/Hospital Medicine Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat adult patients with medical illnesses. These privileges include, but are not limited to, providing care via inpatient service and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.

- Lumbar Puncture
- Paracentesis
- Thoracentesis
Patrick T. Schofield, MD, Active Staff
Department of Anesthesiology
- Anesthesiology Core Privileges: Privileges to evaluate including performance of H&P, consult and administer anesthesia to patients for relief and prevention of pain during and following surgical, therapeutic and diagnostic procedures, including the monitoring and maintenance of normal physiology during the perioperative period and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods. Supervision of Anesthesiologist Assistants is included in these privileges. These privileges include supervision of residents, fellows, and other persons in training.
- Critical Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat as an attending physician adult patients in need of critical care. These privileges include, but are not limited to, Swan Ganz catheter insertion and management; endotracheal intubation; management of mechanical ventilation; management of noninvasive ventilation; fiberoptic bronchoscopy; direct laryngoscopy; chest tube placement; supervision of physician assistants with prescriptive authority and supervision of residents, fellows, and others in training.
- Advanced Transesophageal Echocardiography (TEE)

Elizabeth A. Scholzen, MD, Active Staff
Department of Anesthesiology/Fellow
- Anesthesiology Core Privileges: Privileges to evaluate including performance of H&P, consult and administer anesthesia to patients for relief and prevention of pain during and following surgical, therapeutic and diagnostic procedures, including the monitoring and maintenance of normal physiology during the perioperative period and perform waived laboratory testing not requiring an instrument; including but not limited to fecal occult blood, urine dipstick, and pH by paper methods. Supervision of Anesthesiologist Assistants is included in these privileges. These privileges include supervision of residents, fellows, and other persons in training.

Charles P. Shahan, MD, Active Staff
Department of Surgery/Acute Care and Regional General
- General Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with disorders, illnesses or injuries of the alimentary tract, the abdomen and its contents, breast, skin, soft tissue, head and neck, endocrine system and minor extremity surgery. These privileges include, but are not limited to, laparoscopic surgery, upper gastrointestinal endoscopy, colonoscopy, insertion and management of arterial catheter, insertion and management of chest tubes, insertion and management of central venous catheters, lumbar puncture, pericardiocentesis, tracheostomy, paracentesis, management of trauma, and complete care of critically ill patients with underlying surgical conditions; performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training. These privileges include care of patients via telemedicine.
- Critical Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat as an attending physician adult patients in need of critical care within an ICU type setting. These privileges include, but are not limited to, Swan Ganz catheter insertion and management; endotracheal intubation; management of mechanical ventilation; management of noninvasive ventilation; fiberoptic bronchoscopy; direct laryngoscopy; chest tube placement; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows, and others in training.
- Adult Moderate Sedation-- All locations - includes UH, TAC, DHC, and UWHC Clinics

Josef N. Toffe, MD, Active Staff
Department of Orthopedics and Rehabilitation/Orthopedic Surgery
- Orthopedic Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with illnesses, injuries and disorders of the musculoskeletal system; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; and supervision of residents, fellows and others in training. supervision of physician assistants with prescriptive authority
- Complex hand surgery
- Fluoroscopy

Patrick R. Varley, MD, Active Staff
Department of Surgery/Surgical Oncology
- General Surgery Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult, and treat patients presenting with disorders, illnesses or injuries of the alimentary tract, the abdomen and its contents, breast, skin, soft tissue, head and neck, endocrine system and minor extremity surgery. These privileges include, but are not limited to, laparoscopic surgery, upper gastrointestinal endoscopy, colonoscopy, insertion and management of arterial catheter, insertion and management of chest tubes, insertion and management of central venous catheters, lumbar puncture, pericardiocentesis, tracheostomy, paracentesis, management of trauma, and complete care of critically ill patients with underlying surgical conditions; performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in
training. These privileges include care of patients via telemedicine.

Megan E. Yanny, MD, Active Staff
Department of Pediatrics/General
- Pediatric Major Care Core Privileges: Privileges to admit, evaluate including performance of H&P, diagnose, consult and provide care for infants, children and adolescents with complex problems or severe illnesses, including those that are potentially life-threatening. These privileges also include care of patients via telemedicine. These privileges include, but are not limited to, lumbar puncture; peripheral arterial puncture; peripheral venous puncture; neonatal circumcision; intubation; suprapubic bladder tap in the care of newborn infants greater than 2000 grams; and performing waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and pH by paper methods; supervision of physician assistants with prescriptive authority; and supervision of residents, fellows and others in training.

Status Changes

<table>
<thead>
<tr>
<th>Name</th>
<th>Department/Section</th>
<th>Staff Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Byrne, Siobhan M., MD</td>
<td>Medicine/Gastroenterology</td>
<td>Change from Courtesy to Active Staff</td>
</tr>
<tr>
<td>Kinda, Hajnal K., MD</td>
<td>Medicine/General Internal Medicine</td>
<td>Change from Courtesy to Active Staff</td>
</tr>
<tr>
<td>Schmidt, Ann M., MD</td>
<td>Medicine/General Internal Medicine</td>
<td>Change from Courtesy to Active Staff</td>
</tr>
<tr>
<td>Streyle, Johanna C., MD</td>
<td>Medicine/General Internal Medicine</td>
<td>Change from Courtesy to Active Staff</td>
</tr>
</tbody>
</table>

Focused Professional Practice Evaluation Review

The following focused review applications have been endorsed by the UWHC Credentials Committee and are recommended to the Medical Board for approval/action:

<table>
<thead>
<tr>
<th>Name</th>
<th>Department/Section</th>
<th>Staff Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helgager, Jeffrey J., MD</td>
<td>Pathology and Lab. Medicine</td>
<td>Active Staff</td>
</tr>
<tr>
<td>Marsh, Anne M., MD</td>
<td>Pediatrics/Hematology/Oncology</td>
<td>Active Staff</td>
</tr>
<tr>
<td>Morel Valdes, Gloria M., PsyD</td>
<td>Neurology</td>
<td>Clin Psych</td>
</tr>
<tr>
<td>Tester, Gregory A., MD</td>
<td>Medicine/Cardiovascular Medicine</td>
<td>Active Staff</td>
</tr>
</tbody>
</table>

Focused Professional Practice Evaluation Review - Additional Privileges

The following focused review applications have been endorsed by the UWHC Credentials Committee and are recommended to the Medical Board for approval/action:

<table>
<thead>
<tr>
<th>Name</th>
<th>Department/Section</th>
<th>Staff Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eisenmenger, Laura B., MD</td>
<td>Radiology/Neuroradiology</td>
<td>Active Staff</td>
</tr>
</tbody>
</table>

Advanced Practice Provider Privileges -- New Applications

Therese A. Aschkenase, NP, UW Advance Practice Nurse

Department of Neurology/General
- Adult NP Core Privileges: Privileges to assess/evaluate, perform history and physical, diagnose, consult, manage, prevent disease and promote the health of adolescent and adult patients in any setting. Treatment of these patients includes the following, but not limited to, ordering and performing diagnostic studies, performing routine therapeutic procedures, injections, and ordering respiratory therapy and blood products.
- NP Neurology Core Privileges: Privileges to manage and treat patients with neurology disorders and related issues.
- Prescriptive Authority

Cecily C. Cassel, PA, UW Physician Assistant

Department of Surgery/Vascular
- General PA Core Privileges: Privileges to assess/evaluate, perform history and physical, diagnose, consult, manage, prevent disease and promote the health of any patient regardless of age and in any setting. Treatment of these patients includes the following, but not limited to, ordering and performing diagnostic studies, performing routine therapeutic procedures, incision and drainage of abscess, injections, suturing, wound care, and ordering respiratory therapy and blood products. Assist in surgery to include, but not limited to, first assist on major or minor surgeries.
- Prescriptive Authority

Jackie Kiltz, NP, UW Advance Practice Nurse

Department of Medicine/Hematology/Oncology
- Adult NP Core Privileges: Privileges to assess/evaluate, perform history and physical, diagnose, consult, manage,
prevent disease and promote the health of adolescent and adult patients in any setting. Treatment of these patients includes the following, but not limited to, ordering and performing diagnostic studies, performing routine therapeutic procedures, injections, and ordering respiratory therapy and blood products.

- NP Hematology/Oncology Core Privileges: Privileges to manage and treat patients with documented or possible hematologic and oncologic diseases.
- Prescriptive Authority

**Angela Maginn, NP, UW Advance Practice Nurse**

**Department of Pediatrics/Neonatology**

- Pediatrics/Neonatology NP Core Privileges: Under the direction of and in collaboration with a physician, the NP is granted privileges to promote health, prevent disease, assess/evaluate including performance of H & P, diagnose, consult and manage premature & critically ill neonatal patients and ill newborns through 6 months of life. These privileges include but are not limited to the following core procedures: umbilical catheter insertion (arterial or venous catheter); endotracheal tube placement/intubation; PICC insertion; thoracentesis, suturing, and wound debridement. These privileges include ordering respiratory therapy and blood products.
  - Prescriptive Authority
  - Arterial lines insertion
  - Chest tube insertion and removal
  - Lumbar puncture

**Sean Penaranda, PA, UW Physician Assistant**

**Department of Surgery/Cardiothoracic**

- General PA Core Privileges: Privileges to assess/evaluate, perform history and physical, diagnose, consult, manage, prevent disease and promote the health of any patient regardless of age and in any setting. Treatment of these patients includes the following, but not limited to, ordering and performing diagnostic studies, performing routine therapeutic procedures, incision and drainage of abscess, injections, suturing, wound care, and ordering respiratory therapy and blood products. Assist in surgery to include, but not limited to, first assist on major or minor surgeries.
  - PA CT Surgery Core Privileges: Privileges to manage and treat patients in need of cardiothoracic surgical care and related issues.
  - Prescriptive Authority

**Alyssa N. Reding, NP, UW Advance Practice Nurse**

**Department of Medicine/Cardiovascular Medicine**

- Adult NP Core Privileges: Privileges to assess/evaluate, perform history and physical, diagnose, consult, manage, prevent disease and promote the health of adolescent and adult patients in any setting. Treatment of these patients includes the following, but not limited to, ordering and performing diagnostic studies, performing routine therapeutic procedures, injections, and ordering respiratory therapy and blood products.
  - NP Cardiovascular Medicine Core Privileges: Privileges to manage and treat patients with cardiovascular disease.
  - Prescriptive Authority

**Advanced Practice Provider Privileges—Additional Privileges**

**Sarah J. Benedict, NP (Adult Gerontology Primary Care NP)**

**Department of Medicine/General Internal Medicine**

- Minor skin/subcutaneous procedure

**Linda K. Geren, NP (Family Nurse Practitioner)**

**Department of Radiology/Interventional Radiology**

- Chest Tube Removal

**Margo Hubbard, PA**

**Department of Neurology**

- Deep Brain Stimulation

**Ashley A. Macy, NP (Adult Gerontology Acute Care NP)**

**Department of Medicine/Cardiovascular Medicine**

- VAD Management

**Laura G. Ozkan, PA**

**Department of Neurology**

- Botox & Trigger Point injections, Occipital & Supraorbital nerve blocks

**Amy M. Reid, NP (Family Nurse Practitioner)**

**Department of Neurology**

- Botox injections, Occipital nerve block, Trigger point injections

**Melanie A. Schmuhl, NP (Adult Gerontology Primary Care NP)**

**Department of Obstetrics and Gynecology/Gynecologic Oncology**

- Cervical Biopsy
Focused Professional Practice Evaluation Review

The following focused review applications have been endorsed by the UWHC Credentials Committee after review by their applicable sub-committees (if appropriate) and are recommended to the Medical Board for approval/action:

<table>
<thead>
<tr>
<th>Name</th>
<th>Department/Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Browne, Amanda E., NP</td>
<td>Medicine/Cardiovascular Medicine</td>
</tr>
<tr>
<td>Higby, Bailey E., NP</td>
<td>Orthopedics and Rehabilitation/Rehab Medicine</td>
</tr>
<tr>
<td>Borg, Mikal D., PA</td>
<td>Medicine/Allergy, Pulmonary &amp; Critical Care</td>
</tr>
<tr>
<td>Hermsdorf, Chad E., PA</td>
<td>Surgery/Cardiothoracic</td>
</tr>
</tbody>
</table>

Focused Professional Practice Evaluation Review- Additional Privileges

The following focused review applications have been endorsed by the UWHC Credentials Committee and are recommended to the Medical Board for approval/action:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hatch, Kimberly E., NP</td>
<td>Surgery/Cardiothoracic</td>
</tr>
<tr>
<td>Vandenberg, Krista M., NP</td>
<td>Medicine/Geriatrics</td>
</tr>
<tr>
<td>Beck, John D., PA</td>
<td>Surgery/CT</td>
</tr>
<tr>
<td>Bolliger, Janyne R., PA</td>
<td>Surgery/CT</td>
</tr>
<tr>
<td>Crocetti, Daniel P., PA</td>
<td>Surgery/CT</td>
</tr>
<tr>
<td>Mei, Leslie A., PA</td>
<td>Surgery/CT</td>
</tr>
</tbody>
</table>
Attachment

UWHC Medical Staff Bylaws
Executive Summary
Medical Staff Bylaws Amendments—2020

Recommendations and Approvals:
- Approved by the Bylaws Committee: 7/8/2020
- Approved by the Medical Board: 7/9/2020
- Approved by the Medical Staff: 8/10/2020
- Submitted to the UWHCA Board of Directors: 8/25/2020
- Approved by UWHCA Board of Directors: 9/23/2020

RECOMMENDED SUBSTANTIVE AMENDMENTS:

<table>
<thead>
<tr>
<th>Section</th>
<th>Amendment</th>
<th>Explanation/Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article VII (Procedure for Appointment and Reappointment), Section 2</td>
<td>Deleted reference to “United Credentials Committee.”</td>
<td>The United Credentials Committee is no longer part of the appointment process so this reference has been deleted.</td>
</tr>
<tr>
<td>subsection a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Article IX (Collegial Intervention and Corrective Action), Section 4</td>
<td>Added the following:</td>
<td>Added language to clarify that a practitioner is not considered to be in “good standing” when their privileges are currently suspended pursuant to an automatic suspension.</td>
</tr>
<tr>
<td>(Automatic Suspension)</td>
<td>During the period that any or all of an individual’s clinical privileges are automatically suspended or limited pursuant to this Section 4, that individual is not considered to be in good standing.</td>
<td></td>
</tr>
<tr>
<td>Article IX (Collegial Intervention and Corrective Action), Section 4</td>
<td>Added a new subsection (k) stating the following:</td>
<td>Under the current bylaws, a faculty physician’s medical staff membership and clinical privileges are automatically suspended if the faculty member is placed on administrative leave by SMPH (the employer). We are updating the bylaws to similarly state that if an APP is placed on</td>
</tr>
<tr>
<td>(Automatic Suspension) subsection k (APP Employment)</td>
<td>APP Employment. If an APP employed by the hospital, the University of Wisconsin Medical Foundation, or the University of Wisconsin-Madison, in accordance with the requirement set forth in Article V, Section 3(b), is placed on administrative leave by the APP’s employer, the APP’s clinical privileges shall be automatically suspended for the duration of the leave. Privileges shall be reinstated upon reinstatement from the administrative leave.</td>
<td></td>
</tr>
</tbody>
</table>
administrative leave by the APP’s employer, the APP’s clinical privileges will also be automatically suspended while on administrative leave.

RECOMMENDED AMENDMENTS FOR CLARITY, TO CORRECT TYPOGRAPHICAL ERRORS, AND TO REFLECT CURRENT PROCEDURES:

<table>
<thead>
<tr>
<th>Section</th>
<th>Amendment</th>
<th>Explanation/Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Throughout Bylaws</td>
<td>We have changed references to “Medical Staff Affairs” to “Medical Staff Administration” throughout the bylaws.</td>
<td></td>
</tr>
<tr>
<td>Throughout Bylaws</td>
<td>We have changed references to “Practitioner Excellence Executive Committee” to “Peer Review Executive Committee,” as the name of this Committee was changed in the relevant hospital policies.</td>
<td></td>
</tr>
<tr>
<td>Article V (Advanced Practice Providers), Section 1 (Definition)</td>
<td>Changed reference to “Exhibit 2” to “Exhibit 3” as this was a typo.</td>
<td></td>
</tr>
</tbody>
</table>

Proposed Amendments to the Fair Hearing and Appellate Review Plan—2020

<table>
<thead>
<tr>
<th>Section</th>
<th>Amendment</th>
<th>Explanation/Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1.2.1</td>
<td>Proposed Amendments just re-state or re-organize the concepts currently in the Fair Hearing Plan. Not intended to be a substantive change.</td>
<td></td>
</tr>
<tr>
<td>Section 1.2.2</td>
<td>Proposed Amendments just re-state or re-organize the concepts currently in the Fair Hearing Plan. Not intended to be a substantive change.</td>
<td></td>
</tr>
<tr>
<td>Section 1.2.3</td>
<td>Proposed Amendments just re-state or re-organize the concepts currently in the Fair Hearing Plan. Not intended to be a substantive change.</td>
<td></td>
</tr>
<tr>
<td>Section 1.3.1</td>
<td>Proposed Amendments just re-state or re-organize the concepts currently in the Fair Hearing Plan. Not intended to be a substantive change.</td>
<td></td>
</tr>
<tr>
<td>Section 1.3.2</td>
<td>1.3.2 The Notice of Adverse Recommendation or Action can be amended or added to at any time by written notice to the practitioner by certified mail or e-mail. In no event shall the</td>
<td>This language was added to pre-empt potential arguments if the case presented at a hearing is</td>
</tr>
<tr>
<td>Section</td>
<td>Amendment</td>
<td>Explanation/Comment</td>
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<td></td>
<td>statement of the reasons for the recommendation or action included in the initial Notice of Adverse Recommendation or Action be interpreted as limiting the ability of the Medical Staff or Board of Directors to justify its recommendation or action at a hearing or appeal with additional supporting reasons not directly articulated in this notice.</td>
<td>not verbatim the same as the notice of hearing, or if additional facts are presented as evidence or rebuttal that were not included in the notice.</td>
</tr>
<tr>
<td>Section 1.4.1</td>
<td>1.4.1 Except as may otherwise be specified in the Medical Staff Bylaws, any request for a hearing must be made in writing and delivered to the CEO or CCO President of the Medical Staff within thirty (30) calendar days after the practitioner receives written notice of the adverse action or recommendation which gives rise to a hearing.</td>
<td>The current FHP has a confusing mix of responsibility, with various tasks split up among the CEO, CCO or President of the Medical Staff. Throughout the FHP, our proposed amendments simplify this by making it just the President of the Medical Staff or designee.</td>
</tr>
<tr>
<td>Section 1.4.2</td>
<td>Proposed Amendments just re-state or re-organize the concepts currently in the Fair Hearing Plan. Not intended to be a substantive change.</td>
<td></td>
</tr>
<tr>
<td>Article II Pre-Hearing Process</td>
<td>Our proposed amendments re-organize the articles into: Article II – Pre-Hearing Process; Article III – Hearing Process; Article IV – Appellate Review, and Article V – General Provisions. This is an organizational change, not a substantive one.</td>
<td></td>
</tr>
<tr>
<td>Section 2.3</td>
<td>Proposed Amendments just re-state or re-organize the concepts currently in the Fair Hearing Plan. Not intended to be a substantive change.</td>
<td></td>
</tr>
<tr>
<td>Section 2.4</td>
<td>Proposed Amendments just re-state or re-organize the concepts currently in the Fair Hearing Plan. Not intended to be a substantive change.</td>
<td></td>
</tr>
<tr>
<td>Section 2.4.2</td>
<td>2.4.2 The scheduling of a hearing in accordance with this Fair Hearing and Appellate Review plan is solely within the discretion of the President of the Medical Staff, or designee. A practitioner does not have the right to demand that a hearing date be rescheduled or otherwise modified. The practitioner may request that a hearing be rescheduled, and such request may be approved by the Hearing Officer upon good cause. The denial of such a request shall not constitute a violation of the practitioner’s due process rights under this Fair Hearing and Appellate Review Plan. The</td>
<td>This new paragraph clarifies that the scheduling of a hearing is completely within the discretion of the President of the Medical Staff, and a Practitioner does not have the right to delay the hearing. This issue previously came up at the</td>
</tr>
<tr>
<td>Section</td>
<td>Amendment</td>
<td>Explanation/Comment</td>
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</tr>
<tr>
<td></td>
<td>President of the Medical Staff, or designee, shall also have the sole discretion to determine whether the hearing shall be held in-person or, if warranted under the circumstances, via secure video conference.</td>
<td>hearing we were preparing to have.</td>
</tr>
<tr>
<td>Section 2.5.1</td>
<td>2.5.1. At least fifteen (15) calendar days prior to the hearing, the practitioner involved shall be sent by certified and regular mail or e-mail delivery a statement:</td>
<td>This addition removes the requirement that it be sent by certified and “regular mail” and also allows for e-mail delivery.</td>
</tr>
<tr>
<td>Section 2.5.1.b</td>
<td>b. identifying any witnesses expected to testify before the committee Hearing Panel in support of the recommendation under consideration; and,</td>
<td>The previous FHP alternately referred to the Hearing Panel as a “Hearing Panel” “Hearing Committee” and “committee.” This created confusion since the Hearing Panel is a smaller subset of the Hearing Committee. This was revised throughout to make the reference only to Hearing Panel except where referring to the entire committee.</td>
</tr>
<tr>
<td>Section 3.1.a</td>
<td>a. Representation by an attorney or other person of choice. If such attorney or other person of choice is not available at the scheduled time for the hearing, the denial of a request to reschedule the hearing shall not be considered a violation of this right to representation.</td>
<td>This addition was made to clarify that attorney availability will not dictate the scheduling of the hearing. Otherwise, a practitioner could indefinitely delay a hearing by claiming unavailability of his/her preferred attorney. This issue came up at the hearing we were preparing for.</td>
</tr>
<tr>
<td>Section</td>
<td>Amendment</td>
<td>Explanation/Comment</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Section 3.2 – 3.7</td>
<td>Proposed Amendments just re-state or re-organize the concepts currently in the Fair Hearing Plan. Not intended to be a substantive change.</td>
<td></td>
</tr>
<tr>
<td>Section 3.8</td>
<td>3.8. Discovery. Except as specifically provided in this Fair Hearing and Appellate Review Plan, there shall be no right to conduct discovery in connection with any hearing and no practitioner shall be permitted access to any peer review records, medical records, minutes or other documents relating to any other practitioner, or any action taken or not taken with regard to any other practitioner. The practitioner requesting a hearing shall, however, be entitled to any documents relied on by the Medical Board or Board of Directors in making any recommendation or decision, any documents to be introduced at the hearing, and any medical records relied on or to be introduced at the hearing, so long as the practitioner and his/her counsel attorney agree in writing to keep all such documents confidential and not use them for any purpose other than in the hearing and appellate review proceedings. The production of such documents shall not constitute a waiver of any peer review protection for those documents or any other documents. <strong>Nothing in this Fair Hearing and Appellate Review Plan shall be interpreted as giving the practitioner the authority to subpoena or otherwise compel the production of any documents, records or witnesses.</strong></td>
<td>The added sentence at the end is the only new part. The rest was just re-organized. The new sentence was added to address a legal dispute that came up during the hearing we were preparing for.</td>
</tr>
<tr>
<td>Section 3.9-3.14</td>
<td>Proposed Amendments just re-state or re-organize the concepts currently in the Fair Hearing Plan. Not intended to be a substantive change.</td>
<td></td>
</tr>
<tr>
<td>Section 3.15</td>
<td>3.15. Report and Recommendations of Hearing Panel. After final adjournment of the hearing, including receipt of all written submissions, the Hearing Panel shall deliver a written report to the Medical Board stating in full its findings, the reasons and evidence upon which it based its findings, and its recommendations. <strong>If the practitioner submitted a written statement to the Hearing Panel in accordance with section 3.12, such statement shall be appended to the report and recommendation delivered</strong></td>
<td>The first addition was added to streamline the process. The current FHP has the practitioner sending a separate written statement to both the Hearing Panel, and the Medical Board. It is simpler and faster to</td>
</tr>
<tr>
<td>Section</td>
<td>Amendment</td>
<td>Explanation/Comment</td>
</tr>
<tr>
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<tr>
<td>to the Medical Board. The recommendations of the Hearing Panel need not be unanimous and any minority views may be reduced to writing, supported by reasons and references, and transmitted with the majority report. A copy of the Hearing Panel's report and recommendation, along with any minority views reduced to writing shall be delivered to the practitioner.</td>
<td>consolidate this by attaching the practitioner statement to the hearing panel report. The second addition is only a revision for clarity.</td>
<td></td>
</tr>
<tr>
<td>Old Section 2,9-2.10</td>
<td>2.9. Practitioner Response to Report and Recommendations. Within fifteen (15) calendar days after the report and recommendations of the Hearing Panel are delivered to the practitioner, the practitioner shall submit a written statement to the Medical Board specifying the findings of fact, conclusions, or procedural matters with which the practitioner disagrees and the reasons for such disagreement. Failure to identify any findings of fact, conclusions, or procedural matters with which the practitioner disagrees shall constitute a waiver of those issues. The practitioner may not submit new information, nor evidence not previously considered by the hearing committee, except as may be requested or approved by the Medical Board. 2.10. Appearance before Medical Board. The medical staff president may, in his/her sole discretion, permit or require the practitioner or his/her representative to appear before the Medical Board, to present oral argument or respond to inquiries.</td>
<td>These sections established what is essentially a mini-appeal to the Medical Board following a hearing. We do not think this is necessary, as the FHP already has an appeal to the Board of Directors. Adding an unnecessary step like this only creates an additional delay in the process, so we recommend removing.</td>
</tr>
<tr>
<td>Section 3.16</td>
<td>Proposed Amendments just re-state or re-organize the concepts currently in the Fair Hearing Plan. Not intended to be a substantive change.</td>
<td></td>
</tr>
<tr>
<td>Section 4.1</td>
<td>4.1. Request for Appellate Review. The practitioner may, within ten (10) calendar days after the practitioner is notified receipt of the recommendations of the Medical Board, request the opportunity to appear before appellate review by the Board of Directors, or any Committee of the Board designated by the Board (collectively referred to as the “Board”), to present oral argument. Such a request must be submitted in writing to the Board within ten (10) calendar days after the practitioner is notified receipt of the recommendations of the Medical Board.</td>
<td>Most of these edits are stylistic and not substantive, but the one substantive change is that the old section could be read as giving the practitioner the right to oral argument for any...</td>
</tr>
<tr>
<td>Section</td>
<td>Amendment</td>
<td>Explanation/Comment</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>Section 4.3</td>
<td><strong>4.3. Nature of appellate review.</strong>&lt;br&gt;4.3.1 The Chair of the Board of Directors shall determine, in his/her sole discretion, whether the appellate review shall be conducted by the full Board of Directors, or by a committee of the Board composed of not less than three (3) persons. For the purposes of this Article IV, any reference to the “Board” shall include any committee designated to conduct a review.&lt;br&gt;4.3.2 The practitioner and the Medical Board shall each have the right to submit written statements in support of their respective positions on appeal. In addition, the Board may decide, in its sole discretion, to allow each party or the party’s representative to appear before the Board for oral argument and/or questioning by the Board. The failure of the Board to allow such personal appearance shall not be considered a violation of the practitioner’s right to appellate review.</td>
<td>This addition was made to further explain that the Board has the discretion to determine the method by which the appellate review will occur. The content of 4.3.1 is not a substantive change in that the current appeal process allows it to be conducted by a subcommittee of the Board, but this language clarifies that such a subcommittee should have at least 3 members.</td>
</tr>
<tr>
<td>Section 4.4</td>
<td><strong>4.4 Notice.</strong>&lt;br&gt;4.4.1 When a timely request for appellate review is received, the Chair of the Board of Directors, or designee, shall notify the practitioner in writing, by certified mail or e-mail delivery, of the deadline to submit a written statement to the Board. Such deadline shall not be less than fifteen (15) calendar days from the date the practitioner receives the notice.&lt;br&gt;4.4.2 If the Board allows personal appearance of the parties or their</td>
<td>This is all new language, but not a substantive change.</td>
</tr>
<tr>
<td>Section</td>
<td>Amendment</td>
<td>Explanation/Comment</td>
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<td>representatives, the notice shall include the date, time and place of such appearance, which shall not be less than seven (7) calendar days from the date the practitioner receives the notice. 4.4.3 The notice shall include a statement that the failure of the practitioner to submit a timely written report, or appear at a scheduled personal appearance shall be deemed a waiver of the right to appellate review.</td>
<td></td>
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<tr>
<td>Section 4.5.1</td>
<td>4.5.1 A written statement from the practitioner to the Board shall set forth with specificity any findings of fact, conclusions, recommendations and procedural matters with which the practitioner disagrees and the reasons therefore. Such statement shall be limited to facts and evidence introduced at the hearing or otherwise considered by the Medical Board, or facts or evidence that the practitioner feels were wrongly excluded from consideration.</td>
<td>This addition was made to clarify that the scope of appellate review is whether the hearing was conducted fairly, not to introduce new evidence not previously considered.</td>
</tr>
<tr>
<td>Section 4.5.2</td>
<td>4.5.2 The Board shall provide a copy of the practitioner’s written statement to the President of the Medical Board. The Medical Board may submit a response to the Board within fifteen (15) calendar days of receiving the practitioner’s statement. The Medical Board may elect instead to rely on the report and recommendation it previously submitted to the Board of Directors, and the failure of the Medical Board to submit a written response shall not be considered acceptance of any objections raised by the practitioner.</td>
<td>This new language gives the Medical Board the option to rely on previous reports and recommendations, instead of submitting new reports, and that doing so is not considered a waiver of any arguments.</td>
</tr>
<tr>
<td>Section 4.6</td>
<td>4.6. Oral Argument Personal Appearance before the Board of Directors. If personal appearance of the parties before the Board is allowed, such appearance shall be limited to oral argument and/or questioning from the Board. The practitioner shall not be permitted to introduce any new facts or evidence which was not introduced at any hearing, unless there are</td>
<td>This addition adds that questioning from the Board is permitted in oral arguments. It also replaces the language “unless there are extenuating circumstances” with a more</td>
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<td>extenuating circumstances except for facts or evidence which the practitioner contends was wrongly excluded from consideration at the hearing. The practitioner may be accompanied by an attorney who may advise and speak on behalf of the practitioner; however, the members of the Board shall be permitted to direct questions to the practitioner who shall be required to respond personally. The amount of time available for the practitioner’s presentation may be limited by the Board or Committee Chair or subject to such conditions as the Board determines to be appropriate.</td>
<td>precisely stated exception. We feel “unless there are extenuating circumstances” is too vague and could lead to unnecessary dispute.</td>
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<tr>
<td>Sections 4.7-5.5</td>
<td>Proposed Amendments just re-state or re-organize the concepts currently in the Fair Hearing Plan. Not intended to be a substantive change. The deleted provisions in Article V were all just reorganized elsewhere.</td>
<td></td>
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<td>Exhibit 2: FHP for APPs and other individuals granted clinical privileges</td>
<td>Throughout Exhibit 2, changes were made to match the amendments to Exhibit 1. These will not be separately addressed here.</td>
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<tr>
<td>Old Section 1.2.5</td>
<td>1.2.5. Before requesting a hearing under this plan, the practitioner must submit a written request for reconsideration to the CCO or chief medical officer within fifteen (15) calendar days of written notice of adverse action or recommendation which gives rise to the hearing. The CCO, chief medical officer, or designee shall consult with the chief nurse executive or designee before issuing a response with respect to an advanced practice nurse. The CCO, chief medical officer, or designee shall issue a written response within fifteen (15) calendar days. The written response shall state the action or intended action and charges or complaints that are the basis for the action. If the action that would have entitled the practitioner to hearing is modified so that no action entitling the practitioner to a hearing remains then the practitioner shall not be entitled to a hearing.</td>
<td>We think this step is unnecessary and would only delay the process. In addition, it seems strange to give the CCO/CMO the authority to unilaterally modify a recommendation of the Medical Board.</td>
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<tr>
<td>Section 2.1.1</td>
<td>2.1.1. Upon receipt of a request for a hearing, the President of the Medical Staff, or designee shall identify a Hearing Panel and chair of the Hearing Panel. The Hearing Panel shall be a subcommittee of the Hearing</td>
<td>We believe the removed language is unnecessary, as the section already requires that the</td>
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<tr>
<td>Section</td>
<td>Amendment</td>
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<td>Committee that is assigned the responsibility to conduct the hearing, unless the President of the Medical Staff, or designee, determines that conflicts or other reasons require that medical staff members who are not members of the Hearing Committee be appointed to the Hearing Panel. In addition to medical staff members of the Hearing Panel, the Hearing Panel shall be further augmented with at least two persons in the same discipline as the practitioner who requested the hearing. When the practitioner requesting the hearing is an advanced practice nurse, the Hearing Panel shall have at least two persons from the hospital’s department of nursing selected in consultation with the chief nurse executive or designee. The Hearing Panel shall have not less than three members. There also may be appointed one or more alternate members of the Hearing Panel.</td>
<td>Hearing Panel include 2 individuals in the same discipline as the individual who requested the hearing.</td>
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</tbody>
</table>
Resolution

Adoption of Amended and Restated Bylaws of UWHC Medical Staff
RESOLUTION OF
THE BOARD OF DIRECTORS OF
UNIVERSITY OF WISCONSIN HOSPITALS AND CLINICS AUTHORITY

Approval of Amendments to Medical Staff Bylaws and Rules and Regulations

September 23, 2020

Whereas, the Board of Directors of the University of Wisconsin Hospitals and Clinics Authority, having reviewed and discussed the proposed amendments to the Bylaws and Rules and Regulations of the Medical Staff, hereby approves the proposed amendments as adopted by the Medical Staff and in accordance with Article XVII, Section 1 of the Bylaws and Rules and Regulations of the Medical Staff.
# 2019–2021 Bylaws and Rules and Regulations of the Medical Staff

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Preamble

The medical staff is accountable for the quality of care in the University of Wisconsin Hospitals and Clinics ("UWHC"), and it accepts and assumes this responsibility subject to the authority of the University of Wisconsin Hospitals and Clinics Authority Board of Directors ("Board of Directors"). The medical staff practicing in the University of Wisconsin Hospitals and Clinics hereby organizes themselves in conformity with the Bylaws and Rules and Regulations hereinafter stated. University of Wisconsin Hospitals and Clinics comprises all locations of the hospital, including, but not limited to, University Hospital, American Family Children’s Hospital, and UW Health at The American Center. For the purpose of these Bylaws, the term “medical staff” shall be as defined in Article IV.

Article I: Name

The name of this organization shall be the medical staff of the University of Wisconsin Hospitals and Clinics.

Article II: Purpose

The purposes of this organization shall be:

1. To monitor and be responsible for the quality of medical care in the hospital.
2. To recommend to the Board of Directors the appointment or reappointment of applicants to the medical staff of the hospital, the granting or limiting of clinical privileges, and other actions affecting members of the medical staff.
3. To promote clinical education and research.

Article III: Membership

Section 1. Qualifications.

a. Membership on the medical staff is limited to physicians, dentists, podiatrists, and certain other professional staff, as authorized in Article IV, licensed to practice in the State of Wisconsin who can document their background, experience, training, health status, and competence; their adherence to the ethics of their profession; and their ability to work with others sufficiently to assure the appropriate department, medical staff, and the Board of Directors that patients in the hospital will be given high quality medical care. In these Bylaws, “licensed” to practice in the State of Wisconsin shall mean having a professional license, certificate or other permit from the state permitting practice in the state.

b. Each member shall be free of any significant physical, mental, or behavioral impairment that interferes with, or presents a substantial probability of interfering with patient care, the exercise of clinical privileges, or the assumption and discharge of required responsibilities. Each member shall cooperate in any health assessment required by the UW Health chief executive officer ("CEO"); Chief Clinical Officer ("CCO"); or chief medical officer.

c. Each applicant must agree to participate in the educational programs associated with the University of Wisconsin Hospitals and Clinics. Appointments must be adjudged by the department to be consistent with its overall goals.

d. Medical staff membership is contingent upon initial and continued appointment to the faculty of the appropriate clinical department of the University of Wisconsin School of Medicine and Public Health ("SMPH"). "Faculty," for the purpose of these Bylaws, includes tenure track, clinical health sciences track, clinician teacher track, and emeritus. "Faculty," for purposes of these Bylaws, also includes faculty recruited and hired into tenure track, clinical health sciences track, or clinician teacher track with an
interim title of visiting professor. This “faculty” designation shall have no effect on an individual’s appointment as faculty under UW-Madison faculty policies and procedures.

e. Membership shall not be denied on the basis of age, race, color, sex, religion, creed, sexual orientation, national origin, ethnic/national identity, or type of procedure or patient (e.g., Medicaid) in which the applicant specializes.

f. A member is expected to comply with the hospital’s state licensure requirements by having both a pre-appointment and a periodic health assessment. A member shall undergo a pre-appointment assessment which includes a health history, physical examination, and tuberculin (TB) skin test. Periodically during the appointment, the TB status will be checked by Medical Staff Affairs/Medical Staff Administration, consistent with hospital policy. Prior to reappointment a member must document compliance with the hospital’s TB skin test policy and confirm that there have been no changes in his/her health status which would affect their ability to practice medicine. A file will be maintained in the Employee Health Department, and that department will verify a member’s compliance with the TB skin test requirement to Medical Staff Affairs/Medical Staff Administration during the reappointment process.

g. Applicants and members must have no record of conviction of Medicare, Medicaid, or insurance fraud and abuse; payment of civil money penalties for same; or exclusion or prohibition from participation in such programs.

h. Physician applicants and members of the medical staff must either:
   1. be board certified or board eligible by a certifying board accredited by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA). “Board eligible” is as defined by ABMS and AOA; or
   2. demonstrate equivalent training and experience, plus (1) secure individual approval to be participants in all managed care plans for which UWHC performs delegated credentialing that do not accept delegated credentialing for persons without board eligibility or certification, or (2) present a plan approved by the physician, the applicable department(s), the chief medical officer and the hospital chief financial officer, that addresses how the practice of the physician will be structured to address the lack of participant status in managed care plans for which UWHC performs delegated credentialing.

This section does not apply to physicians who were granted membership on the medical staff before July 1, 2012 and have maintained their membership continuously since July 1, 2012.

Section 2. Ethics and Ethical Relationships. Members of the medical staff shall conduct themselves in the highest ethical tradition. Specifically, members shall abide by the Principles of Medical Ethics and Code of Medical Ethics adopted by the American Medical Association, the American Dental Association Principles of Ethics and Code of Conduct, American Podiatric Medical Association Code of Ethics, and any other applicable professional ethical standards and interpretations. In addition, members of the medical staff will not engage in the practice of rebating a portion of a fee or utilizing other inducements in exchange for referral of patients.

Section 3. Additional Conditions of Appointment.
   a. Appointments to the medical staff shall confer on the appointees only such clinical privileges as are specified in the notice of appointment.
   b. Active members must be able to provide for continuous care and supervision of their patients, agree to accept staff committee assignments, and provide emergency care and consultation.
c. Every member must abide by the Bylaws and Rules and Regulations of the Medical Staff; policies and procedures of UW Health and the medical staff; the Bylaws of the Board of Directors of the University of Wisconsin Hospitals and Clinics Authority; UW Health code of conduct; and applicable laws.

d. A member is expected to cooperate in any required review of his or her credentials, qualifications, or compliance with these Bylaws, and to refrain from directly or indirectly interfering with any such review.

e. Each practitioner or other professional granted clinical privileges or with a pending application for clinical privileges shall notify the CCO or chief medical officer or designee within ten (10) calendar days after any of the following. Failure to notify shall constitute grounds for corrective action. Upon request from Medical Staff Affairs/Medical Staff Administration, the practitioner or other professional shall promptly provide copies of documents regarding such reported matter.

1. Any voluntary or involuntary loss or lapse of any license, registration, or certification regarding professional practice; any disciplinary or monitoring measure and any change in such discipline or monitoring measure by any licensing or registration body or certification board that licenses, registers, or certifies clinical or professional practice.

2. Any settlements, judgments, or verdicts entered in an action in which the practitioner or other professional was alleged to have breached the standard of care other than those arising out of his/her employment by the University of Wisconsin or his/her practice at the University of Wisconsin Hospitals and Clinics.

3. Pending investigation, disciplinary action, or other adverse action by a governmental agency and the progress of any investigation or action.

4. The voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or termination of privileges or ability or permission to practice at another hospital or health care facility.

5. Initiation of any corrective action or other disciplinary action at another hospital or health care facility. The affected practitioner or other professional shall provide complete information as to the reasons for the initiation of corrective or disciplinary action and the progress of the proceedings.

6. Any changes to information included in the application for medical staff membership or clinical privileges, including any change of the person’s health status or other change that affects his or her ability to safely and competently exercise privileges.

7. Exclusion or preclusion from participation in Medicare, Medicaid, or other federal or state health care programs.

8. Any notice of complaint or investigation by any licensing or registration body or certification board that licenses, registers, or certifies clinical professional practice.

9. Any indictment, conviction, or plea of guilty, no contest, or nolo contendere pertaining to any felony; or to any misdemeanor involving (i) controlled substances, (ii) illegal drugs, (iii) Medicare, Medicaid, or insurance or health care fraud or abuse, or (iv) violence against another.

f. The CCO or chief medical officer will forward to the chair of the applicable clinical service a copy of any notice received under subsection (e).

g. Each practitioner or other professional granted clinical privileges or with a pending application for such clinical privileges authorizes the University of Wisconsin and any other individual or entity where he or
she has worked or is working or is or was permitted to practice to release to the hospital any
information pertaining to the medical practice or professional behavior of such practitioner or other
professional. Release of information under this subsection (g) does not satisfy the notice requirement
in subsection (e).

h. Each practitioner or other professional granted clinical privileges is responsible for maintaining current
contact information with Medical Staff Affairs Medical Staff Administration and promptly reporting any
changes. Except as otherwise provided in these Bylaws, any notice to practitioners or other
professionals granted clinical privileges may be provided by email. Persons granted clinical privileges
are responsible for timely retrieval of communications from hospital or medical staff representatives
at the contact information provided to Medical Staff Affairs Medical Staff Administration.

Article IV: Categories of the Medical Staff

Section 1. The Medical Staff. The medical staff shall be divided into active medical, courtesy medical, and
honorary medical. The “privileged medical staff” shall include the active medical and courtesy medical.

Section 2. The Active Medical Staff. The active medical staff shall consist of physicians, dentists, and podiatrists
who are granted membership on the active medical staff and who regularly utilize the hospital, and who assume
all the functions and responsibilities that membership on the active medical staff entails. Members of the active
medical staff shall be appointed to a clinical service; shall be eligible to vote in the medical staff organization,
hold office, and serve on medical staff committees; and are required to attend medical staff meetings.

Section 3. The Courtesy Medical Staff. The courtesy medical staff shall consist of physicians, dentists, and
podiatrists who are granted membership on the courtesy medical staff and who are privileged to act as
consultants, to admit no more than 20 patients per year to the hospital, and to have no more than 20 scheduled
outpatient appointments per year in UWHC clinics. Courtesy medical staff members shall be appointed to a
clinical service, but shall not be eligible to vote or hold office in this medical staff organization, except they may
be members of the Medical Board.

Section 4. The Honorary Medical Staff. The honorary medical staff shall consist of individuals who are granted
membership on the honorary medical staff and who have retired from active hospital service or who are of
outstanding competence. Honorary staff members are not eligible to vote or hold office, will not be permitted to
admit patients, and shall have no clinical privileges, including consultation. Membership on the honorary
medical staff may be granted or terminated by the Board of Directors on recommendation of the Medical Board.
The other procedures regarding appointment and reappointment in these Bylaws shall not apply to the
honorary medical staff.

Article V: Advanced Practice Providers

Section 1. Definition. Advanced practice providers shall mean professionals other than physicians, dentists, and
podiatrists who are eligible to apply for clinical privileges. The categories of professionals eligible to apply for
privileges as advanced practice providers are listed in Exhibit 2 of these Bylaws. The categories of professionals
listed in Exhibit 2 may be expanded as provided in Section 7 of this Article V.

Section 2. Qualifications and Practice.

a. Advanced practice providers granted clinical privileges may provide patient care services only within
the scope of their licenses and hospital policies, and in accordance with clinical privileges granted to
the individual by the Board of Directors, which cannot include admitting privileges.

b. Advanced practice providers shall have appropriate supervision and/or collaboration as required by
law or hospital policy.
c. Anyone applying for or receiving clinical privileges under this Article V shall also have to comply with the requirements in Article III except as otherwise provided in this Article.

Section 3. Application Process. The procedure and requirements for accepting and processing applications for appointment and reappointment in Article VII shall be followed for applications for clinical privileges from advanced practice providers, except that:

a. Advanced practice providers shall not be members of the medical staff;

b. Such individuals must have a faculty appointment at SMPH or be employed by the hospital, the University of Wisconsin Medical Foundation, or the University of Wisconsin-Madison. Persons who do not have such employment or SMPH faculty appointment shall automatically lose their clinical privileges without right to hearing or review under these Bylaws; and

c. Applications for privileges submitted by advanced practice nurse prescribers, certified nurse midwives, nurse practitioners, and certified registered nurse anesthetists must be submitted for approval first to the designated APNP approval body in accordance with Hospital policy. The chief nurse executive or designee shall make the recommendation whether to approve or renew approval of the advanced practice nurse. Recommendations regarding approval or renewal of approval shall be made to the Credentials Committee.

Section 4. Corrective Action; Hearing and Appeals. Sections 1, 2, and 3 of Article IX shall not apply to advanced practice providers granted clinical privileges under this section. The Board of Directors, CEO, CCO, chief medical officer, or their designees may terminate or restrict any clinical privileges granted under this section. The chiefs of the clinical services, any officer of the medical staff, or the chief medical officer may submit a request to the CEO, CCO, or their designees to take action under this subsection; such request shall not be required to initiate action. The chief nurse executive or his/her designee may also terminate or restrict any clinical privileges granted to an advanced practice nurse. When clinical privileges are terminated or restricted under this section, the advanced practice providers may be entitled to an opportunity for hearing and appellate review as specified in Article X.

Section 5. Peer Review. Peer review of persons granted clinical privileges shall be conducted in accordance with the policies and procedures of UW Health and the medical staff.

Section 6. Trainees. To the extent permitted by law, persons who are trainees in UWHC-sponsored or UWHC-affiliated training programs may assist in providing services within the training program under supervision of persons who have the clinical privileges to provide the services. Such trainees will be reviewed, approved, evaluated, and supervised pursuant to hospital policies and procedures. They may act within the scope of such approval. This section does not apply to Graduate Medical Education (GME) trainees, who are governed by Article VI, Section 1.

Section 7. Determining Need for New Advanced Practice Providers.
Whenever a health care professional of a type not included in Exhibit 2 as permitted to apply for privileges as an advanced practice provider requests permission to practice at the hospital, the Board of Directors, with input from the Medical Board, shall evaluate the need for that type of health care professional as an advanced practice provider, taking into consideration the following factors:

a. The nature of the services that could be offered;

b. Any state license or regulation that outlines the scope of practice for the health care professional;

c. The business and patient care objectives of the hospital;

d. How well the community’s needs are currently being met and whether they could be better met if the
services offered by the health care professional were provided by the hospital;
e. The type of training that is necessary to perform the services that could be offered and whether there
are individuals with more training that are currently providing those services;
f. The availability of supplies, equipment, and other necessary resources to support the health care
professional;
g. The availability of trained staff;
h. Patient convenience; and
i. The ability to appropriately supervise performance.
Whenever the Board of Directors approves a new type of health care professional as an advanced practice
provider, Exhibit 3 of these Bylaws shall be supplemented to reflect such approval.

Article VI: Trainees and Learners

Section 1. GME trainees. GME trainees (residents and fellows) shall be graduates of approved schools of
medicine, osteopathy, podiatry, or dentistry who are in graduate training programs approved by or formally
affiliated with the University of Wisconsin Hospitals and Clinics. GME trainees must be licensed. GME trainees
are not members of the medical staff, are not eligible to vote or hold office in the medical staff, but GME
trainees in hospital sponsored training programs shall have voting representation on the Medical Board and its
committees as provided in these Bylaws. Members of the medical staff may permit GME trainees to function
under supervision within the scope of the clinical privileges granted to the supervising medical staff member.
Whenever the term “supervision” is used in these Bylaws and Rules and Regulations with reference to GME
trainees or other students, it means direction, supervision, and oversight by a supervising member of the
medical staff, but does not include a requirement that the medical staff member be present for the conduct of
the supervised patient care unless such presence is appropriate under the circumstances or required by law or
hospital policy.

Section 2. Other physician learners. Visiting physicians may attend training at the University of Wisconsin
Hospitals and Clinics as observers and/or delegated learners (hereinafter “learners”). Visiting physicians may
have direct patient contact as learners only when approved pursuant to UW Health policies. Such learners will
be reviewed, approved, evaluated, and supervised pursuant to UW Health policies and procedures. They may
act only within the scope of such approval. These learners have no independent clinical privileges and shall not
be members of the medical staff. They shall not bill for their services and shall not give orders or make entries in
the medical record. To the extent permitted by law and such approval, delegated learners may assist in
providing services under direct supervision of members of the medical staff who have the clinical privileges to
provide the services. Delegated learners may be approved for gloves-on training for a period not to exceed ten
days, and such training must be to learn specific defined patient techniques. The learners shall comply with the
requirements in Article III, Section 3(c) through (g) to the same extent as members of the medical staff, but shall
not be entitled to the corrective action procedures. Unless otherwise provided by UW Health policy, the CEO,
CCO chief medical officer, or their designees may terminate any approval of a learner, and there shall be no right
to hearing or appeal. This section does not apply to GME trainees, who are governed by Article VI, Section 1.

Article VII: Procedure for Appointment and Reappointment

Section 1. Application for Appointment.

a. Applications to the privileged medical staff shall be submitted on the prescribed forms and shall
include detailed information on the applicant’s professional qualifications and indicate professional references and shall include a statement granting the hospital and others immunity in civil liability cases. The applicant shall indicate whether any of his/her previous memberships, clinical privileges, licenses, or registrations have been revoked, suspended, reduced, not renewed, or voluntarily terminated or limited. The applicant shall also indicate any settlement, judgment, or verdict entered in an action or currently pending action, where the applicant was alleged to have breached the professional standard of care, currently pending or previously successful challenges to any licensure or registration, the voluntary relinquishment of such licensure or registration, or any lapse in licensure or registration. In these cases the applicant shall provide a written explanation. The applicant must submit a photograph and all other information requested to assist in confirming the identity of the applicant. All materials will be forwarded by Medical Staff Affairs/Medical Staff Administration to the Credentials Committee.

b. By applying for membership on the privileged medical staff, the applicant signifies a willingness to appear before the Credentials Committee and authorizes members of those committees to consult with any and all members of medical staffs of other hospitals with which the applicant has been associated, as well as with other persons or entities who may have information bearing on his/her competence, ethical qualifications, and current health status. If there is doubt as to the competence, ethical character, or health status of the applicant, the applicant shall not be granted privileges unless the doubts can be resolved to the satisfaction of the Board of Directors.

c. All applicants for appointment or reappointment must have professional liability coverage for their activities on the medical staff. Coverage for state employees by the state self-funded liability program or for hospital employees by the hospital liability program satisfies this requirement. All applicants not covered by one of these programs must demonstrate professional liability coverage in the amount required for physician participants in the Wisconsin Injured Patients and Families Compensation Fund (“Fund”), even if exempt from participation in the Fund. Any member who does not have coverage that satisfies this requirement must immediately report the absence of coverage to Medical Staff Affairs/Medical Staff Administration and all privileges will be automatically suspended in accordance with Article IX, Section 4.

d. An application submitted to the Credentials Committee shall include a statement from the chief of clinical service indicating whether the chief recommends the privileges requested and the category of appointment. Applications for privileges that overlap departments must have a statement from each of the chairs of affected departments. An application may be accepted and processed prior to receipt of the required SMPH faculty appointment, but only if the applicable department chair has provided written notice that faculty appointment has been recommended. Any approval of membership or clinical privileges shall not be effective until the faculty appointment is received.

Section 2. Appointment Process.

a. The Credentials Committee shall review the qualifications, character, professional competence, and ethical standing of the applicant to the privileged medical staff and verify that all necessary qualifications for staff membership and requested privileges are met. Through Medical Staff Affairs/Medical Staff Administration or United Credentials Committee, UWHC shall (i) verify in writing and from the primary source whenever feasible or from a credentials verification organization the following: the applicant’s current license, specific relevant training, and current competence, (ii) verify the applicant’s ability to perform the privileges requested, and (iii) confirm that the individual requesting approval is the same individual identified in the credentialing documents. UWHC shall
query the National Practitioner Data Bank (NPDB) at the time of initial medical staff appointments and initial granting of privileges and at the time of expanding privileges or requesting to add new privileges. Upon receipt of the completed application, confirmation of required verifications, and the results of the NPDB query, the Credentials Committee shall review the application and all supporting documentation and may conduct further investigation. The Credentials Committee shall submit a report of its findings in whole or in part recommending that the application be accepted or rejected.

1. If the recommendation is to accept, the report shall be submitted to the Medical Board and any recommendation for appointment shall include the recommended staff status and a delineation of privileges.

2. When an applicant has submitted insufficient documentation to support one or more requested privileges, the Credentials Committee shall report on appointment and other privileges, but does not have to report on privileges with insufficient documentation; the committee shall respond to the applicant with a written request that the applicant provide additional documentation or rescind the request for such privileges.

3. If the recommendation of the Credentials Committee is to reject the application, the report shall be submitted to the chief medical officer. The chief medical officer or his/her designee shall review the recommendation and assess whether the recommendation was made in a discriminatory manner on the basis of a characteristic listed in Article III, section 1(e). If this review confirms that the recommendation was made in a nondiscriminatory manner, the recommendation shall be forwarded to the Medical Board. If this review cannot confirm that the recommendation was made in a nondiscriminatory manner, the matter may be referred back to the Credentials Committee for further review or to the Medical Board with a report from the chief medical officer or his/her designee recommending other steps that may be taken to address the possible discrimination.

4. The Credentials Committee may defer consideration of the application as needed.

b. When the Credentials Committee has conducted its evaluation and recommended privileges, an applicant for new privileges may be granted temporary privileges in accordance with Article VIII, Section 2.

c. When the Medical Board recommends denial of appointment or denial of requested privileges, the applicant may be entitled to an opportunity for hearing and appellate review as specified in Article X. The CEO or CCO shall give notice of the adverse recommendation. The CEO may delegate this and any other duty under these Bylaws.

d. Favorable recommendations of the Medical Board regarding appointment and granting of clinical privileges shall be forwarded to the Board of Directors to be acted upon in accordance with Board of Director procedures. If the Board of Directors’ decision is not to approve appointment or the requested clinical privileges and the affected member has not had a prior opportunity for the procedural rights provided in Article X, the affected member may be entitled to such procedural rights as specified in Article X. After any such procedural rights are waived or exhausted, the Board of Directors shall make the final decision. However, if the Board of Directors’ decision is contrary to the recommendation of the Medical Board, the matter shall be returned to the Medical Board for an opportunity to comment before a final decision is made by the Board of Directors.

e. When the final decision of the Board of Directors is made, it shall send notice of such decision through the CEO to the applicant. The notice shall specify the period of appointment and privileges, which shall not exceed two years. If the medical staff category or privileges granted differ from those requested
or recommended, notice shall also be provided to the chief of the clinical service concerned and the Credentials Committee.

f. Except in extraordinary circumstances, all action on an application shall be accomplished within one hundred twenty (120) calendar days of receipt of a completed application.

g. An application once deemed complete may thereafter be deemed incomplete if at any time during the consideration of the application new, additional, or clarifying information is requested. An incomplete application will not be processed until all requested information is received.

Section 3. Reappointment Process.

a. At least ninety (90) calendar days prior to the end of the appointment term, the chief of each clinical service shall submit to the Credentials Committee a list of all recommended changes in appointment status and/or assigned privileges for each member of the service.

b. The Credentials Committee shall review these recommendations and all other pertinent information available on each member for the purpose of determining its recommendations for reappointment to the medical staff, and for the delineation and granting of clinical privileges for the ensuing period. The information shall include a query of the National Practitioner Data Bank (NPDB).

c. Each recommendation concerning the reappointment of a medical staff member and the clinical privileges to be granted shall be based upon such member’s professional competence and clinical judgment in the treatment of patients; clinical and/or technical skills as indicated in part by the results of quality assurance activities, conduct, health status, attendance at medical staff and departmental meetings, and participation in staff affairs; compliance with the bylaws of the Board of Directors, the Bylaws and Rules and Regulations of the Medical Staff, and policies and procedures of UW Health and the medical staff; cooperation with hospital personnel; use of the hospital’s facilities for patients; and relationships with other members of the staff. Each medical staff member must comply with continuing medical education requirements for licensure.

d. The Credentials Committee shall submit a written report of its recommendations.

1. If the recommendation is not to approve the reappointment, the report shall be submitted to the chief medical officer. The chief medical officer or his/her designee shall review the recommendation and assess whether the recommendation was made in a discriminatory manner on the basis of a characteristic listed in Article III, section 1(e). If this review confirms that the recommendation was made in a nondiscriminatory manner, the recommendation shall be forward to the Medical Board. If this review cannot confirm that the recommendation was made in a nondiscriminatory manner, the matter may be referred back to the Credentials Committee for further review or to the Medical Board with a report from the chief medical officer or his/her designee recommending other steps that may be taken to address the possible discrimination.

2. If the recommendation is to approve the reappointment, the report shall be submitted to the Medical Board, which shall, after review, act on the recommendations of the Credentials Committee. Recommendations by the Medical Board for reappointment shall be forwarded to the Board of Directors to be acted upon at the next regular meeting. Where the Medical Board recommends non-reappointment or a denial or reduction in clinical privileges, the CEO or CCO shall promptly notify the affected person of such recommendation by certified mail, return receipt requested. No such adverse recommendation shall be forwarded to the Board of Directors until after the affected person has exercised or waived any applicable right to a hearing as provided in Article X. The Board of Directors’ decision with respect to reappointment shall be final.
Thereafter, the procedure provided in Section 2(e) of this Article VII shall be followed and Sections 2(f) and 2(g) shall apply to the processing of a reappointment application.

Section 4. Education. Each individual with clinical privileges must complete training in risk management, safety and infection control, and such other topics as are designated by the Medical Board in programs approved by the Medical Board. Reappointment will not be approved until this requirement is met.

Section 5. License check at time of expiration of license or certification. When the Wisconsin license or certification of a medical staff member or other person with clinical privileges is scheduled to expire, renewal of Wisconsin license or certification shall be verified.

Article VIII: Clinical Privileges

Section 1. Clinical Privileges.

a. Medical staff members and advanced practice providers shall be entitled to exercise only those clinical privileges granted to him/her based on training, experience, current competence, and health status.

b. Initial applications for staff appointment must contain a request for the specific clinical privileges desired by the applicant.

c. The Credentials Committee shall list each member’s specific clinical privileges. However, it is recognized that the listing of clinical privileges may not provide sufficient detail to cover all procedures done and that acceptable new practices may be developed.

d. Periodic determination of clinical privileges and increase or limitation of same shall be based on the recommendations of the chief of the clinical service following consultation with the head of the appropriate subspecialty section.

e. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the chief of the clinical service in which they have clinical privileges. Patients admitted by a dentist or podiatrist shall be examined upon admission by a physician member of the medical staff who shall be responsible for the care of medical problems that may be present at the time of admission or that may arise during hospitalization.

Section 2. Temporary Privileges.

a. Temporary privileges may be granted to individuals seeking clinical privileges as outlined in this section.

b. An applicant for new privileges with a complete, pending application may be granted temporary privileges, provided (i) the Credentials Committee has recommended granting of such privileges, (ii) the applicant does not have a current or previously successful challenge to licensure or registration, (iii) the applicant has not been subjected to involuntary termination of medical staff membership in another organization, and (iv) the applicant has not been subject to involuntary limitation, reduction, denial or loss of privileges. Temporary privileges under this subsection may be granted for the lesser of the time until the Board approves or denies the privileges, the Medical Board recommends not granting a particular privilege, or one hundred and twenty (120) calendar days. “Applicant for new privileges” includes an individual applying for clinical privileges at the hospital for the first time, an individual currently holding clinical privileges who is requesting one or more additional privileges, and an individual who is seeking renewal of privileges and is requesting one or more additional privileges.

c. Temporary privileges may be granted to meet an important patient care need, provided the individual granting privileges has appropriate documentation and information available to him/her that may be reasonably relied upon to establish the competence and ethical standing of the applicant. The information shall include verification of current licensure and current competence. Temporary privileges
granted under this subsection shall ordinarily be granted for brief periods, not to exceed ninety (90) calendar days, but may be renewed if necessary to address an important patient care need.

d. All temporary privileges are granted by the chief medical officer (as designee of the Chief Executive Officer) on the recommendation of the chief of the appropriate clinical service (as designee of the medical staff president). The chief medical officer may terminate temporary privileges at any time, and there shall be no right to a hearing.

e. All applicants with temporary privileges shall abide by the bylaws of the Board of Directors, the Bylaws and Rules and Regulations of the Medical Staff, and the policies and procedures of UW Health and the medical staff, and shall be under the supervision of the chief of the appropriate clinical service. Specific requirements for supervision and reporting may be imposed on any temporary appointment.

Section 3. Emergencies. In an emergency situation, any medical staff member or other licensed professional staff, to the degree permitted by his/her license and regardless of service or staff status or lack of it, shall be permitted to do everything possible to save the life of a patient, and/or prevent permanent harm to the patient. Every facility of the hospital necessary may be used, including consultations. For the purpose of this section, an “emergency” is defined as a condition in which serious permanent harm would result to a patient, or in which the life of a patient is in immediate danger, and any delay in initiation of treatment would add to that danger.

Section 4. Disaster Privileges. Clinical privileges may be granted in disasters by the CEO, CCO, or chief medical officer, or their designees, in accordance with policies and procedures approved by the Medical Board and CEO, when the hospital emergency management plan has been activated and the hospital is unable to handle immediate patient needs.

Section 5. Leave of Absence.

a. Any medical staff member or advanced practice provider may request a voluntary leave of absence by submitting a written request to the chief medical officer.

b. Individuals with clinical privileges shall request a leave of absence whenever such individual intends to be absent or knows that he or she may be absent from usual practice for a period of ninety (90) or more days, or a for fewer than ninety (90) days when such individual has reason to think that such leave may affect his or her ability to safely exercise clinical privileges upon return to practice. Any such request shall be made in writing to the chief medical officer. This section is not intended to apply to practitioners or professionals who have a low volume at the hospital but are otherwise maintaining an active practice outside the hospital.

c. A request for leave must include the reason for the request and state the beginning date and expected ending date for the period of leave requested.

d. The chief medical officer shall forward any request for leave to the Credentials Committee, which shall determine whether to grant the leave, subject to the approval of the Medical Board. Denial of a request for leave does not entitle the requesting person to a hearing or appeal under these Bylaws.

e. During the period of leave, the medical staff member or advanced practice provider shall not exercise any clinical privileges, and any responsibilities or prerogatives of medical staff membership shall be inactive. A medical staff member on leave is required to maintain his or her appointment to the faculty of SMPH, in accordance with Article III, Section 1(d). A person granted a leave of absence is still required to timely submit an application for reappointment and/or renewal of clinical privileges to avoid expiration of membership and privileges.

f. At least thirty (30) calendar days prior to the requested termination of a leave of absence, a person granted leave may request reinstatement of membership and privileges by submitting a written
request to the chief medical officer. The request for reinstatement shall include a summary of relevant activities during leave; a written plan from the clinical service chief or designee for reintroduction to clinical practice; and, if requested by the Credentials Committee or Medical Board, information regarding the person’s current competence and health. The Credentials Committee shall determine whether to grant the request for reinstatement, subject to the approval of the Medical Board, and shall promptly notify the person in writing whether the request has been granted. A person granted reinstatement shall provide a written report to the Credentials Committee promptly upon completion of the reintroduction plan. Any right to hearing or appeal for denial of reinstatement shall be governed by Exhibit 1 or Exhibit 2 to these Bylaws.

Article IX: Collegial Intervention and Corrective Action

Section 1. Collegial Intervention.

a. It is the policy of UWHC and its medical staff to encourage the use of progressive steps by medical staff leadership and the hospital, beginning with collegial and educational efforts, to address concerns regarding a medical staff member’s clinical practice or professional conduct. The goal of collegial intervention is to arrive at voluntary, responsive actions by the medical staff member to resolve questions that have been raised.

b. Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, or additional training or education.

c. Collegial intervention efforts are encouraged, but are not mandatory.

Section 2. Corrective Action Procedure.

a. The Medical Board or Board of Directors may take corrective action against any member of the medical staff or other person with clinical privileges (i) for violation of the bylaws of the Board of Directors, Bylaws and Rules and Regulations of the Medical Staff, or policies and procedures of UW Health and the medical staff, (ii) for activities or professional conduct considered to be lower than the standards or aims of the medical staff, or (iii) for disruption of the operations of the hospital. Corrective action may also be initiated based on disciplinary action by the applicable state licensing or certification agency.

b. Requests for corrective action may be initiated by the chiefs of clinical services, an officer of the medical staff, the CEO, the CCO, the chief medical officer, or by the Board of Directors. Requests must be submitted in writing to the president of the medical staff and be supported by reference to the specific activities or conduct that constitutes the grounds for the request. The person for whom corrective action is requested shall be called the “practitioner” in this Article IX.

c. The president of the medical staff shall review the request and may determine whether further consideration is warranted. If there is a determination that further consideration is not warranted, the president of the medical staff shall notify the Medical Board at its next scheduled meeting, and the Medical Board may override the decision of the president of the medical staff.

d. If the president of the medical staff decides that further consideration of the request is warranted, or the Medical Board votes to override a decision not to consider the request, the Medical Board shall decide, in its sole discretion (i) that the request contains sufficient information to allow the Medical Board to make a recommendation for corrective action without the need for further investigation; or (ii) that additional investigation is necessary to determine whether corrective action is warranted. If the Medical Board determined that additional investigation is necessary, the president of the medical staff shall notify the practitioner in writing that an investigation is being conducted, and shall direct the
Investigation Committee to investigate the matter, unless the president of the medical staff, in consultation with the CCO or designee, decides that external review is necessary due to the nature of the matter and the available resources to conduct internal review and investigation.

e. The UW Health Provider Services department is expressly authorized by the medical staff to conduct inquiries regarding professional conduct of medical staff members. Such inquiries may precede a formal request for corrective action, or may support an investigation conducted by the Investigation Committee in accordance with Section (f) below. No corrective action investigation is considered to have started concerning a medical staff member until the president of the medical staff receives a request for corrective action or a summary suspension is imposed in accordance with Section 2 of this Article IX.

f. Investigation Committee

a. If the Investigation Committee is directed to investigate the matter, the president of the medical staff, after consultation with the chief medical officer, shall select at least three members of the Investigation Committee to conduct the investigation. The Investigation Committee may be assisted by other individuals designated by the committee.

b. The chair of the Investigation Committee shall notify the practitioner in writing of the names of the participating members. Prior to making findings or recommendations, the Investigation Committee shall notify the practitioner in writing of the nature of the charges against him/her and invite the practitioner to discuss, explain, or refute the charges in an interview with the committee. This interview shall not constitute a hearing, and none of the rights or procedural rules for hearings in these Bylaws shall apply. The practitioner does not have the right to have an attorney present, nor shall recording devices be permitted in the interview. Failure to attend the interview shall be a waiver of the opportunity for the interview unless excused by the committee. The practitioner is expected to cooperate in providing all information requested by the Investigation Committee.

g. The Investigation Committee shall report the results of its investigation and its recommendations, if any, to the president of the medical staff within ninety (90) calendar days of referral from the president of the medical staff. When the committee cannot complete its investigation and/or make recommendations within the allotted time, it can request additional time or recommend external review. The president of the medical staff may authorize up to sixty (60) additional calendar days; a longer extension may be authorized by agreement of the practitioner and the president of the medical staff.

h. The president of the medical staff shall send a copy of the results of the investigation and recommendations of the Investigation Committee or the external review to the practitioner by certified mail, return receipt requested, or by hand delivery. The practitioner shall have ten (10) calendar days in which to submit a written statement to the Medical Board. At its next meeting following receipt of the written statement of the practitioner or the expiration of the period to submit a written statement, the Medical Board shall consider the results of the investigation and recommendations of the Investigation Committee or the external review and any submitted statement and decide what corrective action, if any, is warranted.

i. Upon receipt of the report and recommendation of the Investigation Committee, or following a determination that further investigation was not necessary, the Medical Board shall take action upon the request for corrective action. Such action may include, without limitation: (i) a warning; (ii) a letter of reprimand; (iii) a term of probation; (iv) a requirement for consultation; (v) a reduction, suspension,
or revocation of clinical privileges; or (vi) a suspension or revocation of staff membership.

j. If the action taken by the Medical Board does not constitute a materially adverse recommendation as defined in the Fair Hearing and Appellate Review Plan, the action shall take effect immediately without action of the Board of Directors, and the Board of Directors shall be notified of the action at its next scheduled meeting. If the Board of Directors modifies the action taken by the Medical Board, and such modified action would constitute a materially adverse recommendation as defined in the Fair Hearing and Appellate Review Plan, the procedures stated in the Plan shall be followed.

k. If the action taken by the Medical Board constitutes a materially adverse recommendation as defined in the Fair Hearing and Appellate Review Plan, the procedures in the Fair Hearing and Appellate Review Plan shall apply.

l. The president of the medical staff shall notify the practitioner of the Medical Board recommendation in writing, by certified mail, return receipt requested, or hand delivery. If the Medical Board makes a materially adverse recommendation as defined in the Fair Hearing and Appellate Review Plan, the written notice shall comply with the terms of the Plan.

Section 3. Summary Suspension.

a. The CEO, CCO, or chief medical officer shall have the authority to summarily suspend or restrict all or any portion of the clinical privileges of any person with clinical privileges whenever, in that person’s sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the hospital. When possible, the individual initiating summary suspension shall seek prior consultation with the appropriate chief of service (or his/her delegate), the president of the medical staff, and the chief medical officer. Such summary suspension shall become effective immediately upon imposition. During the period that any or all of the clinical privileges of a medical staff member are suspended, that member is not in good standing.

b. At any time prior to the medical board meeting to review and consider the summary suspension, the individual who imposed the summary suspension may, after consultation with the appropriate chief of service or his/her delegate and with approval of the president of the medical staff or the chief medical officer, terminate or modify the scope of any summary suspension of clinical privileges. Such termination or modification shall take effect immediately upon imposition. If the suspension is modified but not lifted entirely, any time deadlines in this section shall be based on the date the suspension was originally imposed.

c. The individual initiating summary suspension shall provide the practitioner with written notice of the suspension by certified mail, return receipt requested, e-mail, or personal delivery. Such written notice shall state the reasons for the imposition of the summary suspension, and shall inform the practitioner of his/her right to submit a written statement in response to the suspension, which must be delivered to the president of the medical staff within five (5) calendar days of the imposition of the suspension.

d. Within fourteen (14) calendar days of the imposition of a summary suspension, the medical board shall meet to review and consider the summary suspension. The medical board shall vote to: (i) lift the summary suspension and close the matter without further corrective action; (ii) lift the summary suspension, but consider the suspension a request for corrective action and follow the procedures under Section 1 of this Article IX; or (iii) keep the summary suspension in effect and follow the corrective action procedures under Section 1 of this Article IX.
Section 4. Automatic Suspension.

In the instances outlined below, the individual's medical staff membership and privileges will be considered automatically suspended, relinquished, terminated or limited as described, and the action shall be final without right to a hearing.

Prior to reinstating privileges that have been automatically suspended for a period of ninety (90) days or longer, the person shall submit a written request to Medical Staff Administration for reinstatement. Such request shall include a summary of relevant activities during suspension; a written plan from the clinical service chief or designee for reintroduction to clinical practice; and, if requested, information regarding the person’s current competence and health.

The Credentials Committee shall determine whether to grant the request for reinstatement, subject to the approval of the Medical Board, and shall promptly notify the person in writing whether the request has been granted. A person granted reinstatement shall provide a written report to the Credentials Committee promptly upon completion of the reintroduction plan. Any right to hearing or appeal for denial of reinstatement shall be governed by Exhibit 1 or Exhibit 2 to these Bylaws.

During the period that any or all of an individual’s clinical privileges are automatically suspended or limited pursuant to this Section 4, that individual is not considered to be in good standing.

a. Medical Record Completion. A temporary suspension in the form of withdrawal of admitting privileges, effective until medical records are completed, shall be imposed automatically after warning the person of his/her delinquency regarding failure to complete medical records within a reasonable period after a patient’s outpatient visit or inpatient discharge as defined by hospital and medical staff policies and procedures. There is no right to hearing or appeal for such suspensions. If the suspension exceeds fourteen (14) calendar days despite diligent efforts to complete records, the person under temporary suspension may submit a written request to the president of the medical staff for informal review. The president of the medical staff, in his/her discretion, may (a) leave the suspension in place, (b) reinstate admitting privileges subject to conditions that will result in completion of medical records, or (c) initiate corrective action, with or without reinstatement of admitting privileges pending the outcome of the corrective action process.

b. Licensure.

1. Expiration. If a person’s license or certification to practice in the State of Wisconsin expires, all of his/her clinical privileges related to such license or certification shall immediately and automatically be suspended and shall be reinstated upon verification of renewal.

2. Revocation or Suspension of License or Certification. If any license or certification required to enable a person to practice his/her profession in the State of Wisconsin is suspended or revoked, the person’s privileges and medical staff membership shall be automatically terminated. Any subsequent request for privileges and medical staff membership shall be handled in accordance with the requirements for applications for initial appointment and privileges.

3. Restriction or Limitation. If any license or certification required to enable a person to practice his/her profession in the State of Wisconsin is restricted or limited, the person’s privileges and medical staff membership shall be automatically suspended until the restriction or limitation is terminated. Upon termination of the restriction or limitation, the person’s privileges and medical staff membership shall be reinstated. At any point during the suspension, the person under suspension may submit a written request to the president of the medical staff for informal review. The president of the medical staff, in his/her discretion, may (a) leave the suspension in place, (b) reinstate admitting privileges subject to conditions that will result in completion of medical records, or (c) initiate corrective action, with or without reinstatement of admitting privileges pending the outcome of the corrective action process.
discretion, may (a) leave the suspension in place, (b) reinstate privileges subject to the limitations or restrictions imposed on the person’s license or certification, or (c) initiate corrective action, with or without reinstatement of privileges pending the outcome of the corrective action process.

c. Medicare/Medicaid Participation. A person’s medical staff membership and privileges will be automatically relinquished upon termination, exclusion, or preclusion by government action from participation in Medicare, Medicaid, or other federal or state health programs. Any subsequent request for privileges and medical staff membership shall be handled in accordance with the requirements for applications for initial appointment and privileges.

d. Health Requirements. A temporary suspension of all clinical privileges shall be imposed automatically for failure to comply with obligations regarding health status, health assessments or screenings, and immunizations, including, but not limited to, the requirements outlined in Article III, Sections 1(b) and (f). Reinstatement of privileges will occur automatically when the person provides acceptable evidence of meeting applicable obligations.

e. Educational Requirements. A temporary suspension of all clinical privileges shall be imposed automatically for failure to comply with the educational requirements outlined in Article VII, Section 4. Reinstatement of privileges will occur automatically when completion of the educational requirements is verified.

f. Professional Liability Coverage. A temporary suspension of all clinical privileges shall be imposed automatically for failure to maintain professional liability coverage as required by Article VII, Section 1(d). Reinstatement of privileges will occur automatically when the person again demonstrates the required professional liability coverage.

g. Onboarding Activities. A temporary suspension of all clinical privileges shall be imposed automatically for failure to complete all necessary onboarding activities including but not limited to electronic medical record training.

h. Faculty Status.
   i. The loss of faculty status with SMPH automatically results in termination of medical staff membership and clinical privileges.
   ii. If a person is placed on administrative leave with SMPH, the individual’s medical staff membership and clinical privileges shall be automatically suspended for the duration of the leave. Medical staff membership and privileges shall be reinstated upon reinstatement from the administrative leave.

i. Drug Enforcement Administration (DEA) Registration. If a practitioner’s DEA registration is suspended or revoked, the person’s privileges and medical staff membership shall be automatically terminated. Any subsequent request for privileges and medical staff membership shall be handled in accordance with the requirements for applications for initial appointment and privileges.

j. Board Certification or Board Eligibility. Failure to meet the requirements outlined in Article III, Section 1(h) relating to board certification, board eligibility, or equivalent training and experience, including failure due to lapse in board certification, shall result in an automatic temporary suspension of all clinical privileges.

APP Employment. If an APP employed by the hospital, the University of Wisconsin Medical Foundation, or the University of Wisconsin-Madison, in accordance with the requirement set forth in Article V, Section 3(b), is placed on administrative leave by the APP’s employer, the APP’s clinical
privileges shall be automatically suspended for the duration of the leave. Privileges shall be reinstated upon reinstatement from the administrative leave.

Article X: Hearing Procedure

Section 1. Medical Staff Members. Medical staff members and applicants to the medical staff shall be entitled to fair hearing and appellate review when authorized by and in accordance with the Fair Hearing and Appellate Review Plan incorporated into these Bylaws as Exhibit 1.

Section 2. Advanced Practice Providers. Persons who apply for or are granted clinical privileges as advanced practice providers shall be entitled to fair hearing and appellate review when authorized by and in accordance with the Fair Hearing and Appellate Review Plan incorporated into these Bylaws as Exhibit 2.

Article XI: Medical Board

Section 1. Composition. The Medical Board shall be composed of the chiefs of clinical services, the officers of the medical staff, 14 at-large members elected by the staff, two advanced practice providers serving in a non-voting capacity elected as described in Article XIII, two GME trainees from hospital sponsored training programs, the CCO, and the chief medical officer (individually or as designee of the CEO). There shall be no more than three elected members, including officers, from any one clinical department. In addition, the CEO and the chief nurse executive shall serve on the Medical Board as ex-officio members without vote. Subject to the approval of the president of the medical staff or designee, any member of the Medical Board may designate an alternate who may attend and vote in place of the Medical Board member. Such designation must be made annually within two months of the start of each medical staff year unless otherwise approved by the president of the medical staff or designee. The president of the medical staff shall serve as chair of the Medical Board.

Section 2. Function and Delegated Authority

a. The Medical Board shall establish a framework for self-government and a means of accountability to the Board of Directors. The Medical Board shall be the executive committee for the medical staff as set forth in Article II. The Medical Board shall act on behalf of the medical staff between meetings of the medical staff. It shall concern itself primarily with the quality of care within the hospital. It shall receive and act upon committee reports and make recommendations regarding medical staff status, privileges, and quality assurance to the Board of Directors. The Medical Board may adopt and amend from time-to-time medical staff policies and procedures which shall take effect upon approval by the CEO, who has been delegated this authority by the Board of Directors. Medical staff policies and procedures must be consistent with hospital policies and procedures. In most cases, there will not be separate medical staff policies and procedures. As appropriate, UW Health policies and procedures of a clinical nature will be developed in consultation with appropriate medical staff and will be reviewed as needed by the Medical Board.

b. In cases of documented need for an urgent amendment to the Rules and Regulations in Article XVI of these Bylaws and Rules and Regulations necessary to comply with law or regulation, the medical staff delegates the authority to the Medical Board to provisionally adopt an urgent amendment without prior notification or approval by the voting medical staff, and this amendment shall take effect upon approval by the Board of Directors. The Medical Board shall immediately notify the voting members of the medical staff by posting the urgent amendment on the hospital intranet and sending emails to those voting members who have a UW Health email address or have provided a current email address to Medical Staff Affairs Medical Staff Administration. Voting medical staff members may submit comments to the Medical Board up to thirty (30) calendar days after the Board of Directors approves
the provisional amendment. If no timely comments are received, the provisional amendment stands. Any timely comments that are received shall be considered at the next meeting of the Medical Board after the close of comments. The Medical Board may (a) reaffirm the provisional amendment or (b) submit a revised amendment to the Board of Directors which take effect upon approval by the Board of Directors. Medical staff members who disagree with the Medical Board’s decision may pursue the amendment process provided in Article XVII, Section 2.

Section 3. Conflicts with Medical Staff. If twenty (20) percent of the medical staff sign a petition stating a matter of conflict, the matter shall be placed on the agenda of the Medical Board and at least one of the petitioners shall be permitted to make an oral presentation at the meeting when it is considered.

Article XII: Clinical Services

Section 1. Services. The clinical services of the medical staff include the following:

a. Anesthesiology
b. Dermatology
c. Emergency Medicine
d. Family Medicine and Community Health
e. Human Oncology
f. Medicine
g. Neurological Surgery
h. Neurology
i. Obstetrics and Gynecology
j. Ophthalmology and Visual Sciences
k. Orthopedics and Rehabilitation Medicine
l. Pathology and Laboratory Medicine
m. Pediatrics
n. Psychiatry
o. Radiology
p. Surgery
q. Urology

Section 2. Organization of Services. The Board of Directors, upon the joint recommendation of the CEO or CCO and the dean of SMPH, shall appoint the chief of each clinical service. If the chief of clinical service is to be other than the corresponding SMPH departmental chair, the additional recommendation of the department chair is required. Each chief of a clinical service shall be a member of the active medical staff in good standing. All such appointments shall be for one year and be reviewed periodically by the Board of Directors. Chief of clinical service appointments may be made on an interim basis by the CEO or CCO and dean. The chief of each clinical service must be certified by the appropriate specialty board or have comparable competence affirmatively established through the credentialing process.

Section 3. Functions of Chief of Clinical Service.

Each chief shall:

a. Be responsible for all professional, clinical, and administrative activities within the service;
b. Be responsible for continuing surveillance of the professional performance of all individuals who have clinical privileges in the department;
c. Be responsible for enforcement of the Bylaws and Rules and Regulations of the Medical Staff affecting
his/her service;

d. Implement actions taken by the Medical Board affecting his/her service;

e. Transmit to the Medical Board the service’s recommendations concerning (i) the staff classification, reappointment, and delineation of clinical privileges for all members of the staff, and (ii) the granting and renewal of clinical privileges for other Advance Practice Professionals;

f. Participate in every phase of administration of the service through cooperation with the nursing service and UW Health administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders, policies, procedures, and space;

g. Be responsible for recommending to the medical staff the criteria for clinical privileges in the department;

h. Be responsible for continuous assessment and improvement of quality of care, and for the implementation of quality control programs as appropriate;

i. Be responsible for the orientation and continuing education of all persons in the service; and

j. Coordinate and integrate interdepartmental and intradepartmental services.

Article XIII: Officers and At-Large Members

Section 1. Officers of the Medical Staff. The officers of the medical staff shall be: president, vice president who shall also be president-elect, and secretary-treasurer. The vice president shall succeed to the presidency for the two years following a term as vice president. The secretary-treasurer shall succeed to the vice presidency for the two years following a term as secretary-treasurer.

Section 2. Qualifications. Officers of the medical staff must be members of the active medical staff, and at-large members of the Medical Board must be members of the privileged medical staff. Officers of the medical staff and at-large members of the Medical Board must remain members in good standing through their term of office.

Section 3. Term of Office. Officers and other elected members of the Medical Board shall serve a two-year term or until a successor is appointed or elected. The term shall begin on the first day of September. When vacancies occur during a term, the successor shall serve the balance of the term.

Section 4. Election.

a. The secretary-treasurer of the medical staff and at-large members of the Medical Board shall be elected by a majority of those voting in a secret mail ballot. The offices of president and vice president of the medical staff shall be filled by succession as outlined in Article XIII, Section 1, unless a vacancy shall occur, in which case the process outlined in Section 5 shall be followed. Only members of the active medical staff are eligible to vote.

b. A nominating committee of members of the active medical staff and selected by the president of the medical staff shall offer one or more nominees for each position. At least ten (10) calendar days prior to elections by the membership of the medical staff, nominations may be submitted to Medical Staff Affairs/Medical Staff Administration provided three members of the medical staff support the nomination and the nominated person agrees to serve. Such nominations may be submitted by hard copy or by email.

c. The Advanced Practice Providers Council (APP Council) shall solicit candidates from among the advanced practice providers to serve on the Medical Board. At least ten (10) calendar days prior to
election by advanced practice providers with privileges, the APP Council shall nominate candidates to serve on the Medical Board. For each election, the APP Council shall nominate at least one more candidate than advanced practice provider positions available on the Medical Board. The candidate(s) receiving the most votes from advanced practice providers with privileges shall be elected to the Medical Board.

Section 5. Vacancies.

a. Officers of the Medical Staff. If the presidency becomes vacant, the vice president shall become president. If the vice presidency becomes vacant, the secretary-treasurer shall become vice president. If the office of secretary-treasurer shall become vacant, an interim secretary-treasurer shall be appointed to complete the remaining term of office. The president shall appoint the interim secretary-treasurer with the approval of the Medical Board. The president shall appoint other interim officers as required with the approval of the Medical Board until the next regular meeting of the medical staff. If all three offices become vacant, the Medical Board shall elect replacements to serve until the next regular meeting of the medical staff.

b. Elected Members of the Medical Board. Vacancies occurring during the term of an at-large member or advanced practice provider member of the Medical Board shall be filled by the president of the medical staff appointing an interim member. In the event the president of the medical staff fills such a vacancy, the Medical Board shall be notified and shall have an opportunity to reject the appointment.

Section 6. Duties.

a. The president shall call and conduct the medical staff meetings and participate in the long-range planning activities of the hospital. The president shall appoint, annually, one or more members of the medical staff to serve on the Dane County Medical Society Board of Trustees. The physician(s) shall serve no more than three two-year terms as representative(s) of the UWHC medical staff.

b. The vice president of the medical staff shall be vice-chair of the Medical Board and serve as the president of the medical staff in the president’s temporary absence. The vice president shall serve as the chair of the Credentials Committee and shall serve as the designee for the president of the medical staff in recommending the granting of temporary privileges.

c. The secretary-treasurer shall serve as the chair of the Medical Record Committee.

Section 7. Removal or Suspension of Officers and Elected Members of the Medical Board. The Medical Board by a majority vote may remove or suspend an officer of the medical staff or an elected member of the Medical Board for failure of the officer or member to perform his/her duties or other good cause. Prior to the Medical Board vote on removal or suspension, the officer or member shall be informed of the intended action and the basis for the action, and shall be given an opportunity to be heard by the Medical Board as to why he/she should not be suspended or removed.

Section 8. Medical Staff Members in Administrative Positions.

Medical staff members employed by the hospital, or otherwise assigned to a hospital administrative position, either full-time or part-time, whose duties are administrative in nature and include medical staff clinical responsibilities or functions involving their professional capability, must be members of the medical staff, achieving the status by the same procedure applicable to other medical staff members. A medical staff member in a hospital administrative position serves at the pleasure of the authorized official who appointed the medical staff member to the position. A medical staff member may be removed from his/her administrative responsibilities without affecting his/her medical staff privileges. Termination of medical staff privileges must follow the same provisions applicable to any other member of the medical staff.
Article XIV: Committees

Section 1. Standing Committees.

a. Bylaws
b. Credentials
c. Critical Care
d. Ethics
e. Graduate Medical Education
f. Hearing
g. Infection Control
h. Investigation
i. Medical Record
j. Medical Staff Behavior
k. Nutrition
l. Operating Room
m. Pharmacy and Therapeutics
n. Practitioner Excellence Executive Peer Review Executive
o. Provider Health
p. Respiratory Care
q. Resuscitation Review
r. Utilization Management
s. UW Health Clinical Policy

Section 2. Committee Members.

a. The president of the medical staff, in consultation with the chief medical officer, shall appoint chairs and members of all medical staff committees. When committees have GME members, appointments of GME members shall be for one year from July 1 through June 30. Other appointments shall be from September 1 through August 31, and shall be for one year except for chairs. Members may be reappointed. Chairs may be appointed for a term of up to four years and may be reappointed. Chairs and members shall continue to serve until their replacements have been appointed. All chairs and members shall serve at the pleasure of the president of the medical staff, and the president of the medical staff shall, in consultation with the chief medical officer, appoint replacements for the balance of the term of the person who has resigned or been removed. When a committee chair or member is unable to perform the committee functions due to unavailability, conflicts or other factors, the president of the medical staff may, in consultation with the chief medical officer, exercise the above appointment power to appoint additional alternates as necessary for the committee to perform its functions.

b. GME trainees may be appointed to serve as voting members of standing and ad hoc medical staff committees listed in Section 1, except the Bylaws, Investigation, Credentials, Hearing Committee, Medical Staff Behavior and Provider Health Committees.

c. Advanced practice providers and others may be appointed to serve as voting members of standing and ad hoc medical staff committees.

d. One advanced practice nurse representative, one physician assistant representative, one
anesthesiologist assistant representative, and one clinical psychologist representative shall be appointed to be liaison members of the Credentials Committee. The advanced practice nurse representative may attend the meetings while the committee is considering the privileges of advanced practice nurses, the physician assistant representative may attend the meetings while the committee is considering the privileges of physician assistants, the anesthesiologist assistant representative may attend the meetings while the committee is considering the privileges of anesthesiologist assistants, and the clinical psychologist representative may attend the meetings while the committee is considering the privileges of clinical psychologists. The representatives may participate in such deliberations, and vote on such privileges. The chief nurse executive, or designee, shall be consulted in the selection of the advanced practice nurse representative, and the responsible physician assistant committee shall be consulted in the selection of the physician assistant representative.

Section 3. Other Committees. The Medical Board may establish additional standing or ad hoc committees as necessary.

Section 4. Duties of Respective Committees. In addition to the duties described below, all standing and ad hoc committees of the medical staff may engage in peer review activities as requested by the chair of the committee, the CCO, the chief medical officer, or the Practitioner Excellence Executive Peer Review Executive Committee.

a. The Bylaws Committee shall consider all proposals for changes in the Bylaws and Rules and Regulations of the Medical Staff. It shall make recommendations to the medical staff relating to revisions of the Bylaws and Rules and Regulations. The Bylaws Committee shall include the chief medical officer; the president, vice-president, secretary treasurer, and immediate past-president of the medical staff; the CEO, CCO, or their representative, and others selected through the committee appointment process. The Bylaws and Rules and Regulations shall be reviewed annually.

b. The Credentials Committee shall review and investigate the credentials of applicants for the medical staff and shall make recommendations on the appointment, staff status, and privileges for each applicant to the Medical Board. It shall also periodically review all information available on the competence of staff members and make recommendations to the Medical Board regarding reappointment, staff status, and privileges. It shall also perform the functions specified in Article V and, upon request of the hospital, review and take action with respect to applications of individuals to be affiliates of the hospital.

c. The Critical Care Committee shall be responsible for reviewing and recommending policies and procedures necessary for the effective operation of all critical care units in the hospital. The committee will actively participate in the institutional review of existing critical care programs and resources and will advise the institution regarding future program development.

d. The Ethics Committee shall serve in an advisory capacity in the following matters: consultation on difficult clinical cases involving medical-ethical issues; consideration, when so requested, of clinical-ethical policy issues related to this hospital; examination of matters referred by the Medical Board; and provision of an educational role in the area of medical ethics. For case review, the committee’s general policy will be one of discussion with consensus development and formal recommendation being offered if requested.

e. The Graduate Medical Education Committee is responsible for monitoring and advising on all aspects of graduate medical education. It carries broad responsibility for overseeing and ensuring the quality of the institution’s graduate medical education programs.

f. The Hearing Committee shall be a permanently constituted peer review committee from which panels
may be selected to perform peer review hearings under Article X of the Bylaws or otherwise as directed by the chief medical officer or the president of the medical staff.

g. The Infection Control Committee shall maintain surveillance and records of infections, investigate sources of infection, promulgate rules for the prevention of infection, and make recommendations for the control of infections.

h. The Investigation Committee shall be a permanently constituted peer review committee from which panels may be selected to perform the peer review responsibilities specified in Article IX of the Bylaws.

i. The Medical Record Committee shall develop guidelines for the general form, accuracy, and completeness of patient records. It shall define the essential elements of all medical records and ensure that these are maintained uniformly in all clinical services and patient care departments. It shall advise and cooperate in the functions of all activities that relate to documentation within the patient medical record.

j. The Medical Staff Behavior Committee shall address issues of inappropriate professional behavior by any member of the medical staff through a professional peer review process. The Committee shall address issues only on referral from the CCO or chief medical officer. When corrective action is required, the matter shall be handled under Article IX.

k. The Nutrition Committee shall work with culinary and clinical nutrition services to ensure the necessary and proper nutrition programming exists within the hospital and shall advise on matters related to the culinary and clinical nutrition services, including the review of hospital diets.

l. The Operating Room Committee shall develop and regularly review Rules and Regulations for the safe and effective functioning of the operating room. Its membership shall be comprised of representatives from the clinical services utilizing the operating rooms.

m. The Pharmacy and Therapeutics Committee shall develop guidelines concerning the activities of the hospital pharmacy and shall review the hospital formulary. It shall develop and recommend programs in drug education and policies to ensure the safe administration and use of drugs, including research and experimental procedures. It shall investigate drug reactions and medication errors as well as appropriate use of drugs.

n. The Practitioner Excellence Executive Peer Review Executive Committee shall be responsible for a coordinated approach to the measurement and continuous improvement of quality, safety and patient experience through its oversight of the effectiveness of the medical staff performance and peer review process. The Practitioner Excellence Executive Peer Review Executive Committee may delegate peer review functions to additional review committees in accordance with medical staff policies.

o. The Provider Health Committee shall be responsible for:

1. Assisting departmental chairs and/or the CCO or chief medical officer with any members of the medical staff who may be impaired secondary to substance use disorders, mental health problems or cognitive and/or physical deficits where such impairment is interfering or may interfere with patient care or other responsibilities;

2. Monitoring such impaired medical staff members who are in treatment or those who require periodic follow-up assessments;

3. Other activities related to such impaired medical staff members; and

4. In carrying out these responsibilities, the Provider Health Committee shall conduct assessments, review treatment plans, establish monitoring procedures, devise plans of
reintegration, and may make recommendations to the Credentials Committee.

p. The Respiratory Care Committee shall develop policies and procedures governing respiratory care. Its membership shall be comprised of representatives from those disciplines included in the delivery of respiratory care.

q. The Resuscitation Review Committee shall be responsible for establishing policies for the initiation, conduct, termination and teaching of cardiopulmonary resuscitation and to outline the procedures and responsibilities of personnel involved in a resuscitative effort.

r. The Utilization Management Committee has the authority and responsibility to carry out the utilization review and management function. The Committee provides oversight of all guidelines, policies, procedures, and protocols involving the utilization management process (including but not limited to medical necessity of hospitalizations, hospital stays, procedures, cost and length-of-stay outliers).

s. The UW Health Clinical Policy Committee shall develop, review, and recommend patient care policies and procedures.

Article XV: Meetings

Section 1. Medical Staff Meetings. The medical staff shall hold at least one meeting per year at which the officers and committee chairs shall make such reports as may be desirable and at which officers shall be nominated. The president of the medical staff shall preside and in his/her absence, the vice-president. Special meetings may be called by the Medical Board or by written petition of at least 10 percent of the members of the active medical staff to the president of the medical staff.

Section 2. Medical Board Meetings. The Medical Board shall meet once a month during at least ten (10) months each medical staff year. Special meetings of the Medical Board may be called by the president of the medical staff, by majority vote, or by written petition of a majority of the Medical Board.

Section 3. Standing and Special Committee Meetings. Each standing committee, with the exception of the Investigation, Hearing, Medical Staff Behavior, and Provider Health Committees, shall meet regularly and keep a permanent record of its proceedings. Standing and special committees shall arrange their own meeting schedules.

Section 4. Agenda.

a. The agenda of all regularly scheduled meetings of the Medical Board shall be set by the president and vice-president of the medical staff.

b. The agenda of all regularly scheduled meetings of the medical staff shall be set by the president of the medical staff.

Section 5. Quorum. A quorum, unless otherwise specified, shall consist of one third of the membership of the Medical Board or a committee. For medical staff meetings, fifteen (15) members of the active staff shall constitute a quorum.

Section 6. Attendance. Each member of the medical staff shall be expected to attend at least 50 percent of the meetings of his/her clinical service and committees of the medical staff.

Section 7. Minutes.

a. Medical Staff and Medical Board Meeting Minutes. Minutes of each regular and special meeting shall be prepared and shall include a record of attendance. The minutes shall be signed and submitted to the attendees for approval. Copies of the approved minutes shall be retained by Medical Staff.
Standing and Special Committee Meeting Minutes. Copies of all minutes shall be submitted to the president of the medical staff for review and approval of recommended action items at Medical Board meetings.

Section 8. Parliamentary Procedure. All meetings shall be in accordance with Robert’s Rules of Order, Newly Revised. The presiding officer may appoint a parliamentarian.

Section 9. Electronic Meetings and Approvals.

a. Any regular or special meeting of a board or committee or other group authorized by these Bylaws may be held electronically or by teleconference at the discretion of the chairperson. Persons participating electronically or by teleconference shall be considered present at the meeting.

b. Any action which may be approved by a board or committee or other group authorized by these Bylaws may be approved by an email, U Connect workspace, or other electronic vote at the discretion of the chairperson of the board or committee or group. Notice may be given of electronic vote by email. Members shall be given at least two business days to respond. If a quorum of the board or committee or group respond by the time set for the vote, the action shall be approved if approved by a majority of the timely respondents, unless one timely respondent requests that the matter be considered at a convened meeting of the board or committee or group.

Article XVI: Rules and Regulations

The Medical Board has adopted the following Rules and Regulations for the proper conduct of its work.

Section 1. General Rules.

a. The attending physician shall have ultimate responsibility and authority for the care of each patient.

b. All patients are considered to be included in teaching programs in University of Wisconsin Hospitals and Clinics unless the patient objects.

c. It is the responsibility of each clinical service to arrange that sufficient numbers of qualified members of its active or courtesy staff are available at all times to ensure prompt and continuing function of essential patient care activities.

d. Members of the medical staff and advanced practice providers granted clinical privileges shall comply with the policies and procedures UW Health and the medical staff, and the applicable clinical department.

Section 2. Patient Care.

a. All patient care should be conducted in accordance with the prevailing professional standards. The attending staff is responsible for supervision of all medical care provided by GME trainees. This supervision will include the presence of the medical staff when appropriate. Specific mechanisms for supervision of GME trainees will be determined by the appropriate departments, consistent with the requirements of accrediting bodies and hospital policies, and will be reviewed by the UWHC Graduate Medical Education Committee. GME trainees may write patient orders.

b. All tissue specimens must be examined, except when exempted by hospital policy. Tissue specimens and body fluids obtained from inpatients and outpatients of UWMC shall be processed under the authority of or pursuant to arrangements by the Department of Pathology and Laboratory Medicine. Special requests and arrangements for specimen testing outside the Department of Pathology and Laboratory
Medicine must be reviewed by the department and reviewed annually by the department and hospital administration.

c. Informed consent shall be obtained in accordance with UW Health policies and procedures concerning informed consent and with the policies and procedures of the applicable clinical department. UW Health policies and procedures shall specify which procedures and treatments require written informed consent.

d. Members of the medical staff can be called for consultation within their area of expertise. The service to which consultations are addressed should answer all requests as soon as practical. A consultant member of the active or courtesy medical staff shall see the patient on every such request and shall record and sign his/her findings and recommendations.

e. The medical staff may delegate to nursing personnel and allied health personnel the performance of medical acts to the extent authorized by policies and protocols approved by UW Health and the Medical Board.

f. Research involving human subjects shall be reviewed and conducted in accordance with hospital policies and procedures which include review and approval by a University of Wisconsin - Madison institutional review boards.

Section 3. Dental Service.

a. The Department of Surgery shall be responsible for service performed by dentists with the...
understanding that dental or oral surgical procedures undertaken in the operating room shall be under
the supervision of the Chief of Surgery.

b. Every dental patient must have a staff physician who is available and will be responsible for other than
dental care of the patient’s care throughout the hospital stay.

Section 4. Pharmacy and Therapeutics.

a. Drugs dispensed at University of Wisconsin Hospitals and Clinics shall be those approved by the
Pharmacy and Therapeutics Committee.

b. When trade or proprietary nomenclature is employed for a drug approved by the Pharmacy and
Therapeutics Committee, the pharmacist may dispense officially accepted University of Wisconsin
Hospitals and Clinics formulary drugs of the same generic name and specific therapeutic action.

c. All orders for medication or treatment shall be documented and otherwise comply with the pharmacy
and therapeutics policies and procedures of UW Health and the medical staff.

d. Automatic stop orders on certain drugs shall take effect as required by the policies and procedures of
UW Health and the medical staff.

e. Investigational drugs and devices may be used only within the scope of approval granted by the
University of Wisconsin-Madison Human Subjects Committee.

Section 5. Admission, Transfer, and Discharge.

a. Patient admissions, transfers, passes and discharges shall comply with hospital and medical staff policies
and procedures. Admissions to the hospital and clinics shall be only:

1. By members of the medical staff in categories that permit admission; or
2. By GME trainees acting under the supervision of such medical staff member.

b. Certification and reporting of deaths shall be in accordance with hospital and medical staff policies and
procedures and with applicable law.

Section 6. Performance Improvement Activities. Medical staff members shall cooperate with the
implementation of the plan for improving organizational performance approved by the hospital and the
Medical Board.

Section 7. Medical Records. Medical records for inpatients and outpatients shall be completed in the manner
and time frame required by hospital and medical staff policies and procedures. Release of medical information
shall be only in accordance with hospital and medical staff policies and procedures which include compliance
with Wisconsin and federal law.

Article XVII: Amendments

Section 1. Annual Review. These Bylaws will be reviewed annually by the Bylaws Committee. Additional
amendments to these Bylaws may be proposed at any meeting of the medical staff or the Medical Board. The
proposal must be in writing and signed by at least 10 members of the active medical staff. The proposal shall be
referred to the Bylaws Committee which shall report at the next meeting of the medical staff. Amendments to
these Bylaws may also be recommended by the Bylaws Committee to the Medical Board. If adopted by a
majority vote of the Medical Board, any proposed amendment shall be presented at the next meeting of the
medical staff or sent to all voting members for a mail or electronic ballot. A written copy of the proposed
amendment shall accompany the notice of the meeting of the medical staff or the notice of the mail or
electronic ballot. A two-thirds majority vote of those present at the meeting or of those submitting mail or electronic ballots shall be required for adoption. The amendment shall become effective when approved by the Board of Directors.

Section 2. Medical Staff Proposals. Written proposals of Bylaws, Rules and Regulations, polices and amendments thereto signed by twenty (20) percent of the voting members may be submitted to Medical Staff Administration. The Medical Board shall review the proposal at its next meeting that is at least ten (10) days after the receipt of the proposal. If the Medical Board approves the proposal, it shall be submitted to the Board of Directors. If the Medical Board does not approve the proposal, it shall be voted on by voting members of the medical staff by a mail or electronic ballot distributed by Medical Staff Administration within ten (10) days of the Medical Board meeting where the proposal is not approved. A written copy of the proposal and any comments by the Medical Board shall accompany the notice of the ballot. A two-thirds majority vote of the voting members submitting mail or electronic ballots shall be required for submission to the Board of Directors. The President of the Medical Board may submit comments to the Board of Directors regarding proposals submitted to the Board of Directors pursuant to medical staff vote. The proposal shall become effective when approved by the Board of Directors.

Article XVIII: Adoption

These Bylaws shall be adopted at any regular meeting of the active medical staff, shall replace any previous Bylaws, and shall become effective when approved by the Board of Directors of the University of Wisconsin Hospitals and Clinics Authority.

Approved by Bylaws Committee........................................... May 23, 2019 July 8, 2020
Approved by Medical Board................................................ June 13, 2019 July 9, 2020
Approved by Medical Staff.................................................... July 3, 2019 August 10, 2020
Approved by Board of Directors........................................... July 25, 2019 September 23, 2020
Exhibit 1: Fair Hearing and Appellate Review Plan

Article I

1.1. Purposes. This Fair Hearing and Appellate Review Plan sets forth procedures to be followed in connection with all hearings to be provided to members of the University of Wisconsin Hospitals and Clinics medical staff, in accordance with the Bylaws and Rules and Regulations of the Medical Staff. For purposes of this Fair Hearing and Appellate Review Plan, members of the medical staff are all referred to as “practitioners.”

1.2. Right to Hearing.

1.2.1. No practitioner shall be entitled to any hearing except as expressly provided in the Medical Staff Bylaws and this Fair Hearing and Appellate Review Plan. A practitioner is entitled to a hearing on timely and proper request when any of the following recommendations are made or actions taken by the Medical Board or the Board of Directors in a manner that is deemed adverse pursuant to section 1.2.2, and where such recommendations or actions are based on the professional competence or professional conduct of the practitioner:

   a. Termination of medical staff membership or clinical privileges,

   b. Suspension of clinical privileges, except for a summary suspension of privileges that lasts for fewer than fifteen (15) days,

   c. Denial of appointment or any requested clinical privileges,

   d. Denial of reappointment, and

   e. Imposition of conditions or restrictions on privileges that limit the practitioner’s ability to exercise clinical privileges.

1.2.2. A recommendation or action listed in section 1.2.1 shall be deemed adverse only when it has been:

   a. recommended by the Medical Board;

   b. taken by the Board of Directors contrary to a favorable recommendation by the Medical Board under circumstances where no prior right to a hearing existed; or

   c. taken by the Board of Directors on its own initiative without benefit of a prior recommendation by the Medical Board.

1.2.3. Notwithstanding any other provision of the Bylaws, the following recommendations or actions, without limitation, do not entitle a practitioner to any of the hearing or appeal rights set forth in this Fair Hearing and Appellate Review Plan: Except as otherwise specifically provided in the Medical Staff Bylaws or this Fair Hearing and Appellate Review Plan, no practitioner shall be entitled to a hearing as a result of any action that is recommended or taken which is not related to the practitioner’s professional qualifications, competence or conduct, including but not limited to, the...
following:

a. Letters of warning, reprimand, censure or admonition;

b. Imposition of monitoring, proctoring, consultation or review requirements that do not restrict the practitioner’s ability to exercise clinical privileges and is not reportable to the National Practitioner Data Bank;

c. Requiring provision of information or documents, such as office records, or notice of events or actions;

d. Imposition of educational or training requirements;

e. Placement on probationary or other conditional status;

f. Failure to place a practitioner on any on-call or interpretation roster, or removal of any practitioner from any such roster;

g. Appointment or reappointment for less than two years;

h. Continuation of provisional appointment;

i. The refusal to waive or extend the time for compliance with any requirement of these Bylaws;

j. Termination or refusal to reappoint for failure to comply with any objective requirement such as board certification or recertification, malpractice insurance coverage, licensure, faculty appointment, or failure to meet any objective requirement imposed on all staff members that specific numbers of procedures be performed to maintain or demonstrate clinical competence;

k. Any action that is not related to the practitioner’s professional conduct or competence and the action is not reportable to the state or the National Practitioner Data Bank, such as termination for failure to pay dues or assessments, automatic suspension identified in Article IX, Section 4, denial of request for privileges because the hospital does not permit certain services or procedures to be performed in the hospital, or the hospital elects to enter into an exclusive contract for the provision of certain services.

1.2.4 If any action is taken that does not entitle a practitioner to a hearing, the practitioner shall be offered the opportunity to submit a written statement or any information which the practitioner wishes to be considered. Such statement or information shall be included in the practitioner’s peer review records along with the documentation regarding the action taken.

1.2.53 No individual shall be entitled to a hearing or any other procedural rights as a result of a refusal by the Hospital to provide an application form to such practitioner.

1.3 Notice of Adverse Recommendation or Action

1.3.1 When a recommendation is made or an action has been taken which, according to section 1.2.1 of this Fair Hearing and Appellate Review Plan entitles a practitioner to a hearing, the practitioner shall promptly be given written notice of the recommendation or action by the President of the Medical Staff by certified mail or e-mail delivery. This notice shall contain:

a. A statement of the recommendation made or action taken;

b. A statement of the reasons for the recommendation or action;

c. A statement that the practitioner her a right to request a hearing on the recommendation or action by delivering such a request in writing to the President of the Medical Staff within thirty
(30) calendar days of the date the practitioner receive the notice;
d. A statement that failure to request a hearing within the specified time period, or failure to
personally appear without good cause at the hearing or appellate review shall constitute a
waiver of the practitioner’s right to a hearing or appeal, and the recommendation or action shall
thereupon become effective immediately upon final Board of Directors approval;
e. A statement that the hearing shall be held before a Hearing Panel constituted of
individuals who practice in the same profession as the Practitioner involved, who are
appointed by the Hospital in accordance with the procedures for appointing a Hearing
Committee, and who are not in direct economic competition with the Practitioner
involved;
f. A statement that upon receipt of the practitioner's hearing request, the President
of the Medical Staff, or designee, will notify the practitioner of the date, time and
place of the hearing;
g. A statement that the practitioner’s rights in any hearing or appeal are outlined in
section 3.1 of the Fair Hearing and Appellate Review Plan;
h. A copy of the Bylaws and Fair Hearing and Appellate Review Plan.

1.3.2 The Notice of Adverse Recommendation or Action can be amended or added to at any
time by written notice to the practitioner by certified mail or e-mail. In no event shall the
statement of the reasons for the recommendation or action included in the initial Notice of
Adverse Recommendation or Action be interpreted as limiting the ability of the Medical Staff
or Board of Directors to justify its recommendation or action at a hearing or appeal with
additional supporting reasons not directly articulated in this notice.

1.43. Request for Hearing.

1.4.1 Except as may otherwise be specified in the Medical Staff Bylaws, any request for a hearing must
be made in writing and delivered to the CEO or CCO President of the Medical Staff within thirty (30)
calendar days after the practitioner receives written notice of the adverse action or recommendation
which gives rise to a hearing.

1.4.2 A practitioner who fails to request a hearing within the time and in the manner specified in
section 1.4.1 waives his/her right to any hearing and appellate review to which the practitioner might
have otherwise been entitled.

Article II Pre-Hearing Process

2.1. Appointment of Hearing Panel.

2.1.1. Upon receipt of a request for a hearing, the President of the Medical Staff, or designee, shall
identify a Hearing Panel and chair of the Hearing Panel. The Hearing Panel shall be a subcommittee of
the Hearing Committee that is assigned the responsibility to conduct the hearing, unless the President
of the Medical Staff, with the approval of the CEO or CCO or designee, determines that conflicts or
other reasons require that individuals other than members of the Hearing Committee be appointed to
the Hearing Panel. The Hearing Panel shall be composed of members of the medical staff and shall
have not less than three members. There also may be appointed one or more alternate members of the
Hearing Panel. No medical staff member who has requested corrective action against the practitioner,
or actively participated in the investigation or consideration of the adverse recommendation, or is in-
direct economic competition with the practitioner shall be a member of the Hearing Panel or an.
alternate, except in unusual circumstances where mutually agreed upon by the practitioner and the president of the medical staff.

2.1.2. Any member of the Hearing Panel, including any alternate, who participates in the entire hearing, or reviews the transcript or audio recording (or listens to the tapes) of any portions of the hearing for which the Hearing Panel member was not in personal attendance, shall be permitted to participate in the deliberations and to vote on the recommendations of the Hearing Panel. The Hearing Panel may make a recommendation as long as a majority of the panel members, including any alternates, have attended all the hearings or read the transcript of any hearings for which a panel member was not in personal attendance. A majority of the members of the Hearing Panel, including any alternates, shall constitute a quorum for purposes of conducting a hearing.

2.1.3. No person shall be a member of any Hearing Panel, or alternate, if that person has (a) previously actively participated in consideration of the matter involved; (b) served on an investigating committee in connection with the corrective action that triggered the practitioner’s hearing rights; (c) voted on the adverse recommendation or action that initiated the hearing; (d) appeared as a witness before an investigating committee in connection with the corrective action that triggered the practitioner’s hearing rights; (e) is in direct economic competition with the practitioner who requested the hearing. A person shall not be disqualified from serving on a Hearing Panel, or as an alternate, merely because such person has heard of the case or has knowledge of the facts involved. A person has had any prior involvement in the specific clinical cases to be considered by the Hearing Panel or is in direct economic competition with the practitioner involved or actively participated in the investigation or consideration of the adverse recommendation.

2.2. Notification of Prospective Hearing Panel Members. The practitioner shall be notified of the prospective members of the Hearing Panel and if the practitioner has any objection to any proposed Hearing Panel member, the practitioner shall, within ten (10) calendar days after notification, state in writing any objection and the reasons for the objection in writing. The President of the Medical Staff, or designee, and the CEO or COO shall, after considering such objections, decide in their sole discretion whether to replace any person objected to and the practitioner shall be notified of the action taken on the objection. The practitioner shall have the same opportunity to object to any replacement panel member.

2.3 Appointment of Hearing Officer

2.3.1. The President of the Medical Staff, or designee, shall select a hearing officer to preside at the hearing. The hearing officer shall be an attorney or other practitioner familiar with procedures relating to medical staff fair hearings.

2.3.2. The practitioner shall be notified of the name of the prospective hearing officer and if the practitioner has any objection to any hearing officer, the practitioner shall, within ten (10) calendar days after notification, state the objection in writing and the reasons for the objection. The President of the Medical Staff, or designee, shall, after considering such objections, decide in their sole discretion whether to uphold the objection and replace any hearing officer.

2.3.3. The hearing officer shall rule on all procedural matters at the hearing, advise the members of the hearing committee concerning procedural and legal issues, rule on any objections to testimony or evidence that is offered at the hearing, decide whether evidence has sufficient relevance and reliability to be submitted to the hearing panel for consideration, rule on requests for postponements or extensions of time, and shall generally be responsible for regulating the proceedings.

2.3.4. The hearing officer shall ensure that all participants in the hearing have an opportunity
to be heard and to present oral and documentary evidence, subject to reasonable limits on
the number of witnesses and duration of direct and cross-examination. The hearing officer
shall determine the order of procedure throughout the hearing and shall have the authority
and discretion to make rulings on all questions which pertain to procedure and to the
admissibility of evidence. The hearing officer shall act to maintain decorum and shall
prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or
abusive, or that causes undue delay.

2.3.5. The hearing officer shall be available to the members of the hearing panel during and after the
conclusion of the hearing to advise them on any procedural matters and to assist the committee
with the preparation of their report and recommendations.

2.4. Notice to Practitioner of Hearing Date and Summary of Hearing Rights of Hearing.

2.4.1. When a proper request for a hearing is received, the President of the Medical Staff, or designee,
shall promptly arrange and schedule a hearing, and shall send the practitioner written notice by certified
mail or e-mail. Such notice shall contain: At least thirty (30) calendar days prior to the date scheduled
for the hearing, a notice shall be sent to the practitioner advising the practitioner of the following:

a. The date, time and place of the hearing. The hearing date shall be not less than thirty
(30) days after the practitioner's receipt of the notice of time and place for the
hearing, unless an earlier hearing date has been specifically agreed to in writing by
the parties; and,

b. A summary of the practitioner's rights in connection with the hearing; and,

c. The names of the hearing panel members and hearing officer.

2.4.2. The scheduling of a hearing in accordance with this Fair Hearing and Appellate Review plan is
solely within the discretion of the President of the Medical Staff, or designee. A practitioner does not
have the right to demand that a hearing date be rescheduled or otherwise modified. The practitioner
may request that a hearing be rescheduled, and such request may be approved by the Hearing Officer
upon good cause. The denial of such a request shall not constitute a violation of the practitioner's due
process rights under this Fair Hearing and Appellate Review Plan. The President of the Medical Staff, or
designee, shall also have the sole discretion to determine whether the hearing shall be held in-person
or, if warranted under the circumstances, via secure video conference.


2.45.1. At least fifteen (15) calendar days prior to the hearing, the practitioner involved shall be sent
by certified and regular mail or e-mail delivery a statement:

a. setting forth the reasons for the proposed action;

b. identifying any witnesses expected to testify before the committee Hearing Panel in support
of the recommendation under consideration; and,

c. identifying all medical records or documents expected to be submitted to the committee
Hearing Panel for consideration. The practitioner shall be provided copies of such documents
not previously provided.

2.45.2. If any expert witnesses are to be called to testify at the hearing in support of the
recommendations of the medical staff, the practitioner shall be notified at least fifteen (15) calendar
days before the hearing the identity of each expert to be called, and provided (i) a copy of each
expert’s curriculum vitae, (ii) a written report from the experts setting forth the substance of the experts’ testimony, the opinions of the experts and the grounds for the opinions, and (iii) copies of all documents or materials provided to the expert for review.

2.45.3. At least ten (10) calendar days prior to the hearing, the practitioner shall provide to Medical Staff Affairs the President of the Medical Staff the following:

a. a statement setting forth the reasons why the practitioner contends that the adverse recommendation or action is unreasonable, inappropriate or lacks any factual basis,

b. A list of any witnesses the practitioner will call to testify and a summary of the subject matter of each witness’s testimony,

c. A copy of all documents the practitioner intends to introduce at the hearing, and

d. If the practitioner intends to call any expert witness to testify at the hearing, the practitioner shall identify each expert to be called and provide (i) a copy of each expert’s curriculum vitae, (ii) a written report from the experts setting forth the substance of each expert’s testimony, including the opinions of the experts and the grounds for the opinions, and (iii) copies of all documents or materials provided for review by each expert.

2.45.4. No witness may be called, and no testimony or opinions may be elicited from any expert nor any documents submitted for consideration by the Hearing Panel, which have not been disclosed in accordance with this section, unless the Hearing Officer (see section 2.6) determines that any failure to disclose was unavoidable. The failure of the practitioner requesting a hearing to comply with the requirements related to the disclosure or exchange of information set forth in this Fair Hearing and Appellate Review Article, or ordered by the Hearing Officer, shall be deemed to be a withdrawal of the request for a hearing, the waiver of the right to a hearing, and agreement to and acceptance of the action which is the subject of the hearing.

Article III Hearing Process

23.15. Rights of Practitioner

a. Representation by an attorney or other person of choice. If such attorney or other person of choice is not available at the scheduled time for the hearing, the denial of a request to reschedule the hearing shall not be considered a violation of this right to representation.

b. To have a record made of the hearing, but not of deliberations, and to obtain copies of same.

c. To call, examine, and cross-examine witnesses. Should the practitioner wish to interview UW Health employees, members of the medical staff, or persons with clinical privileges prior to the hearing, the practitioner shall arrange for such interview by contacting UWHC UW Health corporate counsel, or the president of the medical staff. The practitioner shall not contact such individuals directly.

d. To present relevant evidence.

e. To submit a written statement at the close of the hearing.

f. To receive a written recommendation of the Hearing Panel, including the basis of the recommendation.

g. To receive a written final decision of the hospital, including the basis of the decision.

2.6. Hearing Officer.

2.6.1. The president of the medical staff and the CEO or CCO shall select a hearing officer to preside at the
hearing. The hearing officer shall be an attorney or other practitioner familiar with procedures relating to peer-review hearings.

2.6.1. The practitioner shall be notified of the name of the prospective hearing officer and if the practitioner has any objection to any hearing officer, the practitioner shall, within ten (10) calendar days after notification, state the objection in writing and the reasons for the objection. The president of the medical staff and the CEO or CCO shall, after considering such objections, decide in their sole discretion whether to uphold the objection and replace any hearing officer.

2.6.2. The hearing officer shall rule on all procedural matters at the hearing, advise the members of the hearing committee concerning procedural and legal issues, rule on any objections to testimony or evidence that is offered at the hearing, decide whether evidence has sufficient relevance and reliability to be submitted to the hearing committee for consideration, rule on requests for postponements or extensions of time, and shall generally be responsible for regulating the proceedings.

2.6.3. The hearing officer shall have the authority to resolve all issues regarding scheduling of hearings, and shall have the authority to recess and reconvene the hearing, to impose time limits for examination and cross-examination of witnesses, and to limit the number of witnesses to be called by the medical staff or member.

2.6.4. The hearing officer shall be available to the members of the hearing committee during and after the conclusion of the hearing to advise them on any procedural matters and to assist the committee with the preparation of their report and recommendations.

2.7. Burden of Proof. Whenever a hearing relates to the denial of a practitioner’s request for reappointment or modification of privileges, the practitioner need only be advised of the nature and source of the information upon which the adverse recommendation is based. In all cases the practitioner shall have the burden of proving, by a preponderance of the evidence that the adverse recommendation or decision lacks any factual basis, or that the conclusions drawn therefrom are arbitrary, unreasonable, or capricious. It shall not be a defense to any action proposed by the Medical Board or the Governing Body that different action has been taken in the past with regard to any other staff member, and no evidence shall be introduced regarding actions taken or not taken with regard to other staff members.

3.2. Attorney Representation. The practitioner may be represented by an attorney at any hearing, or before the Medical Board or the Board of Directors; however, the members of the hearing panel, Medical Board and the Board of Directors shall be permitted to direct questions to the practitioner, who shall be required to respond personally. If the practitioner will be represented by counsel or another representative at any hearing or appearance, the practitioner shall notify the medical staff of the name of the attorney or other representative at least fifteen (15) calendar days prior to the hearing or appearance.

3.3. Medical Staff Representative and Attorney Representation. The committee or body whose recommendations are challenged may designate a member of the medical staff to represent the position of the committee before the hearing committee. The CEO or CCO may designate a Hospital representative to represent the position of the Hospital or medical staff committee, department, or section. In addition, the Hospital and medical staff may be represented by an attorney before any hearing committee, the Medical Board, or the Board of Directors. The CEO, CCO, or designee may appear and testify concerning any matters and present evidence to the hearing committee, Medical Board, or the Board of Directors.

3.4. Presence of Practitioner. The practitioner shall be personally present at all hearings, except for good cause shown, and the failure of the practitioner to appear personally shall be a waiver of the right to a hearing.

3.5. Examination and Cross-Examination of Witnesses. The practitioner, any attorney or other person representing the practitioner, any designated representative of the committee or body whose recommendations are challenged, the CEO, CCO, or designee, and the Hospital or medical staff attorney shall have the right to call, examine, cross-examine, and impeach witnesses, to introduce any exhibits, and to rebut
any evidence.

3.6. Testimony of Practitioner. If the practitioner involved does not testify in his or her own behalf, the practitioner may be called and examined as if under cross-examination. The refusal of the practitioner to testify shall constitute a withdrawal of the request for a hearing, a waiver of any further rights to review, a failure to exhaust the remedies, and acceptance by the practitioner and agreement to the recommendations of the adverse recommendation or action.

3.7. Evidence and Testimony Requested by Hearing Panel. The hearing committee may call and examine witnesses and receive and examine such exhibits as it deems appropriate on its own initiative, provided all parties involved shall be given reasonable notice of all witnesses or exhibits to be examined by the committee and adequate opportunity to challenge or rebut such evidence.

3.8. Discovery. Except as specifically provided in this Fair Hearing and Appellate Review Plan, there shall be no right to conduct discovery in connection with any hearing and no practitioner shall be permitted access to any peer review records, medical records, minutes or other documents relating to any other practitioner, or any action taken or not taken with regard to any other practitioner. The practitioner requesting a hearing shall, however, be entitled to any documents relied on by the Medical Board or Board of Directors in making any recommendation or decision, any documents to be introduced at the hearing, and any medical records relied on or to be introduced at the hearing, so long as the practitioner and his/her counsel attorney agree in writing to keep all such documents confidential and not use them for any purpose other than in the hearing and appellate review proceedings. The production of such documents shall not constitute a waiver of any peer review protection for those documents or any other documents. Nothing in this Fair Hearing and Appellate Review Plan shall be interpreted as giving the practitioner the authority to subpoena or otherwise compel the production of any documents, records or witnesses.

3.9. Rules of Evidence. Hearings need not be conducted according to technical rules of evidence relating to the admissibility or presentation of evidence and all evidence determined to be relevant and reliable by the hearing officer shall be considered. All testimony shall be presented under oath or affirmation.

3.10. Recording the hearing. Unless all parties agree otherwise, the hearing shall be recorded by a sound recording. Either party may have a court reporter record the proceedings. The record of the hearing need not be transcribed unless specifically requested and the person or body requesting the transcript shall be responsible for the cost of transcription.

3.11. Burden of Proof. In all cases the practitioner shall have the burden of proving by a preponderance of the evidence that the adverse recommendation or decision lacks any factual basis, or that the conclusions drawn therefrom are arbitrary, unreasonable, or capricious. It shall not be a defense to any action proposed by the Medical Board or the Board of Directors that different action has been taken in the past with regard to any other staff member, and no evidence shall be introduced regarding actions taken or not taken with regard to other staff members.

3.12. Written Statement by Practitioner. The practitioner shall have the right to submit a written statement at the close of the hearing. Such statement shall be submitted within a reasonable time as established by the hearing officer.

3.13. Modification of Time Requirements. All time periods may be modified for good cause shown by the hearing officer.

3.14. Adjournment and Conclusion. The Hearing Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, and upon receipt of the recording and/or transcript of the proceedings, the hearing shall be closed.
The Hearing Panel shall thereupon conduct its deliberations, with assistance from the Hearing Officer, and issue a report and recommendation.

2.83.15. Report and Recommendations of Hearing Panel. After final adjournment of the hearing, including receipt of all written submissions, the Hearing Panel shall deliver a written report to the Medical Board stating in full its findings, the reasons and evidence upon which it based its findings, and its recommendations. If the practitioner submitted a written statement to the Hearing Panel in accordance with section 3.12, such statement shall be appended to the report and recommendation delivered to the Medical Board. The recommendations of the Hearing Panel need not be unanimous and any minority views may be reduced to writing, supported by reasons and references, and transmitted with the majority report. A copy of the Hearing Panel’s report and recommendation, along with any minority views reduced to writing, shall be delivered to the practitioner.

2.9. Practitioner Response to Report and Recommendations. Within fifteen (15) calendar days after the report and recommendations of the Hearing Panel are delivered to the practitioner, the practitioner shall submit a written statement to the Medical Board specifying the findings of fact, conclusions, or procedural matters with which the practitioner disagrees and the reasons for such disagreement. Failure to identify any findings of fact, conclusions, or procedural matters with which the practitioner disagrees shall constitute a waiver of those issues. The practitioner may not submit new information, nor evidence not previously considered by the hearing committee, except as may be requested or approved by the Medical Board.

2.10. Appearance before Medical Board. The medical staff president may, in his/her sole discretion, permit or require the practitioner or his/her representative to appear before the Medical Board, to present oral argument or respond to inquiries.

2.113.16. Medical Board and Board of Directors Action.

3.16.1 The Medical Board shall consider the report and recommendations of the Hearing Panel. If additional information or clarification is needed by the Medical Board, the Board may remand the case to the Hearing Panel for any further proceedings the Medical Board deems appropriate. After receipt of the report of the Hearing Panel and any additional information requested, the Medical Board shall consider the entire case and vote on its recommendations to the Board of Directors. The recommendations of the Medical Board need not be unanimous and any minority views may be reduced to writing, supported by reasons and references, and transmitted with the majority report. A copy of all reports and recommendations of the Medical Board, the Medical Board’s report and recommendation, along with any minority views reduced to writing, shall be sent to the practitioner.

3.16.2 If the recommendation of the Medical Board is adverse to the practitioner, the President of the Medical Staff shall notify the practitioner in writing, by certified mail or e-mail delivery, of his/her right to request appellate review by the Board of Directors in accordance with Article IV of this Fair Hearing and Appellate Review Plan. Such notice shall include the deadline to submit a written request for appellate review, and a statement that failure to make such a timely request shall be deemed a waiver of the right to appellate review and acceptance of the recommendation involved.

3.16.3 If the recommendation of the Medical Board is favorable to the practitioner, the Board of Directors may adopt or reject the recommendation, in whole or in part. If the Board of Directors adopts a favorable recommendation of the Medical Board, it becomes the final decision of the Board of Directors. If the Board of Directors rejects a favorable recommendation from the Medical Board and takes action that is adverse to the practitioner, the CCO, or designee, shall notify the practitioner in writing, by certified mail or e-mail delivery, of his/her right to request appellate review by the Board of Directors.
Directors in accordance with Article IV of this Fair Hearing and Appellate Review Plan. Such notice shall include the deadline to submit a written request for appellate review, and a statement that failure to make such a timely request shall be deemed a waiver of the right to appellate review and acceptance of the recommendation involved.

2.12. Board of Directors Action. Final action by the Board of Directors shall be taken in accordance with the provisions of the Medical Staff Bylaws.

Article III. Appellate Review

34.1. Request for Appellate Review. The practitioner may, within ten (10) calendar days after receipt of the recommendations of the Medical Board, request the opportunity to appear before appellate review by the Board of Directors, or any Committee of the Board designated by the Board (collectively referred to as the “Board”), to present oral argument. Such a request must be submitted in writing to the CEO or CCO. The practitioner may appear before the Board and the Chair of the Board may require the parties to appear before the Board and present oral argument and respond to inquiries. If the practitioner does not request appellate review, the recommendations of the Medical Board shall be forwarded to the Board of Directors for final action. If a timely request for appellate review is not received, the practitioner shall be deemed to have waived the right to appellate review and accepted the recommendation involved, which shall thereupon become effective upon final approval by the Board of Directors.

34.2. Standard of Appellate Review. Appellate review by the Board of Directors, or any Committee of the Board designated by the Board, shall be limited to determining whether the practitioner has established by clear and convincing evidence that:

a. There has been a substantial failure to comply with the Bylaws during the course of the corrective action which has materially prejudiced the practitioner;

b. The recommendation is arbitrary or unreasonable; or,

c. The recommendation is not supported by any reliable evidence.

34.3. Nature of appellate review.

4.3.1 The Chair of the Board of Directors shall determine, in his/her sole discretion, whether the appellate review shall be conducted by the full Board of Directors, or by a committee of the Board composed of not less than three (3) persons. For the purposes of this Article IV, any reference to the “Board” shall include any committee designated to conduct a review.

4.3.2 The practitioner and the Medical Board shall each have the right to submit written statements in support of their respective positions on appeal. In addition, the Board may decide, in its sole discretion, to allow each party or the party’s representative to appear before the Board for oral argument and/or questioning by the Board. The failure of the Board to allow such personal appearance shall not be considered a violation of the practitioner’s right to appellate review.

4.4 Notice.

4.4.1 When a timely request for appellate review is received, the Chair of the Board of Directors, or designee, shall notify the practitioner in writing, by certified mail or e-mail delivery, of the deadline to submit a written statement to the Board. Such deadline shall not be less than fifteen (15) calendar days from the date the practitioner receives the notice.

4.4.2 If the Board allows personal appearance of the parties or their representatives, the notice shall
include the date, time and place of such appearance, which shall not be less than seven (7) calendar
days from the date the practitioner receives the notice.
4.4.3 The notice shall include a statement that the failure of the practitioner to submit a timely written
report, or appear at a scheduled personal appearance shall be deemed a waiver of the right to appellate
review.

4.5 Written Statements.

4.5.1 A written statement from the practitioner to the Board shall set forth with specificity of-
Practitioner. In lieu of appearing before the Board to present oral argument, the practitioner may-
submit a written statement to the Board setting forth specifically any findings of fact, conclusions,
recommendations and procedural matters with which the practitioner disagrees and the reasons
therefore. Such statement shall be limited to facts and evidence introduced at the hearing or
otherwise considered by the Medical Board, or facts or evidence that the practitioner feels were
wrongly excluded from consideration.

4.5.2 The Board shall provide a copy of the practitioner’s written statement to the President of the
Medical Board. The Medical Board may submit a response to the Board within fifteen (15) calendar
days of receiving the practitioner’s statement. The Medical Board may elect instead to rely on the
report and recommendation it previously submitted to the Board of Directors, and the failure of the
Medical Board to submit a written response shall not be considered acceptance of any objections
raised by the practitioner.

3.3.1 If the practitioner requests an opportunity to appear before the Board and present oral argument, the-
practitioner shall be required to submit a written statement as set forth in section 3.3 above. Any written-
statement must be delivered to the CEO or CCO within fifteen (15) calendar days after the practitioner receives-
the report and recommendations of the Medical Board. Failure to identify any findings of fact, conclusions, or-
procedural matters with which the practitioner disagrees shall constitute a waiver of those issues and the-
practitioner shall not be permitted to raise in any future proceedings or litigation any issues not identified by the
practitioner.

3.3.2 The practitioner shall provide a copy of the practitioner’s written statement to the Medical Board, which may-
submit a response to the Board of Directors, with a copy to the practitioner, within ten (10) calendar days after-
receipt.

3.3.3 The President of the Medical Board may, but is not required to, submit to the Appellate Review Body a-
response to the Practitioner’s written statement. Any response from the President of the Medical Board shall-
be submitted fifteen (15) calendar days after receipt of the practitioner’s statement and a copy of the-
response shall be sent to the practitioner.

3.4 Notice of Appearance before Board. The practitioner shall be notified of the date, time and place the-
practitioner is to appear before the Board at least seven (7) calendar days in advance. The failure of the-
practitioner to appear shall be considered a withdrawal of any request to appear before the Board.

3.54.6 Oral Argument Personal Appearance before the Board of Directors. If personal appearance of the parties-
before the Board is allowed, such appearance shall be limited to any presentation before the Board shall be-
limited to oral argument and/or questioning from the Board. The practitioner shall not be permitted to introduce any new facts or evidence which was not introduced at any hearing, unless there are extenuating-
circumstances except for facts or evidence which the practitioner contends was wrongly excluded from-
consideration at the hearing. No witnesses shall be permitted to present testimony before the Board unless the
Board consents to such testimony. The practitioner may be accompanied by an attorney who may advise and
speak on behalf of the practitioner; however, the members of the Board shall be permitted to direct questions to the practitioner who shall be required to respond personally. The amount of time available for the practitioner's presentation may be limited by the Board or Committee Chair or subject to such conditions as the Board determines to be appropriate.

3.6. Issues on Appeal. The issues considered on appeal shall be limited to the following:

a. Whether there was material failure to comply with the Bylaws or applicable policies of the Hospital or medical staff during or prior to the hearing, so as to deny a fair hearing; and/or

b. Whether the recommendations of the Medical Board were arbitrary, unreasonable or capricious and/or were not supported by any credible evidence.

3.7. Action by Board of Directors.

4.7.1 Within sixty (60) calendar days of submission of all written statements, or of the practitioner’s appearance before the Board, whichever is later, or sixty (60) calendar days after the date of the report of the Medical Board if the practitioner does not appear before the Board, the Board of Directors shall act to accept, reject, or accept with modification, the recommendations of the Medical Board, or refer the matter back to the Medical Board for further consideration or investigation. If the Board of Directors refers the matter back to the Medical Board for further consideration, the Board of Directors shall state the reasons for such referral and the Medical Board shall conduct any further investigation as it deems appropriate and submit a written report to the Board of Directors.

4.7.2 3.8. Reconsideration by Medical Board. In the event the decision of the Board of Directors differs substantially from the recommendations of the Medical Board, further action on that decision shall be held in abeyance for a period not to exceed sixty (60) calendar days. The Medical Board shall be advised of the intended action by the Board of Directors and the reasons for such action. The Medical Board shall review the proposed action of the Board of Directors, conduct any further investigation and make such additional comments or recommendations as the Medical Board deems appropriate. The medical staff president shall prepare a further report to the Board of Directors setting forth any additional findings or recommendations of the Medical Board and the reasons for the recommendations. If the Medical Board continues to disagree with the action proposed by the Board of Directors, the matter shall be referred to a Joint Conference Committee which shall consider the issues and make a final recommendation to the Board of Directors. The practitioner shall be notified of any further findings or recommendations of the Medical Board or Joint Conference Committee and provided a copy of any report. The practitioner may, within seven (7) calendar days of receiving any such report, submit to the Board of Directors any written comments the practitioner wishes to make concerning the further report of the Medical Board or Joint Conference Committee.

4.7.3 3.9. Final Action of Board. After receiving any further comments or recommendations from the Medical Board, the Board of Directors shall take final action. In the event no comments or recommendations are received from the Medical Board within sixty (60) calendar days of the original decision of the Board of Directors, the decision of the Board of Directors shall become final, unless the Board of Directors extends the time for the Medical Board to submit a report or comments. The final action of the Board of Directors shall be effective at such time as the Board designates and such action shall not be stayed without the consent of the Board or a court order.

3.104.7.4. Written Statement from Board. If the final decision of the Board of Directors is materially
adverse to the practitioner, the practitioner shall be provided a statement from the Board of Directors setting forth the reasons for the action taken.

3.114.7.5. Right to Hearing after Board Action. If the decision of the Board of Directors is more severe than the recommendations of the Medical Board, and the practitioner has not previously had a hearing concerning the matters that gave rise to the adverse recommendation or action, the practitioner may, within thirty (30) calendar days after receipt of notice of the final action of the Board of Directors, request a hearing and further review by delivering a written request to the CEO or CCO. Any such hearing and review shall be conducted in accordance with the Fair Hearing and Appellate Review article. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review under this Article IV on any matter which shall have been the subject of action by the Medical Board or by the Board of Directors or both.

3.124.7.6. Notification of Board Action. The CEO or CCO shall notify the applicant, the Medical Board and chair of the appropriate department of the final action taken by the Board of Directors.

Article IV General Provisions

45.1. Timely Objections to Actions. In the event any applicant or member of the medical staff has any objection to any action taken or procedures followed by the Hospital, the medical staff, or any individual or committee with regard to the consideration of any application for appointment or reappointment, any investigation, any corrective action, any hearing, or other action, the applicant or practitioner shall immediately state such objection and the reasons for the objection to the individual or body concerned in writing, or verbally if the objection arises during any recorded proceedings, in order to permit the Hospital to address the objection and take any corrective action the Hospital deems necessary. The failure to give such notice of any objection shall be deemed to be a waiver of any such objection and consent to the procedures being followed or action being taken.

4.2. Attorney Representation. The practitioner may be represented by an attorney at any hearing, or before the Medical Board or the Board of Directors; however, the members of the hearing committee, Medical Board and the Board of Directors shall be permitted to direct questions to the practitioner, who shall be required to respond personally. If the practitioner will be represented by counsel or another representative at any hearing or appearance, the practitioner shall notify the medical staff of the name of the attorney or other representative at least fifteen (15) calendar days prior to the hearing or appearance.

4.3. Medical Staff Representative and Attorney Representation. The committee or body whose recommendations are challenged may designate a member of the medical staff to represent the position of the committee before the hearing committee. The CEO or CCO may designate a Hospital representative to represent the position of the Hospital or medical staff committee, department, or section. In addition, the Hospital and medical staff may be represented by an attorney before any hearing committee, the Medical Board, or the Board of Directors. The CEO, CCO, or designee may appear and testify concerning any matters and present evidence to the hearing committee, Medical Board, or the Board of Directors.

4.4. Presence of Practitioner. The practitioner shall be personally present at all hearings, except for good cause shown, and the failure of the practitioner to appear personally shall be a waiver of the right to a hearing.

4.5. Examination and Cross-Examination of Witnesses. The practitioner, any attorney or other person representing the practitioner, any designated representative of the committee or body whose recommendations are challenged, the CEO, CCO, or designee, and the Hospital or medical staff attorney...
shall have the right to call, examine, cross-examine, and impeach witnesses, to introduce any exhibits, and to rebut any evidence.

4.6. Testimony of Practitioner. If the practitioner involved does not testify in his or her own behalf, the practitioner may be called and examined as if under cross-examination. The refusal of the practitioner to testify shall constitute a withdrawal of the request for a hearing, a waiver of any further rights to review, a failure to exhaust the remedies, and acceptance by the practitioner and agreement to the recommendations of the Medical Board.

4.7. Evidence and Testimony Requested by Hearing Committee. The hearing committee may call and examine witnesses and receive and examine such exhibits as it deems appropriate on its own initiative, provided all parties involved shall be given reasonable notice of all witnesses or exhibits to be examined by the committee and adequate opportunity to challenge or rebut such evidence.

4.8. Discovery. Except as specifically provided in this Fair Hearing and Appellate Review Plan, there shall be no right to conduct discovery in connection with any hearing and no practitioner shall be permitted access to any peer review records, medical records, minutes or other documents relating to any other practitioner, or any action taken or not taken with regard to any other practitioner. The practitioner requesting a hearing shall, however, be entitled to any documents relied on by the Medical Board or Board of Directors in making any recommendation or decision, any documents to be introduced at the hearing, and any medical records relied on or to be introduced at the hearing, so long as the practitioner and his/her counsel agree in writing to keep all such documents confidential and not use them for any purpose other than in the hearing and appellate review proceedings. The production of such documents shall not constitute a waiver of any peer review protection for those documents or any other documents.

4.9. Rules of Evidence. Hearings need not be conducted according to technical rules of evidence relating to the admissibility or presentation of evidence and all evidence determined to be relevant and reliable by the hearing officer shall be considered. All testimony shall be presented under oath or affirmation.

4.10. Recording the hearing. Unless all parties agree otherwise, the hearing shall be recorded by a sound recording. Either party may have a court reporter record the proceedings. The record of the hearing need not be transcribed unless specifically requested and the person or body requesting the transcript shall be responsible for the cost of transcription.

4.11. Recess of Hearing. The hearing committee may recess any hearing to obtain further information.

4.12. Written Statement by Practitioner. The practitioner shall have the right to submit a written statement at the close of the hearing. Such statement shall be submitted within a reasonable time as established by the hearing officer.

4.13. Failure to Make Request or Appearance. If any practitioner fails to make a required request or appearance within the time specified herein or otherwise fails to comply with procedures for hearing and review set forth herein, the practitioner shall be deemed to have waived all further rights hereunder and shall be deemed to have consented to the recommendations then under consideration.

4.14. Modification of Time Requirements. All time periods may be modified for good cause shown by the hearing officer or chair of the committee or body before which the case is currently pending.

5. Confidentiality and Privilege. All information received, notes, records, minutes, documents, or materials of any kind which are obtained, reviewed, or considered in connection with any matters considered or action or investigation taken pursuant to the Medical Staff Bylaws relating to medical staff membership and/or clinical privileges shall be confidential and privileged, shall be confidential peer-quality review documents and, to the extent permitted by law, shall not be admissible or discoverable in any legal proceedings, and shall be subject to
4.165.4. Immunity. All practitioners and all those participating in or providing information to any department, section, committee, hearing committee, officer of the medical staff, or others participating in the hearing and appellate review process shall, to the fullest extent permitted by law, not be liable for any actions taken or information provided in connection with the review, granting, or denial of medical staff membership or clinical privileges, or any other action taken pursuant to the Bylaws of the medical staff.

4.175.5. Closed Hearings. Hearings shall be closed unless the practitioner requests an open hearing (see Sec. 19.85, Wis. Stats.). If an open hearing is conducted, no patient names or identities shall be disclosed in the hearing. The hearing committee shall assign numbers for reference which all parties, representatives, witnesses, and the committee shall use.

Exhibit 2: Fair Hearing and Appellate Review Plan for Persons Granted or Applying for Privileges Under Article V

Article I

1.1. Purposes. This Fair Hearing and Appellate Review Plan sets forth procedures to be followed in connection with all hearings to be provided to persons who apply for or are granted professional privileges under Article V of the Bylaws and Rules and Regulations of the Medical Staff, and are not members or applicants for membership on the medical staff, in accordance with the Bylaws of the medical staff. For purposes of this Fair Hearing and Appellate Review Plan for persons who apply for or are granted professional privileges under Article V of the Bylaws are all referred to as “practitioners.”

1.2. Right to Hearing. No practitioner shall be entitled to any hearing except as expressly provided in the Medical Staff Bylaws.

1.2.1. No practitioner shall be entitled to any hearing except as expressly provided in the Medical Staff Bylaws and this Fair Hearing and Appellate Review Plan. A practitioner is entitled to a hearing on timely and proper request when any of the following recommendations are made or actions taken by the Medical Board or the Board of Directors in a manner that is deemed adverse pursuant to section 1.2.2 and where such recommendations or actions are based on the professional competence or professional conduct of the practitioner:

In the event a practitioner is entitled to a hearing after a materially adverse recommendation by the Medical Board, or a materially adverse decision by the Board of Directors, such hearing shall be held before a committee of designated under and in accordance with Article II of this Fair Hearing and Appellate Review Plan. A recommendation shall be considered to be materially adverse if the recommendation would have a significant adverse effect on the practitioner’s professional privileges. A material adverse recommendation shall include, but not necessarily be limited to, a recommendation of:

a. Termination of professional privileges,

b. Suspension of professional privileges, except for a summary suspension of privileges that lasts for fewer than fifteen (15) days,

c. Denial of appointment or any requested professional privileges,

d. Denial of reappointment, and

e. Imposition of conditions or restrictions on professional privileges that limit the practitioner’s ability to exercise professional privileges.

1.2.2 A recommendation or action listed in section 1.2.1 shall be deemed adverse only when it has been:
a. recommended by the Medical Board;
b. taken by the Board of Directors contrary to a favorable recommendation by the Medical Board under circumstances where no prior right to a hearing existed; or
c. taken by the Board of Directors on its own initiative without benefit of a prior recommendation by the Medical Board.

1.2.23. Notwithstanding any other provision of the Bylaws, the following recommendations or actions, without limitation, do not entitle a practitioner to any of the hearing or appeal rights set forth in this Fair Hearing and Appellate Review Plan except as otherwise specifically provided in the Medical Staff Bylaws or this Fair Hearing and Appellate Review Plan, no practitioner shall be entitled to a hearing as a result of any action that is recommended or taken which is not related to the practitioner’s professional qualifications, competence or conduct, including but not limited to, the following:

a. Letters of warning, reprimand, censure or admonition;
b. Imposition of monitoring, proctoring, consultation or review requirements that do not restrict the practitioner’s ability to exercise professional privileges and is not reportable to the National Practitioner Data Bank;
c. Requiring provision of information or documents, such as office records, or notice of events or actions;
d. Imposition of educational or training requirements;
e. Placement on probationary or other conditional status;
f. Failure to place a practitioner on any on-call or interpretation roster, or removal of any practitioner from any such roster;
g. Appointment or reappointment for less than two years;
h. Continuation of provisional appointment;
i. The refusal to waive or extend the time for compliance with any requirement of these Bylaws;
j. Termination or refusal to reappoint for failure to comply with any objective requirement such as board certification or recertification, malpractice insurance coverage, licensure, faculty appointment, employment, or failure to meet any objective requirement imposed on all staff members that specific numbers of procedures be performed to maintain or demonstrate clinical competence;
k. Any action that is not related to the practitioner’s professional conduct or competence and the action is not reportable to the state or the National Practitioner Data Bank, such as termination for failure to pay dues or assessments, automatic suspension identified in Article IX, Section 4, denial of request for professional privileges because the hospital does not permit certain services or procedures to be performed in the hospital, or the hospital elects to enter into an exclusive contract for the provision of certain services. If any action is taken that does not entitle a practitioner to a hearing, the practitioner shall be offered the opportunity to submit a written statement or any information which the practitioner wishes to be considered. Such statement or information shall be included in the practitioner’s peer review records along with the documentation regarding the action taken.
l. Any action that is taken as an employment action by the practitioner’s employer and not as an
action under these Bylaws.

1.2.34. No individual shall be entitled to a hearing or any other procedural rights as a result of a refusal by the Hospital to provide an application form to such practitioner.

1.2.45. No practitioner shall be entitled to a hearing under this plan as a result of actions that are taken as employment actions by the practitioner’s employer.

1.2.5. Before requesting a hearing under this plan, the practitioner must submit a written request for reconsideration to the CCO or chief medical officer within fifteen (15) calendar days of written notice of adverse action or recommendation which gives rise to the hearing. The CCO, chief medical officer, or designee shall consult with the chief nurse executive or designee before issuing a response with respect to an advanced practice nurse. The CCO, chief medical officer, or designee shall issue a written response within fifteen (15) calendar days. The written response shall state the action or intended action and charges or complaints that are the basis for the action. If the action that would have entitled the practitioner to hearing is modified so that no action entitling the practitioner to a hearing remains then the practitioner shall not be entitled to a hearing.

1.3. Notice of Adverse Recommendation or Action

1.3.1 When a recommendation is made or an action has been taken which, according to section 1.2.1 of this Fair Hearing and Appellate Review Plan entitles a practitioner to a hearing, the practitioner shall promptly be given written notice of the recommendation or action by the President of the Medical Staff by certified mail or e-mail delivery. This notice shall contain:

a. A statement of the recommendation made or action taken;

b. A statement of the reasons for the recommendation or action;

c. A statement that the practitioner has a right to request a hearing on the recommendation or action by delivering such a request in writing to the President of the Medical Staff within thirty (30) calendar days of the date the practitioner receive the notice;

d. A statement that failure to request a hearing within the specified time period, or failure to personally appear without good cause at the hearing or appellate review shall constitute a waiver of the practitioner’s right to a hearing or appeal, and the recommendation or action shall thereupon become effective immediately upon final Board of Directors approval;

e. A statement that upon receipt of the practitioner’s hearing request, the President of the Medical Staff, or designee, will notify the practitioner of the date, time and place of the hearing;

f. A statement that the practitioner’s rights in any hearing or appeal are outlined in section 3.1 of the Fair Hearing and Appellate Review Plan;

g. A copy of the Bylaws and Fair Hearing and Appellate Review Plan.

Request for Hearing. Except as may otherwise be specified in the Medical Staff Bylaws, any request for a hearing must be made in writing and delivered to Medical Staff Affairs within thirty (30) calendar days after the practitioner receives written response from the CCO, Chief medical officer, or designee stating that there remains an adverse action or recommendation which gives rise to a hearing.

1.3.2 The Notice of Adverse Recommendation or Action can be amended or added to at any time by written notice to the practitioner by certified mail or e-mail. In no event shall the statement of the reasons for the recommendation or action included in the initial Notice of Adverse Recommendation or Action be interpreted as limiting the ability of the Medical Staff or Board of Directors to justify its recommendation or action at a hearing or appeal with additional supporting reasons not directly articulated in this notice.
1.4 Request for Hearing

1.4.1 Except as may otherwise be specified in the Medical Staff Bylaws, any request for a hearing must be made in writing and delivered to the President of the Medical Staff within thirty (30) calendar days after the practitioner receives written notice of the adverse action or recommendation which gives rise to a hearing.

1.4.2 A practitioner who fails to request a hearing within the time and in the manner specified in section 1.4.1 waives his/her right to any hearing and appellate review to which the practitioner might have otherwise been entitled.

Article II Pre-Hearing Process

2.1. Appointment of Hearing Panel.

2.1.1. Upon receipt of a request for a hearing, the CCO, Chief medical officer, President of the Medical Staff, or designee shall identify a Hearing Panel and chair of the Hearing Panel. The Hearing Panel shall be a subcommittee of the Hearing Committee that is assigned the responsibility to conduct the hearing, unless the CCO or Chief medical officer, President of the Medical Staff, or designee, determines that conflicts or other reasons require that medical staff members who are not members of the Hearing Committee be appointed to the Hearing Panel. In addition to medical staff members of the Hearing Panel, the Hearing Panel shall be further augmented with at least two persons in the same discipline as the practitioner who requested the hearing. When the practitioner requesting the hearing is an advanced practice nurse, the Hearing Panel shall have at least two persons from the hospital’s department of nursing selected in consultation with the chief nurse executive or designee. The Hearing Panel shall have not less than three members. There also may be appointed one or more alternate members of the Hearing Panel.

2.1.2. Any member of the Hearing Panel, including any alternate, who participates in the entire hearing, or reviews the transcript (or listens to the tapes) of any portions of the hearing for which the Hearing Panel member was not in personal attendance, shall be permitted to participate in the deliberations and to vote on the recommendations of the Hearing Panel. The Hearing Panel may make a recommendation as long as a majority of the panel members, including any alternates, have attended all the hearings or read the transcript of any hearings for which a panel member was not in personal attendance. A majority of the members of the Hearing Panel, including any alternates, shall constitute a quorum for purposes of conducting a hearing.

2.1.3. No person shall be a member of any Hearing Panel, or alternate, if that person has (a) previously actively participated in consideration of the matter involved; (b) served on an investigating committee in connection with the corrective action that triggered the practitioner’s hearing rights; (c) voted on the adverse recommendation or action that initiated the hearing; (d) appeared as a witness before an investigating committee; (e) is in direct economic competition with the practitioner who requested the hearing. A person shall not be disqualified from serving on a Hearing Panel, or as an alternate, merely because such person has heard of the case or has knowledge of the facts involved. No person shall be a member of any Hearing Panel, or alternate, if that person has had any prior involvement in the specific clinical cases to be considered by the committee or is in direct economic competition with the practitioner involved or actively participated in the investigation or consideration of the adverse recommendation.
2.1.4. The chair of the Hearing Panel shall rule on all procedural matters at the hearing. The chair shall have the authority to resolve all issues regarding scheduling of hearings, and shall have the authority to recess and reconvene the hearing, to impose time limits for presentations.

2.2. Notice of Hearing.

2.2.1. When a proper request for a hearing is received, the President of the Medical Staff, or designee, shall promptly arrange and schedule a hearing, and shall send the practitioner written notice by certified mail or e-mail. Such notice shall contain:

   a. The date, time and place of the hearing. The hearing date shall be not less than fifteen (15) days after the practitioner's receipt of the notice of time and place for the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties;
   
   b. A summary of the practitioner’s rights in connection with the hearing; and
   
   c. The available documentary evidence against the practitioner.

2.2.2. The scheduling of a hearing in accordance with this Fair Hearing and Appellate Review plan is solely within the discretion of the President of the Medical Staff, or designee. A practitioner does not have the right to demand that a hearing date be rescheduled or otherwise modified. The practitioner may request that a hearing be rescheduled, and such request may be approved by the President of the Medical Staff upon good cause. The denial of such a request shall not constitute a violation of the practitioner’s due process rights under this Fair Hearing and Appellate Review Plan. The President of the Medical Staff, or designee, shall also have the sole discretion to determine whether the hearing shall be held in-person or, if warranted under the circumstances, via secure video conference.

2.2. Notice to Practitioner of Hearing Date and Summary of Hearing Rights. At least fifteen (15) calendar days prior to the date scheduled for the hearing, a notice shall be sent to the practitioner advising the practitioner of the following:

   a. The date, time and place of the hearing; and,
   
   b. A summary of the practitioner’s rights in connection with the hearing.
   
   c. The available documentary evidence against the practitioner.

2.3. At least five (5) calendar days prior to the hearing, the practitioner shall provide to the Medical Staff Office the following:

   a. A statement setting forth the reasons why the practitioner contends that the adverse recommendation is unreasonable, inappropriate or lacks any factual basis, and

   b. A copy of all documents the practitioner intends to introduce at the hearing.

2.4. No documents shall be submitted for consideration by the Hearing Panel, which have not been disclosed in accordance with sections 2.2 and 2.3, unless the chair of the Hearing Panel determines that any failure to disclose was unavoidable.

Article III Hearing Process

2.53.1. Rights of Practitioner
a. Representation by an attorney or other person of choice;
b. To present relevant documentary evidence and arguments concerning allegations and the action or proposed action.
c. To submit a written statement at the close of the hearing;
d. To receive a written recommendation, including the basis of the recommendation;
e. To receive a written final decision of the hospital, including the basis of the decision.

3.2. Attorney Representation. The practitioner may be represented by an attorney at any hearing; however, the members of the Hearing Panel and the Board of Directors shall be permitted to direct questions to the practitioner, who shall be required to respond personally. If the practitioner will be represented by counsel or another representative at any hearing or appearance, the practitioner shall notify the President of the Medical Staff of the name of the attorney or other representative at least fifteen (15) calendar days prior to the hearing or appearance.

3.3. Medical Staff Representative and Attorney Representation. The committee or body whose recommendations are challenged may designate a member of the medical staff to represent the position of the committee before the hearing committee. The President of the Medical Staff may designate a Hospital representative to represent the position of the medical staff or medical staff committee, department, or section. In addition, the Hospital and medical staff may be represented by an attorney before any hearing committee, the Medical Board, or the Board of Directors. The CEO, CCO, or designee may appear and testify concerning any matters and present evidence to the hearing committee, Medical Board, or the Board of Directors.

3.4. Presence of Practitioner. The practitioner shall be personally present at all hearings, except for good cause shown, and the failure of the practitioner to appear personally shall be a waiver of the right to a hearing.

2.83.5. Witnesses. No witnesses shall be presented at the hearing other than the practitioner.

2.7. Chair of Hearing Panel.

2.7.1. The chair of the Hearing Panel shall rule on all procedural matters at the hearing.

2.7.2. The chair shall have the authority to resolve all issues regarding scheduling of hearings, and shall have the authority to recess and reconvene the hearing, to impose time limits for presentations.

3.6. Discovery. Except as specifically provided in this Fair Hearing and Appellate Review Plan, there shall be no right to conduct discovery in connection with any hearing and no practitioner shall be permitted access to any peer review records, medical records, minutes or other documents relating to any other practitioner, or any action taken or not taken with regard to any other practitioner. The production of documents in accordance with this Fair Hearing and Appellate Review Plan shall not constitute a waiver of any peer review protection for those documents or any other documents. Nothing in this Fair Hearing and Appellate Review Plan shall be interpreted as giving the practitioner the authority to subpoena or otherwise compel the production of any documents, records or witnesses.

2.83.7. Burden of Proof. Whenever a hearing relates to the denial of a practitioner’s request for reappointment or modification of professional privileges, the practitioner need only be advised of the nature and source of the information upon which the adverse recommendation is based. In all cases the practitioner shall have the burden of proving by a preponderance of the evidence that the adverse recommendation or decision lacks any factual basis, or that the conclusions drawn therefrom are arbitrary, unreasonable, or capricious. It shall not be a defense to any action or proposed action that different action has been taken in the past with regard to any other practitioner, and no evidence shall be introduced regarding actions taken or not taken with regard to other practitioners.
3.8. Modification of Time Requirements. All time periods may be modified for good cause shown by the President of the Medical Staff, or designee.

23.9. Report and Recommendations of Hearing Panel. Within fifteen (15) calendar days after final adjournment of the hearing, including receipt of all written submissions, the Hearing Panel shall deliver a written report to the CEO, CCO, or designee and the President of the Medical Staff or designee stating in full its findings, the reasons and evidence upon which it based its findings, and its recommendations. The recommendations of the Hearing Panel need not be unanimous and any minority views may be reduced to writing, supported by reasons and references, and transmitted with the majority report. A copy of all reports and recommendations shall be delivered to the practitioner.

23.10. The CEO, CCO, or designee shall review the matter and, after consultation with the president of the medical staff or designee, shall make the final decision, subject only to appeal to the Board of Directors. The decision of the CEO, CCO, or designee shall be submitted in writing to the practitioner and the president of the medical staff. If the action that would have entitled the practitioner to hearing is modified so that no action entitling the practitioner to a hearing remains then the practitioner shall not be entitled to request an appellate review hearing. If the action remains one that would have entitled the practitioner to a hearing, the practitioner may request an appellate review by the Board of Directors by submitting a written request to the Chair of the Board within fifteen (15) days of receipt of the decision of the CEO, CCO, or designee. The request shall specify the findings of fact, conclusions, or procedural matters with which the practitioner disagrees and the reasons for such disagreement. Failure to identify any findings of fact, conclusions, or procedural matters with which the practitioner disagrees shall constitute a waiver of those issues. The practitioner may not submit new information, nor evidence not previously considered by the hearing committee, except as may be requested or approved by the Chair of the Board of Directors.

23.11 The decision of the CEO or CCO shall be final if no timely request or appellate review is received.

Article IV Appellate Review

34.1. Request for Appellate Review. The Chair of the Board of Directors or designee shall review any timely request for appellate review, the decision of the CEO, CCO, or designee and the report of the Hearing Panel, and shall determine whether to grant a discretionary appellate review. If the Chair of the Board of Directors grants discretionary appellate review, the matter shall be reviewed by the Board of Directors, or any Committee of the Board designated by the Chair of the Board (collectively referred to as the “Board”). The Board may request additional information from the hospital or the practitioner. If the practitioner fails to provide requested additional information, it shall be considered a waiver of appellate review. The Board shall review the request for appellate review, the decision of the CEO, CCO or designee, the report of the hearing subcommittee, and any additional information requested by the Board, and shall make a final decision within sixty (60) calendar days after the Chair grants discretionary appellate review. The written decision of the Board, including the reasons therefore, shall be provided to the CEO or CCO.

34.2. Standard of Appellate Review. Appellate review by the Board of Directors, or any Committee of the Board designated by the Board, shall be limited to determining whether the practitioner has established by clear and convincing evidence that:

a. There has been a substantial failure to comply with the Bylaws during the course of the corrective action which has materially prejudiced the practitioner;

b. The recommendation is arbitrary or unreasonable; or,
c. The recommendation is not supported by any reliable evidence.

34.3. Notification of Board Action. The CEO or CCO shall notify the applicant, the Medical Board and chair of the appropriate department of the final action taken by the Board of Directors.

Article IV General Provisions

45.1. Timely Objections to Actions. In the event any practitioner has any objection to any action taken or procedures followed by the Hospital, the medical staff, or any individual or committee with regard to the consideration of any application for appointment or reappointment, any investigation, any corrective action, any hearing, or other action, the applicant or practitioner shall immediately state such objection and the reasons for the objection to the individual or body concerned in writing, or verbally if the objection arises during any recorded proceedings, in order to permit the Hospital to address the objection and take any corrective action the Hospital deems necessary. The failure to give such notice of any objection shall be deemed to be a waiver of any such objection and consent to the procedures being followed or action being taken.

4.2. Presence of Practitioner. The practitioner shall be personally present at all hearings, except for good cause shown, and the failure of the practitioner to appear personally shall be a waiver of the right to a hearing.

4.3. Testimony of Practitioner. If the practitioner involved does not testify in his or her own behalf, the practitioner may be called and examined as if under cross-examination. The refusal of the practitioner to testify shall constitute a withdrawal of the request for a hearing, a waiver of any further rights to review, a failure to exhaust the remedies, and acceptance by the practitioner and agreement to the recommendations of the Medical Board.

4.4. Evidence and Testimony Requested by Hearing Committee. The hearing committee may receive and examine such exhibits as it deems appropriate on its own initiative, provided all parties involved shall be given reasonable notice of all exhibits to be examined by the committee and adequate opportunity to challenge or rebut such evidence.

4.5. Discovery. Except as specifically provided in this Fair Hearing and Appellate Review Plan, there shall be no right to conduct discovery in connection with any hearing and no practitioner shall be permitted access to any peer review records, medical records, minutes or other documents relating to any other practitioner, or any action taken or not taken with regard to any other practitioner. The practitioner requesting a hearing shall, however, be entitled to any documents relied on by the hearing subcommittee, CEO, CCO, or Board of Directors in making any recommendation or decision and, any documents to be introduced at the hearing, so long as the practitioner agrees in writing to keep all such documents confidential and not use them for any purpose other than in the hearing and appellate review proceedings. The production of such documents shall not constitute a waiver of any peer review protection for those documents or any other documents.

4.6. Rules of Evidence. Hearings need not be conducted according to technical rules of evidence relating to the admissibility or presentation of evidence and all evidence determined to be relevant and reliable by the hearing officer shall be considered. All testimony shall be presented under oath or affirmation.

4.7. Recording the hearing. Unless all parties agree otherwise, the hearing shall be recorded by a sound recording. Either party may have a court reporter record the proceedings. The record of the hearing need not be transcribed unless specifically requested and the person or body requesting the transcript shall be responsible for the cost of transcription.

4.8. Recess of Hearing. The hearing committee may recess any hearing to obtain further information.

4.9. Written Statement by Practitioner. The practitioner shall have the right to submit a written statement at the close of the hearing. Such statement shall be submitted within a reasonable time as established by the chair
of the hearing subcommittee.

4.10. Failure to Make Request or Appearance. If any practitioner fails to make a required request or appearance within the time specified herein or otherwise fails to comply with procedures for hearing and review set forth herein, the practitioner shall be deemed to have waived all further rights hereunder and shall be deemed to have consented to the recommendations then under consideration.

45.112. Modification of Time Requirements. All time periods may be modified for good cause shown by the chair of the committee or body before which the case is currently pending.

45.123. Confidentiality and Privilege. All information received, notes, records, minutes, documents, or materials of any kind which are obtained, reviewed, or considered in connection with any matters considered or action or investigation taken pursuant to the Medical Staff Bylaws relating to medical staff membership and/or professional or clinical privileges shall be confidential and privileged, shall be confidential peer review documents and, to the extent permitted by law, shall not be admissible or discoverable in any legal proceedings, and shall be subject to all other protection afforded to such documents or proceedings by law.

45.134. Immunity. All practitioners and all those participating in or providing information to any department, section, committee, hearing committee, officer of the medical staff, or others participating in the hearing and appellate review process shall, to the fullest extent permitted by law, not be liable for any actions taken or information provided in connection with the review, granting, or denial of professional privileges, or any other action taken pursuant to the Bylaws of the medical staff.

45.145. Closed Hearings. Hearings shall be closed unless the practitioner requests an open hearing (see Sec. 19.85, Wis. Stats.). If an open hearing is conducted, no patient names or identities shall be disclosed in the hearing. The hearing committee shall assign numbers for reference which all parties, representatives, witnesses, and the committee shall use.

HA-43165-15
Exhibit 3: Advanced Practice Providers

The following categories of health care professionals are eligible to apply for clinical privileges as advanced practice professionals.

- Advanced practice nurse prescriber;
- Nurse practitioner;
- Physician assistant;
- Certified nurse midwife;
- Certified registered nurse anesthetist;
- Anesthesiologist assistant;
- Clinical psychologist.
Attachment

Executive Summary

Isthmus Project, Inc. Bylaws
Revisions
EXECUTIVE SUMMARY

TO: UWHCA Board of Directors
DATE: September 23, 2020
RE: Isthmus Project, Inc.

Dear UWHCA Board Member:

We are seeking your approval of the following:

1) Isthmus Project, Inc. – Chief Innovation Officer
2) Isthmus Project, Inc. – Amended and Restated Bylaws
3) Isthmus Project, Inc. – Investment Guidelines

The Isthmus Project, Inc. Board of Directors and Investment Committee jointly held a meeting on September 17, 2020. During the meeting, discussion was held regarding Dr. Thomas (Rock) Mackie’s retirement as Chief Innovation Officer of Isthmus Project, Inc. as of June 30, 2020. Recommendation and endorsement were made for Dr. Elizabeth Hagerman to be named Chief Innovation Officer, Isthmus Project, Inc., subject to approval of the UWHCA Board as the sole Member of the entity. Dr. Hagerman is currently serving as the Executive Director, Isthmus Project, Inc. (Dr. Hagerman’s bio attached for your reference.)

Also discussed and endorsed at the September 17, 2020 meeting, were the Isthmus Project, Inc. Second Amended and Restated Bylaws and Investment Guidelines that also require the approval of the UWHCA Board as the sole Member of the entity.

Summary of the Proposed Isthmus Project, Inc. Second Amended and Restated Bylaws Revisions:

- Combination of former Isthmus Project, Inc. Board of Directors and Investment Committee (due to the overlap of Board and Committee membership and duplicative review processes)
- Number of Board of Directors (no less than 9 and no more than 13 – increase to permit merger of Board and Committee)
- Number of Class I, II, and III Directors (Class I = 3, Class II = 5, Class III = 5)
- References to “Investment Committee” and “Investment Committee Charter” changed to reference “Corporation’s Investment Guidelines” (Investment Committee Charter converted to Investment Guidelines for use of Board in evaluating opportunities)
- Required Annual Reporting to the Member and results of operations
Summary of Changes from “Investment Committee Charter” to “Investment Guidelines”:

- Former Investment Committee Charter converted to Investment Guidelines to be used by Board in evaluating opportunities
- Outlines certain factors to be considered in evaluating investments for Isthmus Project, Inc
- Sets forth authority of Board to make investments and limits on that authority

Attached for your consideration are the following documents:

- Isthmus Project, Inc. Bylaws (Marked)
- Isthmus Project, Inc. Bylaws (Clean)
- Isthmus Project, Inc. Investment Guidelines (Marked)
- Isthmus Project, Inc. Investment Guidelines (Clean)

Thank you for your consideration.

Patti Hutter
Vice President, Deputy General Counsel – Corporate Affairs
Elizabeth M. Hagerman, Ph.D., currently serves as the executive director of UW Health’s Isthmus Project, an innovation initiative in partnership with the UW School of Medicine and Public Health. Elizabeth is responsible for operations of the Isthmus Project, which provides a place for UW Health clinicians, staff, School of Medicine and Public Health faculty and others to seek support for their ideas and projects that aim to achieve better health outcomes or to solve problems facing UW Health patients, providers and the health system. Isthmus Project also seeks to work with outside entities or entrepreneurs with innovations that could benefit the health system.

Elizabeth’s experience includes a series of industry and academic roles focused on biotechnology, product development and commercialization as well as collaborations between industry and academia. She was most recently the Chief Innovation and Strategy officer at Conexus Indiana, whose mission is to lead innovative collaborations among industry, academic and public partners. Prior to that, Elizabeth served as Vice President of Rose-Hulman Ventures, a leading university model for offering prototyping and product development services to companies while providing engineering internships to undergraduate students. Elizabeth began her career at Baxter Healthcare in the regenerative medicine business where she held roles related to R&D, product development and medical affairs.

Elizabeth earned her bachelor’s degree in chemical engineering from the Rose-Hulman Institute of Technology and both master’s and Ph.D. degrees in biomedical engineering from the University of California-Los Angeles.
Attachment

Isthmus Project, Inc. Bylaws (Red-lined)
SECOND AMENDED AND RESTATED BY-LAWS OF ISTHMUS PROJECT, INC.

Effective as of [May 23, 2019]

ARTICLE I
OFFICES

Section 1.01 Principal Office. The address of the initial principal office of Isthmus Project, Inc. (the “Corporation”) in the State of Wisconsin shall be at 600 Highland Avenue, Madison, Wisconsin, 53792. The Corporation may have such principal office and other business offices as the board of directors of the Corporation (the “Board of Directors”) from time to time shall determine or the business of the Corporation may require.

Section 1.02 Registered Office. The registered office of the Corporation required by the Wisconsin Statutes to be maintained in the State of Wisconsin may be, but need not be, identical to the principal office in the State of Wisconsin and shall be such address as is reflected in the records of the Corporation and as may be from time to time determined by the Board of Directors. The business office of the registered agent of the Corporation shall be identical to such registered office.

Section 1.03 Books and Records. Any records maintained by the Corporation in the regular course of its business, books of account, and minute books, may be maintained on any information storage device or method; provided that the records so kept can be converted into clearly legible paper form within a reasonable time. The Corporation shall so convert any records so kept upon the request of any person entitled to inspect such records pursuant to applicable law.

ARTICLE II
PURPOSES

Section 2.01 Purposes. The Corporation is organized and shall be operated exclusively for the purposes set forth in the Corporation’s Articles of Incorporation as in effect from time to time, and the following:

(a) to support the stated missions of the University of Wisconsin Hospitals and Clinics Authority (“UWHCA”), University of Wisconsin Medical Foundation (“UWMF” and, together with UWHCA, “UW Health”), and the University of Wisconsin School of Medicine and Public Health (“UWSMPH”) by facilitating the development and translation of innovations and useful technology developed at UW Health and the University of Wisconsin, including in collaboration with other research institutions and partners, to improve health and healthcare by preventing and alleviating the effects of disease;

(b) to provide in-kind and financial support to further the stated missions of UW Health, UWSMPH and other schools at the University of Wisconsin engaged in activities related to the mission and strategies of UW Health; and

(c) to provide increased opportunities for employees, faculty, and staff of UW Health, UWSMPH, and other schools at the University of Wisconsin engaged in activities related to the mission and strategies of UW Health, to use their skills in the development process, and to gain experience and improve professional skills and abilities for use in the health system.
ARTICLE III
MEMBERS

Section 3.01 Sole Member. University of Wisconsin Hospitals and Clinics Authority (UWHCA) shall be the sole member (the “Member”) of the Corporation. The Member shall have the sole power and voting right to do the following:

(a) The election and removal of the directors of the Corporation;

(b) The approval of the Corporation’s annual budget, as part of the Member’s annual organizational budgeting process;

(c) The approval of any amendments, changes, or modifications to the Corporation’s Articles of Incorporation or these Bylaws;

(d) The approval of any act or omissions, including without limitation changes to the Corporation’s organizational documents or its purpose which would affect its not-for-profit and/or tax-exempt status;

(e) The approval of the incurrence of debt, the pledge or grant of any liens on any Corporation assets, or the guaranty or assumption of the obligations of any other person or entity;

(f) The approval of any transaction or series of related transactions involving the purchase, lease, license, exchange, or other acquisition (including by merger, consolidation, acquisition of stock, or acquisition of assets) by the Corporation of any assets and/or equity interests of any entity, except as permitted by the Corporation’s Investment Committee Charter Guidelines;

(g) The approval of any merger, consolidation, dissolution, wind-up or liquidation of the Corporation;

(h) The approval of the investment in, loan or advance to, capital contribution to, or other material transaction, including any joint venture or other similar business arrangement, with any other entity or person, except as permitted by the Corporation’s Investment Committee Charter Guidelines;

(i) The approval of the Corporation’s Investment Guidelines Committee Charter, any amendments thereto;

(j) The approval of any distributions from the Corporation; and

(k) The approval of the settlement of any lawsuit, action, dispute, or other proceeding, or other assumption of any liability, or the agreement to the provision of any equitable relief by the Corporation.

Section 3.02 Action By Member. The Member shall act by executing and delivering to the Chief Innovation Officer or Secretary of the Corporation a written instrument or instruments, signed by an authorized officer of the Member, setting forth the action taken and the applicable corporate authorization or direction from the Board of Directors of the Member. The action of the Member shall be deemed to have been taken on the dates the written instruments are so delivered unless the instruments expressly provide otherwise.
ARTICLE IV
BOARD OF DIRECTORS

Section 4.01 General Powers. Subject to the reserved powers of the Member as set forth in Article III above, the business and affairs of the Corporation shall be managed by or under the direction of the Board of Directors, which shall determine compliance with the Corporation’s stated purposes and shall have the power and authority to do and perform all acts or functions not inconsistent with these Bylaws or the Corporation’s Articles of Incorporation. The Board of Directors may adopt such rules and procedures, not inconsistent with the Articles of Incorporation, these Bylaws, or applicable law, as it may deem proper for the conduct of its meetings and the management of the Corporation.

Section 4.02 Number; Class; Term of Office.

(a) Number of Directors. The Board of Directors shall consist of no less than nine (9) and no more than thirteen (13) members (each a “Director”). The Board of Directors shall be elected by the Member. The Chairperson of the Board shall be one of the Directors as designated by the Member from time to time.

(b) Classes of Directors. The Board of Directors shall be and is divided into three (3) classes designated: Class I, Class II and Class III, consisting of the following persons:

(i) Class I Directors: The Chief Innovation Officer of the Company, the Chief Executive Officer of UW Health (or his/her designee), and the Dean of UWSMPH (or his/her designee);

(ii) Class II Directors: Up to four (4) Directors designated by the Member, one of whom must not be an officer or employee of the Member or UWSMPH and who has experience relevant to the furtherance of the Corporation’s mission and one (1) Director recommended by UWSMPH and approved by the Member in the Member’s reasonable discretion; and

(iii) Class III Directors: Up to four (4) Directors designated by the Member, one of whom must not be an officer or employee of the Member or UWSMPH and who has experience relevant to the furtherance of the Corporation’s mission and one (1) Director recommended by UWSMPH and approved by the Member in the Member’s reasonable discretion.

The Member shall take all action necessary to act elect the Directors in accordance with this Section 4.02. In the event the Member objects to a person recommended to serve as a Director by UWSMPH pursuant to Section 4.02(b)(ii) or (iii), the Member shall promptly notify UWSMPH of such objection and shall detail the rationale for such objection and UWSMPH and the Member shall cooperate in good faith to reach agreement on election of such designee or another individual.

(c) Terms of Office. Class I Directors each shall serve until his or her death, resignation or removal. Class II and Class III Directors shall each serve for a term ending on the 30th day of June two (2) years following the date of his or her election; provided, however, that each Director initially appointed to Class II shall serve for an initial term ending June 30, 2021; on the 30th day of June three (3) years following the effective date of this provision; provided further, that the term of each Director shall continue until the election and qualification of a successor and be subject to such Director’s earlier death, resignation or removal. No Class II or Class III Director may serve more than three (3) consecutive terms.
Section 4.03 Vacancies. If a vacancy exists in any Director position, the Member shall elect a successor to fill such vacancy such that the resulting composition of the Board of Directors complies with Section 4.02 above.

Section 4.04 Resignation. Any Director may resign at any time by notice given in writing or by electronic transmission to the Corporation. Such resignation shall take effect at the date of receipt of such notice by the Corporation or at such later time as is therein specified.

Section 4.05 Removal. A Director elected by the Member may be removed by the Member at any time by written notification delivered to the Corporation. A Director recommended for election by UWSM may be removed at any time by UWSM delivering written notice to the Member and the Member shall promptly take all required action to remove such Director.

Section 4.06 Compensation; Fees and Expenses. No compensation shall be paid by the Corporation to any Director for serving on the Board of Directors, except that a Director may be reimbursed for expenses actually incurred by such Director in carrying out any activity of the Corporation which is within the scope of the purposes of the Corporation set forth in Article II above and for reimbursement of reasonable expenses actually incurred for attendance at meetings of the Board of Directors, in each case upon the approval of the Board of Directors.

Section 4.07 Regular Meetings. The Board of Directors may provide, by resolution, the time and place for the holding of regular meetings without any notice other than such resolution.

Section 4.08 Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the Chairperson of the Board of Directors, the Chief Innovation Officer, or any two (2) Directors at such times and at such places as may be determined by the person(s) calling such special meeting.

Section 4.09 Notice; Waiver. Notice of special meetings of the Board of Directors shall be given by telephone or by written notice delivered personally or by mail, facsimile, or electronic transmission to each Director’s business address or at such other address as such Director shall have designated in writing filed with the Secretary of the Corporation. Notice in the case of telephone, personal delivery, facsimile, or electronic transmission shall be given not less than twenty-four (24) hours prior to the time of the meeting. If mailed, such notice shall be delivered at least seventy-two (72) hours prior to the meeting and shall be deemed to be delivered when deposited in the United States mail so addressed, with postage thereon prepaid. Whenever any notice is required to be given to any Director of the Corporation under the Articles of Incorporation, these Bylaws or any provision of applicable law, a waiver thereof in writing, signed at any time, whether before or after the time of the meeting, by the Director entitled to such notice, shall be deemed equivalent to the giving of such notice. The attendance of a Director at a meeting shall constitute a waiver of notice of such meeting, except where a Director attends a meeting and objects to the transaction of any business because the meeting is not lawfully called or convened. Neither the business to be transacted at, nor the purpose of, any special meeting of the Board of Directors needs to be specified in the notice or waiver of notice of such meeting. No notice need be given for any regular meeting when the time and place of such regular meeting has been fixed by a duly adopted resolution of the Board of Directors.

Section 4.10 Quorum. Except as otherwise provided by the Articles of Incorporation, these Bylaws or applicable law, a majority of the number of Directors then in office shall constitute a quorum for the transaction of business at any meeting of the Board of Directors.

Section 4.11 Conduct of Meetings. The Chairperson of the Board, and if the Chairperson is absent, the Chief Innovation Officer, and in the Chief Innovation Officer’s absence, any Director chosen...
Section 4.12 Manner of Acting. The act of the majority of the Directors present at a meeting at which a quorum is present shall be the act of the Board, unless the act of a greater number is required by the Articles of Incorporation, these Bylaws or applicable law.

Section 4.13 Action Without Meeting. Any action required or permitted by the Articles of Incorporation, these Bylaws or applicable law to be taken by the Board of Directors at a meeting or by resolution may be taken without a meeting if a written consent, setting forth the action so taken, shall be signed by all the Directors then in office.

Section 4.14 Meetings by Telephone or by Other Communication Technology. Any action required or permitted by the Articles of Incorporation, these Bylaws, or applicable law to be taken by the Board of Directors may be taken at a meeting through the use of any means of communication by which (a) all participating Directors may simultaneously hear each other during the meeting, or (b) all communication during the meeting is immediately transmitted to each participating Director and each participating Director is able to immediately send messages to all other participating Directors.

Section 4.15 Adjourned Meetings. A majority of the Directors present at any meeting of the Board of Directors, including an adjourned meeting, whether or not a quorum is present, may adjourn and reconvene such meeting to another time and place. Notice of any adjourned meeting of the Board of Directors shall be given to each Director whether or not present at the time of the adjournment as provided in Section 4.09. Any business may be transacted at an adjourned meeting that might have been transacted at the meeting as originally called.

Section 4.16 Investment Guidelines Committee. The Board of Directors shall establish an Investment Guidelines Committee, which shall be approved by the Member and which shall set forth the guidelines to utilized by the Corporation in evaluating support of and investment in innovations and useful technologies and the Corporation’s authority to provide such support. The Investment Committee shall consist of the following members: the Chief Innovation Officer, the Chief Executive Officer of UW Health (or his or her designee), the Dean of UWSMPH (or his or her designee), the Vice President of the Corporation, one (1) Director, and two (2) persons named by the Chief Executive Officer of UW Health. Each member of the Investment Committee so named shall be voting members of the Investment Committee. In addition, the Investment Committee shall have three (3) rotating advisory positions, which shall be filled by the Chief Innovation Officer from time to time, and who each shall have experience and expertise relevant to the potential investments then being evaluated by the Investment Committee. Such advisors shall not be voting members of the Investment Committee. The Investment Committee shall be governed by a charter adopted by the Board of Directors (the “Investment Committee Charter”) which shall govern the conduct of its business and activities. Except as specifically set forth in the Investment Committee Charter, the Investment Committee may make, alter, and repeal rules for the conduct of its business. In absence of such rules and procedures and unless otherwise specified in the Investment Committee Charter, the Investment Committee shall conduct its business in the same manner as the Board of Directors conducts its business pursuant to this Article IV.

Section 4.17 Committees of the Board of Directors. The Board of Directors may establish such other standing and special committees as the Board of Directors from time to time deems to be in the best interest of the Corporation. Except as set forth in any committee charter adopted by the Board of Directors, any such committee may make, alter, and repeal rules for the conduct of its business. In absence of such rules and procedures and unless otherwise specified in a committee charter, any such
committee shall conduct its business in the same manner as the Board of Directors conducts its business pursuant to this Article IV.

ARTICLE V
OFFICERS

Section 5.01 Positions and Election. The officers of the Corporation shall be elected by the Board of Directors and shall include a Chief Innovation Officer, Vice President, Secretary, Treasurer, and such other officers and assistant officers as may be deemed necessary by the Board of Directors. Any two or more offices may be held by the same person.

Section 5.02 Term. Each officer of the Corporation shall hold office until such officer’s successor is elected and qualified or until such officer's earlier death, resignation, or removal. Any officer elected or appointed by the Board of Directors may be removed by the Board of Directors at any time with or without cause by the majority vote of the members of the Board of Directors then in office. The removal of an officer shall be without prejudice to his or her contract rights, if any. The election or appointment of an officer shall not of itself create contract rights. Any officer of the Corporation may resign at any time by giving written notice of his or her resignation to the Chief Innovation Officer or the Secretary. Any such resignation shall take effect at the time specified therein or, if the time when it shall become effective shall not be specified therein, immediately upon its receipt. Unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective. Should any vacancy occur among the officers, the position shall be filled for the unexpired portion of the term by appointment made by the Board of Directors.

Section 5.03 The Chief Innovation Officer. The Chief Innovation Officer shall have general supervision over the business of the Corporation and other duties incident to the office of Chief Innovation Officer, and any other duties as may be from time to time assigned to the Chief Innovation Officer by the Board of Directors and subject to the control of the Board of Directors in each case.

Section 5.04 Vice President. In the absence of the Chief Innovation Officer, or the Chief Innovation Officer’s death, inability or refusal to act, or in the event for any reason it shall be impracticable for the Chief Innovation Officer to act personally, the Vice President shall perform the duties of the Chief Innovation Officer, and when so acting shall have all the powers of and be subject to all the restrictions upon the Chief Innovation Officer. The Vice President shall perform such other duties and have such authority as from time to time delegated or assigned to the Vice President by the Chief Innovation Officer or the Board of Directors.

Section 5.05 The Secretary. The Secretary shall (a) attend all sessions of the Board of Directors and record all votes and the minutes of all proceedings in a book to be kept for that purpose, and shall perform like duties for committees when required, (b) give, or cause to be given, notices as required by the Articles of Incorporation, these Bylaws, or applicable law, (c) be the custodian of the corporate records, (d) in general perform all duties incident to the office of the Secretary, and (e) perform such other duties as may be prescribed by the Chief Innovation Officer or the Board of Directors.

Section 5.06 The Treasurer. The Treasurer shall in general perform all the duties incident to the office of Treasurer and have such other duties and exercise such other authority as from time to time may be delegated or assigned to the Treasurer by the Chief Innovation Officer or the Board of Directors.

Section 5.07 Assistants and Acting Officers. The Board of Directors shall have the power to appoint any person to act as an assistant to an officer, or as agent for the Corporation in his/her stead, or
to perform the duties of such officer whenever for any reason it is impracticable for such officer to act personally, and such assistant or acting officer or other agent so appointed by the Board of Directors shall have the power to perform all duties of the officer to which he/she is so appointed to be assistant, or as to which he/she is so appointed to act, except as such power may be otherwise defined or restricted by the Board.

Section 5.08 Compensation. The Board of Directors may provide for the payment of reasonable compensation to any officer of the Corporation. If established, such reasonable compensation shall be fixed from time to time by the Board of Directors.

ARTICLE VI
PROFITS AND DISTRIBUTIONS

Section 6.01 Retention of Profits to Support Corporate Purposes. Generally, all corporate profits of the Corporation shall be retained by the Corporation and utilized as determined by the Board of Directors to support the Corporation’s purposes.

Section 6.02 Distributions of Profits to Support Corporation Purposes. Notwithstanding Section 6.01, the Board of Directors may, in its discretion, and upon the approval of the Member as required by Article III of these Bylaws, make distributions of profits of the Corporation to UW Health to support its mission or to UWSMPH to support its mission provided that any such distributions shall be made in accordance with all applicable law, including, without limitation, Wisconsin Statutes §181.1302, and provided further, that no such distributions shall be made if such distributions would affect the Corporation’s not-for-profit and/or tax-exempt status.

ARTICLE VII
AMENDMENTS

Section 7.01 Amendments. These Bylaws may be amended, altered, changed, adopted and repealed or new Bylaws adopted only upon the consent of the Member.

ARTICLE VIII
DISSOLUTION

Section 8.01 Dissolution. The Corporation may be dissolved only upon the act of the Member. Upon the dissolution of the Corporation, the Board of Directors shall, after paying or making provision for the payment of all of the liabilities of the Corporation, dispose of all of the assets of the Corporation exclusively for the benefit of UW Health and UWSMPH.

ARTICLE IX
GENERAL PROVISIONS

Section 9.01 Fiscal Year. The fiscal year of the Corporation shall begin on July 1 and end on June 30 of each year.

Section 9.02 Contracts. The Board of Directors may authorize any officer or officers, agent or agents, to enter into any contract or execute or deliver any instrument in the name of and on behalf of the Corporation, and such authorization may be general or confined to specific instances. No contract or other transaction between the Corporation and one or more of its Directors or any other corporation, firm, association, or entity in which one or more Directors of the Corporation are financially interested,
shall be either void or voidable because such Director or Directors are present at the meeting of the Board of Directors or a committee thereof which authorizes, approves, or ratifies the contract or transaction, if (a) the fact of such relationship or interest is disclosed or known to the Board of Directors or committee thereof which authorizes, approves or ratifies the contract or transaction by a vote or consent sufficient for the purpose without counting the votes or consents of such interested Directors and (b) the contract or transaction is fair and reasonable to the Corporation. Interested Directors may be counted in determining the presence of a quorum at a meeting of the Board of Directors or committee thereof which authorizes, approves, or ratifies such contract or transactions, but such interested Directors shall abstain from any vote to authorize, approve or ratify such contract or transaction.

Section 9.03 Checks, Notes, Drafts, Deposits. All checks, notes, drafts or other orders for the payment of money of the Corporation shall be signed, endorsed or accepted in the name of the Corporation by such officer, officers, person, or persons as from time to time may be designated by the Board of Directors or by an officer or officers authorized by the Board of Directors to make such designation. All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such banks, trust companies or other depositories as may be selected by or under the authority of a resolution of the Board.

Section 9.04 Seal. The Corporation shall not have a corporate seal.

Section 9.05 Conflict with Applicable Law or Certificate of Incorporation. These Bylaws are adopted subject to any applicable law and the Articles of Incorporation. Whenever these Bylaws may conflict with any applicable law or the Articles of Incorporation, such conflict shall be resolved in favor of such applicable law or the Articles of Incorporation.

Section 9.06 Annual Reporting to the Member. The Corporation’s Chief Innovation Officer shall report on the Corporation’s finances, business and affairs, results of operations, and support of and development of innovative technologies no less than annually.
ARTICLE I
OFFICES

Section 1.01 Principal Office. The address of the initial principal office of Isthmus Project, Inc. (the “Corporation”) in the State of Wisconsin shall be at 600 Highland Avenue, Madison, Wisconsin, 53792. The Corporation may have such principal office and other business offices as the board of directors of the Corporation (the “Board of Directors”) from time to time shall determine or the business of the Corporation may require.

Section 1.02 Registered Office. The registered office of the Corporation required by the Wisconsin Statutes to be maintained in the State of Wisconsin may be, but need not be, identical to the principal office in the State of Wisconsin and shall be such address as is reflected in the records of the Corporation and as may be from time to time determined by the Board of Directors. The business office of the registered agent of the Corporation shall be identical to such registered office.

Section 1.03 Books and Records. Any records maintained by the Corporation in the regular course of its business, books of account, and minute books, may be maintained on any information storage device or method; provided that the records so kept can be converted into clearly legible paper form within a reasonable time. The Corporation shall so convert any records so kept upon the request of any person entitled to inspect such records pursuant to applicable law.

ARTICLE II
PURPOSES

Section 2.01 Purposes. The Corporation is organized and shall be operated exclusively for the purposes set forth in the Corporation’s Articles of Incorporation as in effect from time to time, and the following:

(a) to support the stated missions of the University of Wisconsin Hospitals and Clinics Authority (“UWHCA”), University of Wisconsin Medical Foundation (“UWMF” and, together with UWHCA, “UW Health”), and the University of Wisconsin School of Medicine and Public Health (“UWSMPH”) by facilitating the development and translation of innovations and useful technology developed at UW Health and the University of Wisconsin, including in collaboration with other research institutions and partners, to improve health and healthcare by preventing and alleviating the effects of disease;

(b) to provide in-kind and financial support to further the stated missions of UW Health, UWSMPH and other schools at the University of Wisconsin engaged in activities related to the mission and strategies of UW Health; and

(c) to provide increased opportunities for employees, faculty, and staff of UW Health, UWSMPH, and other schools at the University of Wisconsin engaged in activities related to the mission and strategies of UW Health, to use their skills in the development process, and to gain experience and improve professional skills and abilities for use in the health system.
ARTICLE III
MEMBERS

Section 3.01 Sole Member. UWHCA shall be the sole member (the “Member”) of the Corporation. The Member shall have the sole power and voting right to do the following:

(a) The election and removal of the directors of the Corporation;
(b) The approval of the Corporation’s annual budget, as part of the Member’s annual organizational budgeting process;
(c) The approval of any amendments, changes, or modifications to the Corporation’s Articles of Incorporation or these Bylaws;
(d) The approval of any act or omissions, including without limitation changes to the Corporation’s organizational documents or its purpose which would affect its not-for-profit and/or tax-exempt status;
(e) The approval of the incurrence of debt, the pledge or grant of any liens on any Corporation assets, or the guaranty or assumption of the obligations of any other person or entity;
(f) The approval of any transaction or series of related transactions involving the purchase, lease, license, exchange, or other acquisition (including by merger, consolidation, acquisition of stock, or acquisition of assets) by the Corporation of any assets and/or equity interests of any entity, except as permitted by the Corporation’s Investment Guidelines;
(g) The approval of any merger, consolidation, dissolution, wind-up or liquidation of the Corporation;
(h) The approval of the investment in, loan or advance to, capital contribution to, or other material transaction, including any joint venture or other similar business arrangement, with any other entity or person, except as permitted by the Corporation’s Investment Guidelines;
(i) The approval of the Corporation’s Investment Guidelines, and any amendments thereto;
(j) The approval of any distributions from the Corporation; and
(k) The approval of the settlement of any lawsuit, action, dispute, or other proceeding, or other assumption of any liability, or the agreement to the provision of any equitable relief by the Corporation.

Section 3.02 Action By Member. The Member shall act by executing and delivering to the Chief Innovation Officer or Secretary of the Corporation a written instrument or instruments, signed by an authorized officer of the Member, setting forth the action taken and the applicable corporate authorization or direction from the Board of Directors of the Member. The action of the Member shall be deemed to have been taken on the dates the written instruments are so delivered unless the instruments expressly provide otherwise.

ARTICLE IV
BOARD OF DIRECTORS
Section 4.01 General Powers. Subject to the reserved powers of the Member as set forth in Article III above, the business and affairs of the Corporation shall be managed by or under the direction of the Board of Directors, which shall determine compliance with the Corporation’s stated purposes and shall have the power and authority to do and perform all acts or functions not inconsistent with these Bylaws or the Corporation’s Articles of Incorporation. The Board of Directors may adopt such rules and procedures, not inconsistent with the Articles of Incorporation, these Bylaws, or applicable law, as it may deem proper for the conduct of its meetings and the management of the Corporation.

Section 4.02 Number; Class; Term of Office.

(a) Number of Directors. The Board of Directors shall consist of no less than nine (9) and no more than thirteen (13) members (each a “Director”). The Board of Directors shall be elected by the Member. The Chairperson of the Board shall be one of the Directors as designated by the Member from time to time.

(b) Classes of Directors. The Board of Directors shall be and is divided into three (3) classes designated: Class I, Class II and Class III, consisting of the following persons:

(i) Class I Directors: The Chief Innovation Officer of the Company, the Chief Executive Officer of UW Health (or his/her designee), and the Dean of UWSMPH (or his/her designee);

(ii) Class II Directors: Up to four (4) Directors designated by the Member, one of whom must not be an officer or employee of the Member or UWSMPH and who has experience relevant to the furtherance of the Corporation’s mission and one (1) Director recommended by UWSMPH and approved by the Member in the Member’s reasonable discretion; and

(iii) Class III Directors: Up to four (4) Directors designated by the Member, one of whom must not be an officer or employee of the Member or UWSMPH and who has experience relevant to the furtherance of the Corporation’s mission and one (1) Director recommended by UWSMPH and approved by the Member in the Member’s reasonable discretion.

The Member shall take all action necessary to act elect the Directors in accordance with this Section 4.02. In the event the Member objects to a person recommended to serve as a Director by UWSMPH pursuant to Section 4.02(b)(ii) or (iii), the Member shall promptly notify UWSMPH of such objection and shall detail the rationale for such objection and UWSMPH and the Member shall cooperate in good faith to reach agreement on election of such designee or another individual.

(c) Terms of Office. Class I Directors each shall serve until his or her death, resignation or removal. Class II and Class III Directors shall each serve for a term ending on the 30th day of June two (2) years following the date of his or her election; provided, however, that each Director initially appointed to Class II shall serve for an initial term ending June 30, 2021; provided further, that the term of each Director shall continue until the election and qualification of a successor and be subject to such Director’s earlier death, resignation or removal. No Class II or Class III Director may serve more than three (3) consecutive terms.

Section 4.03 Vacancies. If a vacancy exists in any Director position, the Member shall elect a successor to fill such vacancy such that the resulting composition of the Board of Directors complies with Section 4.02 above.
Section 4.04  Resignation. Any Director may resign at any time by notice given in writing or by electronic transmission to the Corporation. Such resignation shall take effect at the date of receipt of such notice by the Corporation or at such later time as is therein specified.

Section 4.05  Removal. A Director elected by the Member may be removed by the Member at any time by written notification delivered to the Corporation. A Director recommended for election by UWSMPH may be removed at any time by UWSPMH delivering written notice to the Member and the Member shall promptly take all required action to remove such Director.

Section 4.06  Compensation; Fees and Expenses. No compensation shall be paid by the Corporation to any Director for serving on the Board of Directors, except that a Director may be reimbursed for expenses actually incurred by such Director in carrying out any activity of the Corporation which is within the scope of the purposes of the Corporation set forth in Article II above and for reimbursement of reasonable expenses actually incurred for attendance at meetings of the Board of Directors, in each case upon the approval of the Board of Directors.

Section 4.07  Regular Meetings. The Board of Directors may provide, by resolution, the time and place for the holding of regular meetings without any notice other than such resolution.

Section 4.08  Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the Chairperson of the Board of Directors, the Chief Innovation Officer, or any two (2) Directors at such times and at such places as may be determined by the person(s) calling such special meeting.

Section 4.09  Notice; Waiver. Notice of special meetings of the Board of Directors shall be given by telephone or by written notice delivered personally or by mail, facsimile, or electronic transmission to each Director’s business address or at such other address as such Director shall have designated in writing filed with the Secretary of the Corporation. Notice in the case of telephone, personal delivery, facsimile, or electronic transmission shall be given not less than twenty-four (24) hours prior to the time of the meeting. If mailed, such notice shall be delivered at least seventy-two (72) hours prior to the meeting and shall be deemed to be delivered when deposited in the United States mail so addressed, with postage thereon prepaid. Whenever any notice is required to be given to any Director of the Corporation under the Articles of Incorporation, these Bylaws or any provision of applicable law, a waiver thereof in writing, signed at any time, whether before or after the time of the meeting, by the Director entitled to such notice, shall be deemed equivalent to the giving of such notice. The attendance of a Director at a meeting shall constitute a waiver of notice of such meeting, except where a Director attends a meeting and objects to the transaction of any business because the meeting is not lawfully called or convened. Neither the business to be transacted at, nor the purpose of, any special meeting of the Board of Directors needs to be specified in the notice or waiver of notice of such meeting. No notice need be given for any regular meeting when the time and place of such regular meeting has been fixed by a duly adopted resolution of the Board of Directors.

Section 4.10  Quorum. Except as otherwise provided by the Articles of Incorporation, these Bylaws or applicable law, a majority of the number of Directors then in office shall constitute a quorum for the transaction of business at any meeting of the Board of Directors.

Section 4.11  Conduct of Meetings. The Chairperson of the Board, and if the Chairperson is absent, the Chief Innovation Officer, and in the Chief Innovation Officer’s absence, any Director chosen by the Directors present, shall preside at each meeting of the Board of Directors. The Secretary shall act as the secretary at each meeting of the Board of Directors. If the Secretary is absent, the person presiding at the meeting may appoint any person to act as secretary of the meeting.
Section 4.12 Manner of Acting. The act of the majority of the Directors present at a meeting at which a quorum is present shall be the act of the Board, unless the act of a greater number is required by the Articles of Incorporation, these Bylaws or applicable law.

Section 4.13 Action Without Meeting. Any action required or permitted by the Articles of Incorporation, these Bylaws or applicable law to be taken by the Board of Directors at a meeting or by resolution may be taken without a meeting if a written consent, setting forth the action so taken, shall be signed by all the Directors then in office.

Section 4.14 Meetings by Telephone or by Other Communication Technology. Any action required or permitted by the Articles of Incorporation, these Bylaws, or applicable law to be taken by the Board of Directors may be taken at a meeting through the use of any means of communication by which (a) all participating Directors may simultaneously hear each other during the meeting, or (b) all communication during the meeting is immediately transmitted to each participating Director and each participating Director is able to immediately send messages to all other participating Directors.

Section 4.15 Adjourned Meetings. A majority of the Directors present at any meeting of the Board of Directors, including an adjourned meeting, whether or not a quorum is present, may adjourn and reconvene such meeting to another time and place. Notice of any adjourned meeting of the Board of Directors shall be given to each Director whether or not present at the time of the adjournment as provided in Section 4.09. Any business may be transacted at an adjourned meeting that might have been transacted at the meeting as originally called.

Section 4.16 Investment Guidelines. The Board of Directors shall establish the Corporation’s Investment Guidelines, which shall be approved by the Member and which shall set forth the guidelines to utilized by the Corporation in evaluating support of and investment in innovations and useful technologies and the Corporation’s authority to provide such support.

Section 4.17 Committees of the Board of Directors. The Board of Directors may establish standing and special committees as the Board of Directors from time to time deems to be in the best interest of the Corporation. Except as set forth in any committee charter adopted by the Board of Directors, any such committee may make, alter, and repeal rules for the conduct of its business. In absence of such rules and procedures and unless otherwise specified in a committee charter, any such committee shall conduct its business in the same manner as the Board of Directors conducts its business pursuant to this Article IV.

ARTICLE V
OFFICERS

Section 5.01 Positions and Election. The officers of the Corporation shall be elected by the Board of Directors and shall include a Chief Innovation Officer, Vice President, Secretary, Treasurer, and such other officers and assistant officers as may be deemed necessary by the Board of Directors. Any two or more offices may be held by the same person.

Section 5.02 Term. Each officer of the Corporation shall hold office until such officer’s successor is elected and qualified or until such officer’s earlier death, resignation, or removal. Any officer elected or appointed by the Board of Directors may be removed by the Board of Directors at any time with or without cause by the majority vote of the members of the Board of Directors then in office. The removal of an officer shall be without prejudice to his or her contract rights, if any. The election or appointment of an officer shall not of itself create contract rights. Any officer of the Corporation may resign at any time by giving written notice of his or her resignation to the Chief Innovation Officer or
the Secretary. Any such resignation shall take effect at the time specified therein or, if the time when it shall become effective shall not be specified therein, immediately upon its receipt. Unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective. Should any vacancy occur among the officers, the position shall be filled for the unexpired portion of the term by appointment made by the Board of Directors.

**Section 5.03  The Chief Innovation Officer.** The Chief Innovation Officer shall have general supervision over the business of the Corporation and other duties incident to the office of Chief Innovation Officer, and any other duties as may be from time to time assigned to the Chief Innovation Officer by the Board of Directors and subject to the control of the Board of Directors in each case.

**Section 5.04  Vice President.** In the absence of the Chief Innovation Officer, or the Chief Innovation Officer’s death, inability or refusal to act, or in the event for any reason it shall be impracticable for the Chief Innovation Officer to act personally, the Vice President shall perform the duties of the Chief Innovation Officer, and when so acting shall have all the powers of and be subject to all the restrictions upon the Chief Innovation Officer. The Vice President shall perform such other duties and have such authority as from time to time delegated or assigned to the Vice President by the Chief Innovation Officer or the Board of Directors.

**Section 5.05  The Secretary.** The Secretary shall (a) attend all sessions of the Board of Directors and record all votes and the minutes of all proceedings in a book to be kept for that purpose, and shall perform like duties for committees when required, (b) give, or cause to be given, notices as required by the Articles of Incorporation, these Bylaws, or applicable law, (c) be the custodian of the corporate records, (d) in general perform all duties incident to the office of the Secretary, and (e) perform such other duties as may be prescribed by the Chief Innovation Officer or the Board of Directors.

**Section 5.06  The Treasurer.** The Treasurer shall in general perform all the duties incident to the office of Treasurer and have such other duties and exercise such other authority as from time to time may be delegated or assigned to the Treasurer by the Chief Innovation Officer or the Board of Directors.

**Section 5.07  Assistants and Acting Officers.** The Board of Directors shall have the power to appoint any person to act as an assistant to an officer, or as agent for the Corporation in his/her stead, or to perform the duties of such officer whenever for any reason it is impracticable for such officer to act personally, and such assistant or acting officer or other agent so appointed by the Board of Directors shall have the power to perform all duties of the officer to which he/she is so appointed to be assistant, or as to which he/she is so appointed to act, except as such power may be otherwise defined or restricted by the Board.

**Section 5.08  Compensation.** The Board of Directors may provide for the payment of reasonable compensation to any officer of the Corporation. If established, such reasonable compensation shall be fixed from time to time by the Board of Directors.

**ARTICLE VI**

**PROFITS AND DISTRIBUTIONS**

**Section 6.01  Retention of Profits to Support Corporate Purposes.** Generally, all corporate profits of the Corporation shall be retained by the Corporation and utilized as determined by the Board of Directors to support the Corporation’s purposes.

**Section 6.02  Distributions of Profits to Support Corporation Purposes.** Notwithstanding Section 6.01, the Board of Directors may, in its discretion, and upon the approval of the Member as
required by Article III of these Bylaws, make distributions of profits of the Corporation to UW Health to support its mission or to UWSMPH to support its mission provided that any such distributions shall be made in accordance with all applicable law, including, without limitation, Wisconsin Statutes §181.1302, and provided further, that no such distributions shall be made if such distributions would affect the Corporation’s not-for-profit and/or tax-exempt status.

ARTICLE VII
AMENDMENTS

Section 7.01 Amendments. These Bylaws may be amended, altered, changed, adopted and repealed or new Bylaws adopted only upon the consent of the Member.

ARTICLE VIII
DISSOLUTION

Section 8.01 Dissolution. The Corporation may be dissolved only upon the act of the Member. Upon the dissolution of the Corporation, the Board of Directors shall, after paying or making provision for the payment of all of the liabilities of the Corporation, dispose of all of the assets of the Corporation exclusively for the benefit of UW Health and UWSMPH.

ARTICLE IX
GENERAL PROVISIONS

Section 9.01 Fiscal Year. The fiscal year of the Corporation shall begin on July 1 and end on June 30 of each year.

Section 9.02 Contracts. The Board of Directors may authorize any officer or officers, agent or agents, to enter into any contract or execute or deliver any instrument in the name of and on behalf of the Corporation, and such authorization may be general or confined to specific instances. No contract or other transaction between the Corporation and one or more of its Directors or any other corporation, firm, association, or entity in which one or more Directors of the Corporation are financially interested, shall be either void or voidable because such Director or Directors are present at the meeting of the Board of Directors or a committee thereof which authorizes, approves, or ratifies the contract or transaction, if (a) the fact of such relationship or interest is disclosed or known to the Board of Directors or committee thereof which authorizes, approves or ratifies the contract or transaction, if (a) the fact of such relationship or interest is disclosed or known to the Board of Directors or committee thereof which authorizes, approves or ratifies the contract or transaction by a vote or consent sufficient for the purpose without counting the votes or consents of such interested Directors and (b) the contract or transaction is fair and reasonable to the Corporation. Interested Directors may be counted in determining the presence of a quorum at a meeting of the Board of Directors or committee thereof which authorizes, approves, or ratifies such contract or transactions, but such interested Directors shall abstain from any vote to authorize, approve or ratify such contract or transaction.

Section 9.03 Checks, Notes, Drafts, Deposits. All checks, notes, drafts or other orders for the payment of money of the Corporation shall be signed, endorsed or accepted in the name of the Corporation by such officer, officers, person, or persons as from time to time may be designated by the Board of Directors or by an officer or officers authorized by the Board of Directors to make such designation. All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such banks, trust companies or other depositories as may be selected by or under the authority of a resolution of the Board.

Section 9.04 Seal. The Corporation shall not have a corporate seal.
Section 9.05  Conflict with Applicable Law or Certificate of Incorporation. These Bylaws are adopted subject to any applicable law and the Articles of Incorporation. Whenever these Bylaws may conflict with any applicable law or the Articles of Incorporation, such conflict shall be resolved in favor of such applicable law or the Articles of Incorporation.

Section 9.06  Annual Reporting to the Member. The Corporation’s Chief Innovation Officer shall report on the Corporation’s finances, business and affairs, results of operations, and support of and development of innovative technologies no less than annually.
Attachment

Isthmus Project, Inc.
Investment Guidelines (Red-lined)
1. **Purpose.** The Investment Committee of the Board of Directors (the “Board”) of Isthmus Project, Inc. (the “Corporation”) has the responsibility, in consultation with the Corporation’s management, to evaluate the Corporation’s innovative ideas, concepts, inventions, and other intellectual property aimed to improve medicine, healthcare, and public health (each a “Project”), the determination of support (monetary or otherwise) by the Corporation. The guidelines for Project evaluation and the authority granted to the Board with respect to such support (collectively, the “Investment Guidelines”) is set forth herein. for such Projects and such other matters as assigned to the Investment Committee by the Board from time to time.

**Composition.** The Investment Committee shall consist of the Corporation’s Chief Innovation Officer; the Chief Executive Officer of University of Wisconsin Hospitals and Clinics Authority (“UWHCA”) or his or her designee; the Dean of the University of Wisconsin School of Medicine and Public Health (“UWSMPH”) or his or her designee; the Corporation’s Administrative Director; one (1) member of the Corporation’s Board as designated by the Board; two (2) persons designated by the UWHCA Chief Executive Officer; and three (3) non-voting, rotating seats which shall be filled on a project by project basis and which shall be such persons who are members of the Advisory Review Sub-Committee (as hereinafter defined) and as are designated from time to time by the Corporation’s Chief Innovation Officer. Appointees may include persons who are not members of the Board.

2. **Duties.** Evaluation. The Board Investment Committee shall have the responsibility to evaluate Projects submitted to the Corporation by employees of University of Wisconsin Hospitals and Clinics Authority (“UWHCA”) or “Member”), University of Wisconsin Medical Foundation, Inc. (“UWMF”, and together with UWHCA’s and UWMF’s respective subsidiaries and affiliates, collectively, “UW Health”), the University of Wisconsin School of Medicine and Public Health (“UWSMPH”), and others to determine whether support of such any such Project is consistent with the Corporation’s purposes and in the best interest of the Corporation. In evaluating such Projects, the Board shall evaluate:
   a. The Project’s potential to support and further the stated missions of UW Health and/or UWSMPH;
   b. The Project’s impact or potential impact on health and healthcare;
   c. The scope of the community of patients and health care providers potentially served and impacted by the Project;
   d. The Project’s potential to create and sustain a culture of innovation at UW Health, including by helping UW Health recruit and retain the best minds in health care;
   e. Whether the nature of the Project is such that the Project can be further developed and/or disseminated consistent with the Corporation’s mission (including, without limitation, through commercialization);
f. Whether support of the Project is consistent with the Corporation’s then-current strategy, as developed by the Corporation’s management in consultation with the Corporation’s Board;

g. Whether the Corporation can be actively involved in or have a material impact on the development, incubation, acceleration, and/or commercialization of the Project; and

h. Such other factors and criteria as the Corporation’s Board, in consultation with the Corporation’s management, shall determine from time to time.

In evaluating Projects for support, the strength of a Project’s potential for profit, while appropriate to consider, shall not be the primary consideration.

3. Determination of Support. Where the Board Investment Committee has determined that support of a Project is consistent with the furtherance of the Corporation’s mission and is in the Corporation’s best interest, the Board shall, subject to the limitations set forth herein and in the Corporation’s bylaws, determine a Project for which support is appropriate, the Investment Committee shall have direct responsibility for determining the scope, amount, and form(s) of support to be provided to a Project. Subject to the limitations on the Investment Committee’s authority as set forth in this Charter, such support may include, without limitation: (a) financial support (subject to the limitations set forth herein), (b) consulting services (internal or external), including legal, accounting, business, marketing, and other consultants, (c) procurement services, (d) equipment (including leased equipment), (e) space (or rent for space), (f) cost center administration, (g) intellectual property evaluation, consultation, development and protection (including associated applications and filings), (h) intellectual property licensing, (i) intellectual property enforcement, (j) UW Health employee support, (k) assistance with Wisconsin Alumni Research Foundation review, (l) University of Wisconsin equity review, (m) legal services, (n) assistance with third party investment support, (o) new company exploration and formation, and (p) other operational and administrative services as may be appropriate. Any grant of support to a Project shall be in accordance with a budget developed at the time such support is granted.
The Board may not commit support to any Project in excess of $250,000 (whether direct financial support or pass-through expenditures) in the aggregate, without the prior approval of the Member’s Chief Executive Officer;

b. The Board may not commit support to any Projects in any amount which would result in total Project support amounts for the then-current budget period exceeding the Corporation’s then-current approved budget without the approval of the Member;

c. The Board may not agree to form a new legal entity as a subsidiary of the Corporation without the prior approval of the Member;

d. The Board may not commit support to any Project not directly related to health, health care, or medicine without the prior approval of the Member;

e. The Board may not commit support to any Project which does not involve one or more employees of UW Health or UWSMPH; and

e. The Board may not commit support to any Project in which the Corporation has not, does not, or will not have active involvement or a material impact on the furtherance of the Project.

2.5 Project Support Agreements. The Investment Committee shall be directly responsible to approve the terms of any agreements or arrangements pertaining to support provided to a Project, including where appropriate, the terms of a Project Support Agreement, which terms shall be subject to the limitations on the authority of the Investment Committee set forth herein.

3.6 Project Oversight and Evaluation. The Investment Committee shall have general oversight of supported Projects including responsibility for insuring that parties to such support agreements/arrangements comply with all terms, conditions and obligations associated with such support agreements/arrangements. The Investment Committee shall, at least quarterly, evaluate Projects for which support is ongoing to determine whether support therefor should continue, be modified or be terminated. The Investment Committee shall report on Project support and the results of Project evaluation to the Board Member no less than bi-annually.

a. Oversight of the Advisory Review Sub-Committee. The Investment Committee shall establish an Advisory Review Sub-Committee as a Sub-Committee of the Investment Committee. The Advisory Review Sub-Committee shall consist of medical, healthcare, and health industry experts and entrepreneurs, company executives, investors with relevant industry experience and professionals with experience with business incubators and accelerators. The Advisory Review Sub-Committee will critique Project submissions, assist with prioritizing Projects for support, conduct the preliminary screen of Projects and recommend the highest priority Projects to the Investment Committee for further evaluation and possible support. The Investment Committee shall approve the score card to be utilized by the Advisory Review Sub-Committee in the evaluation of Projects.

4. Authority.
a. **Project Support.** The Investment Committee may commit the Corporation’s support for Projects that the Investment Committee has determined are consistent with the furtherance of the Corporation’s mission and which are appropriate for further development and dissemination, subject to the following limitations: (1) the Investment Committee may not commit support in an amount in excess of $100,000 (whether direct financial support or in-kind support) in the aggregate, without the prior approval of the Board; (2) the Investment Committee may not agree to form a new legal entity as a subsidiary or affiliate of the Corporation without the prior approval of the Board; (3) the Investment Committee may not agree to invest Corporation funds in another entity without the prior approval of the Board; (4) the Investment Committee may not commit support to any Project not directly related to health, healthcare or medicine without the prior approval of the Board; and (5) the Investment Committee may not undertake any act or fail to take any action that would be in contravention of the powers reserved to the member of the Corporation in the Corporation’s bylaws.

b. **Professional Advisors and Consultants.** The Investment Committee shall have the authority to engage independent legal, accounting, business, marketing or other advisors or consultants as the Investment Committee deems necessary or appropriate to carry out its responsibilities and/or in furtherance of Project support, subject in all instances to the limitations of the Investment Committee set forth herein. Any independent legal, accounting, business, marketing or other advisors retained in connection with a Project shall be retained in accordance with the relevant Project budget and such budget shall not provide for expenditures for such professional advisors and consultants in an amount greater than 30% of the total support budget without the prior approval of the Board.

c. **Expenses.** The Investment Committee shall have the authority to incur expenses that are reasonable and necessary to carry out its responsibilities, subject to the per Project aggregate limitations set forth herein or otherwise by the Board.

**Meetings and Procedures**

d. **Meetings.** The Investment Committee shall meet as often as it deems necessary in order to perform its responsibilities but no less than quarterly. A majority of the voting Investment Committee members shall constitute a quorum for conducting business at a meeting.

e.a. **Reports to the Board of Directors.** The Investment Committee shall report at least bi-annually to the Board.
1. **Purpose.** The Board of Directors (the “Board”) of Isthmus Project, Inc. (the “Corporation”) has the responsibility, in consultation with the Corporation’s management, to evaluate innovative ideas, concepts, inventions, and other intellectual property aimed to improve medicine, healthcare, and public health (each a “Project”), for support (monetary or otherwise) by the Corporation. The guidelines for Project evaluation and the authority granted to the Board with respect to such support (collectively, the “Investment Guidelines”) is set forth herein.

2. **Evaluation.** The Board shall have the responsibility to evaluate Projects submitted to the Corporation by employees of University of Wisconsin Hospitals and Clinics (“UWHCA” or “Member”), University of Wisconsin Medical Foundation, Inc. (“UWMF”, and together with UWHCA’s and UWMF’s respective subsidiaries and affiliates, collectively, “UW Health”), the University of Wisconsin School of Medicine and Public Health (“UWSMPH”), and others to determine whether support of such any such Project is consistent with the Corporation’s purposes and in the best interest of the Corporation. In evaluating such Projects, the Board shall evaluate:
   a. The Project’s potential to support and further the stated missions of UW Health and/or UWSMPH;
   b. The Project’s impact or potential impact on health and healthcare;
   c. The scope of the community of patients and health care providers potentially served and impacted by the Project;
   d. The Project’s potential to create and sustain a culture of innovation at UW Health, including by helping UW Health recruit and retain the best minds in health care;
   e. Whether the nature of the Project is such that the Project can be further developed and/or disseminated consistent with the Corporation’s mission (including, without limitation, through commercialization);
   f. Whether support of the Project is consistent with the Corporation’s then-current strategy, as developed by the Corporation’s management in consultation with the Corporation’s Board;
   g. Whether the Corporation can be actively involved in or have a material impact on the development, incubation, acceleration, and/or commercialization of the Project; and
   h. Such other factors and criteria as the Corporation’s Board, in consultation with the Corporation’s management, shall determine from time to time.

In evaluating Projects for support, the strength of a Project’s potential for profit, while appropriate to consider, shall not be the primary consideration.
3. **Determination of Support.** Where the Board has determined that support of a Project is consistent with the Corporation’s mission and is in the Corporation’s best interest, the Board shall, subject to the limitations set forth herein and in the Corporation’s bylaws, determine the scope, amount, and form(s) of support to be provided to a Project. Such support may include, without limitation: (a) financial support (subject to the limitations set forth herein), (b) consulting services (internal or external), including legal, accounting, business, marketing, and other consultants, (c) procurement services, (d) equipment (including leased equipment), (e) space (or rent for space), (f) cost center administration, (g) intellectual property evaluation, consultation, development and protection (including associated applications and filings), (h) intellectual property licensing, (i) intellectual property enforcement, (j) UW Health employee support, (k) assistance with Wisconsin Alumni Research Foundation review, (l) assistance with University of Wisconsin onin equity review, (m) assistance with third party investment support, (n) new company exploration and formation, and (o) other operational and administrative services as may be appropriate. Any grant of support to a Project shall be in accordance with a budget developed at the time such support is granted.

4. **Authority.** The Board may commit the Corporation’s support for Projects that the Board has determined are consistent with the furtherance of the Corporation’s mission and in the best interest of the Corporation, subject to the following limitations:

   a. The Board may not commit support to any Project in excess of $250,000 (whether direct financial support or pass-through expenditures) in the aggregate, without the prior approval of the Member’s Chief Executive Officer;

   b. The Board may not commit support to any Projects in any amount which would result in total Project support amounts for the then-current budget period exceeding the Corporation’s then-current approved budget without the approval of the Member;

   c. The Board may not agree to form a new legal entity as a subsidiary of the Corporation without the prior approval of the Member;

   d. The Board may not commit support to any Project not directly related to health, health care, or medicine without the prior approval of the Member;

   e. The Board may not commit support to any Project which does not involve one or more employees of UW Health or UWSMPH; and

   f. The Board may not commit support to any Project in which the Corporation has not, does not, or will not have active involvement or a material impact on the furtherance of the Project.

5. **Project Support Agreements.** The Board shall be directly responsible to approve the terms of any agreements or arrangements pertaining to support provided to a Project, including where appropriate, the terms of a Project Support Agreement, which terms shall be subject to the limitations on the authority of the Board set forth herein.

6. **Project Oversight and Evaluation.** The Board shall have general oversight of supported Projects including responsibility for insuring that parties to such support agreements/arrangements comply with all terms, conditions and obligations associated
with such support agreements/arrangements. The Board shall, at least quarterly, evaluate Projects for which support is ongoing to determine whether support therefor should continue, be modified or be terminated. The Board shall report on Project support and the results to the Member no less than annually.
Attachment

UWMF
Proposed Candidates for
UWMF Board Faculty Director Seat
as
Selected by the UW Health Council of Faculty
Subject to approval by the UWHCA Board of Directors, the UW Health Council of Faculty (CoF) met on September 9, 2020 to evaluate eight (8) candidates to prepare a slate of five (5) candidates for one (1) Faculty Director seat on the UWMF Board of Directors. CoF utilized criteria which included at a minimum gender balance, diversity, experience level, the location of practice, and the type of practice, academic interest and service record of the nominee.

Candidates were limited to those Departments which are not already represented by Faculty Directors.

Below is the list of nominees selected for the Faculty at Large election for the UWMF Board Faculty Director seat:

- Deborah Rusy, MD, MBA (Department of Anesthesiology)
- Sandra Kamnetz, MD (Department of Family Medicine and Community Health)
- J. Igor Iruretagoyena, MD (Department of Obstetrics and Gynecology)
- Aparna Mahajan, MD (Department of Pathology and Laboratory Medicine)
- David Jarrard, MD (Department of Urology)

See Attached - UWMF Policy on Nomination and Election of Faculty Directors Criteria -July 1, 2020 UWMF Bylaws (Article 4 and Exhibit D).
Criteria
July 1, 2020 UWMF Bylaws
(Article 4 and Exhibit D)
BYLAWS OF THE UNIVERSITY OF WISCONSIN MEDICAL FOUNDATION, INC.

AMENDED AND RESTATED EFFECTIVE JULY 1, 2020
4.1 Powers.

(a) General Powers. Subject to § 3.2, including the Authority’s right to approve the capital and operating budgets for UW Health, the Corporation Board shall have the following powers and authority (the “Assigned Powers”):

(i) to develop and oversee principles and procedures for physician compensation plans for the Clinical Departments of UWSMPH (each a “Clinical Department”) pursuant to the Compensation Principles and Procedure Policy of the Corporation Board attached hereto as Exhibit A (the “Compensation Principles and Procedure Policy”);

(ii) to participate in the management of the Funds Flow Model attached hereto as Exhibit B (the “Funds Flow Model”);

(iii) subject to compliance with the requirements of applicable federal law, to manage the Corporation’s retirement plans available to the Faculty;

(iv) subject to compliance with the requirements of applicable law, to manage the Corporation’s tax-qualified retirement plan or plans in which non-Faculty employees of the Corporation participate, which Assigned Power may also be exercised by the Authority with respect to the Corporation’s non-Faculty employees who begin their participation in such plans on or after July 1, 2017 (or such earlier date as is determined in the discretion of the Corporation Board);

(v) to maintain professional standards and oversee the quality of care provided by the Corporation’s providers (including the Faculty and mid-level clinicians), subject to the integrated Quality Program of the Authority and UWSMPH’s ultimate responsibility for the quality, timeliness, and appropriateness of care provided by Faculty;

(vi) to elect non-ex-officio Directors of the Corporation in accordance with the election procedures set forth herein;

(vii) to remove directors of the Corporation for cause, which Assigned Power may also be exercised by the Authority;

(viii) to appoint and remove elected officers of the Corporation;
(ix) to establish and manage committees and advisory bodies of the Corporation Board, and elect and remove members of the same;

(x) to nominate to the Board of Directors of the Authority (the “Authority Board”) candidates for election as non-\textit{ex-officio} non-voting members of the Executive Committee of the Authority Board, which candidates shall be members of the Corporation Board;

(xi) to participate in the selection and evaluation of the Chief Executive Officer of the Authority (the “Authority CEO”);

(xii) to exercise such other powers required to be held by the Corporation Board by applicable law or by accreditation standards applicable to the Corporation and its Subsidiaries as may be in effect from time to time, all as reasonably determined and directed by the Authority Board;

(xiii) to exercise such other powers as may be assigned to the Corporation Board in these Bylaws; and

(xiv) to exercise such other powers as the Authority may, by resolution, assign to the Corporation Board.

(b) \textbf{Statements of Policy.} Exhibits A to I attached to these Bylaws are statements of policy by the Corporation Board. Except for Exhibit A (Compensation Principles & Procedure Policy), and Exhibit B (Funds Flow Model), and except as otherwise provided in these Bylaws, the policies established in these Exhibits may be changed by the Authority Board, or by the Corporation Board subject to the approval of the Authority Board.

4.2 \textbf{Number and Designation}

(a) \textbf{Generally.} The Corporation Board shall consist of fifteen (15) voting members (each, a “Director”). The fifteen (15) voting members shall be made up of the following persons:

(i) the Authority CEO serving \textit{ex-officio} and as Chairman of the Board;

(ii) the Vice Chair and President of the Corporation (the “Corporation President”), serving \textit{ex-officio};

(iii) the Chief Administrative Officer of the Corporation (the “Corporation CAO”), serving \textit{ex-officio};

(iv) four (4) independent members of the public (“Public Directors”) nominated and elected as described in § 4.4(a);
(v) four (4) chairs of Clinical Departments of UWSMPH (“Chair Directors”) appointed as described in § 4.4(b); and

(vi) four (4) Faculty members (“Faculty Directors”) nominated and elected as described in § 4.4(c).

(b) Ex-Officio Directors. The Authority CEO, as Chairman of the Corporation Vice Chair and President, and the Corporation CAO shall be *ex-officio* Directors (collectively, the “Ex-Officio Directors”), and shall be full voting members of the Corporation Board.

### 4.3 Qualifications of Directors

(a) **Residence.** Directors need not be residents of the State of Wisconsin.

(b) **Public Directors.** Public Directors shall be community leaders, health care professionals, or health science professionals who are: (a) not related to the employees or officers of the Corporation or Authority; and (b) not employed by the Corporation, the Authority, UW-Madison, the University of Wisconsin System or the State of Wisconsin.

(c) **Chair Directors.** Only chairs of Clinical Departments of UWSMPH are eligible to serve as Chair Directors.

(d) **Faculty Directors.** Any Faculty member, other than a chair of a Clinical Department, is eligible to serve as a Faculty Director.

### 4.4 Nomination and Election of Directors and Terms of Office

(a) **Public Directors.** The Public Directors will be elected by the Corporation Board pursuant to the process attached as Exhibit C.

(b) **Chair Directors.** The Council of Chairs (as hereinafter defined) shall select the four (4) Chair Directors, subject to approval by the Authority Board.

(c) **Faculty Directors.**

   (i) **Faculty At Large.** The Faculty Directors shall be elected from candidates selected by the Council of Faculty (as hereinafter defined) from nominations received from the Faculty at large.

   (ii) Subject to approval of the candidates by the Authority Board, the Council of Faculty will select candidates from the nominations it receives utilizing criteria which shall include, at a minimum, gender balance, experience level, the location of practice, and the functional practice of the nominee. Candidates shall be limited to those Clinical Departments which are not already represented by Faculty Directors. If the Council of Faculty is unable to fulfill its
responsibility, the Corporation Board’s Executive/Governance Committee will determine the slate of candidates following the same criteria.

(iii) **Nomination and Election.** The Faculty will elect the Faculty Directors pursuant to the process attached as Exhibit D.

(d) **Terms of Office.** The non-Ex-Officio Directors shall each hold office for a term of three (3) years, or as otherwise required to implement staggered terms in accordance with Ch. 181.0806 of the Wisconsin Statutes, or any successor statute thereto.

(e) **Continuation.** Notwithstanding § 4.4(d), members of the Corporation Board shall hold office until their resignation or removal, or until their successor has been elected and qualified.

(f) **Temporary or Interim Appointments.** A person appointed as an “acting” or “interim” Authority CEO, Corporation President, or Corporation CAO will be a Director during the term of such appointment.

(g) **Re-election.** All Directors may be re-appointed or re-elected, except that Ex-Officio Directors serve until his/her resignation or removal.

4.5 **Resignation.** A Director may resign at any time by filing a written declaration of resignation with the Secretary of the Corporation.

4.6 **Removal.**

(a) **Chair Directors.** Chair Directors may be removed from office with or without cause by a written petition submitted to the Corporation Board and signed by two-thirds (2/3) of the members of the Council of Chairs.

(b) **Faculty Directors.** Faculty Directors may be removed from office with or without cause by a vote of two-thirds (2/3) of the eligible Faculty voters casting a ballot in a recall election. A recall election shall be called by the Corporation Board promptly upon presentation to the Corporation Board of a written petition signed by one-third (1/3) plus one (1) of the eligible Faculty voters. Eligible voters shall be all Faculty members.

(c) **Removal for Cause.** In the sole discretion of the Corporation Board or Authority Board, any Director may be removed for cause, as determined by the Corporation Board or Authority Board, taking into consideration the policy attached as Exhibit E to these Bylaws.

(d) **Removal by Chancellor.** The Chancellor of UW-Madison shall have the power to remove, at his or her pleasure, any Faculty Director or any Chair Director, with or without cause.
4.7 **Vacancies.** In the event a vacancy occurs on the Corporation Board for any reason, such vacancy will be filled promptly.

(a) **Public Directors.** If a vacancy occurs among the Public Directors, the Corporation Board shall hold an interim election in accordance with § 4.4(a).

(b) **Chair Directors.** If a vacancy occurs among the Chair Directors, the Council of Chairs will fill the position in accordance with § 4.4(b).

(c) **Faculty Directors.** If a vacancy occurs among the Faculty Directors, the Council of Faculty (as hereinafter defined) shall hold an interim election in accordance with § 4.4(c).

(d) **Ex-Officio Directors.** If a vacancy occurs among the Ex-Officio Directors, the position will be filled by the successor or interim successor to the position of Authority CEO, Corporation Vice Chair and President, or Corporation CAO.

(e) **Term.** A Chair Director, Faculty Director, or Public Director elected in an interim election shall finish the term of his or her predecessor, unless the remainder of the term is less than six (6) months at the time of the interim election. If the remainder of the term is less than six (6) months, the Chair Director, Faculty Director, or Public Director will finish the term of his or her predecessor and serve the succeeding three (3) year term.

4.8 **Advice on Personnel Matters.** At its discretion, the Corporation Board shall seek the advice of interested persons, councils, and committees regarding the performance of the Corporation President and Corporation CAO.

4.9 **Special Faculty Meetings.** Special meetings of the Faculty shall be held on the written petition of not less than twenty percent (20%) of the Faculty, not less than a two-thirds (2/3) vote of the Council of Faculty, or on the call of the Corporation Board. The petition, the vote, or the call of the Corporation Board shall specify the agenda for the meeting and notice shall go to each Faculty employee specifying the date, place, and agenda for the meeting at least ten (10) days in advance.

4.10 **Faculty Vote on Certain Changes to Articles, Bylaws, and Policies.** Certain proposed changes to particular provisions of the Articles of Incorporation and Bylaws of the Corporation, the Compensation Principles & Procedure Policy (Exhibit A), and Funds Flow Model (Exhibit B), all as defined in § 15.2, shall not be adopted unless approved by not less than a two-thirds (2/3) vote of those Faculty voting in person or by proxy or by a mail or electronic ballot.

4.11 **Regular Meeting.** The Corporation Board shall provide by resolution for regular meetings of the Corporation Board, to be held at a fixed time and place, and, upon the passage of any such resolution, such meetings shall be held at the stated time and place without notice other than such resolution.
4.12 **Special Meetings.** Special meetings of the Corporation Board may be held at any
time and place for any purpose or purposes, unless otherwise prescribed by statute,
on call of the Corporation President, the Corporation Board Chair, or upon the
written request of any three (3) Directors delivered to the Secretary of the
Corporation.

4.13 **Notice and Waiver of Notice.**

(a) **Notice.** Except as provided in § 4.11, notice of the date, time, and place of
meetings shall be given to members of the Corporation Board. Unless a
different time is required by Chapter 181 of the Wisconsin Statutes, notice
shall be given orally or in writing delivered personally to each Director at
least twenty-four (24) hours prior to the meeting. Written notice may be
mailed or faxed to each Director at least seventy-two (72) hours prior to the
meeting in lieu of personal delivery of notice. If mailed, such notice shall
be deemed to be delivered when deposited in the United States mail
addressed to the Director at his or her address as it appears on the records
of the Corporation, with postage thereon prepaid. The purpose of and the
business to be transacted at any special meeting of the Corporation Board
shall be specified in the notice or waiver of notice of such meeting.

(b) **Waiver of Notice.** Whenever the Wisconsin Statutes, the Articles of
Incorporation or Bylaws of the Corporation require that the Corporation
give any notice, a waiver thereof in writing signed at any time by the person
or persons entitled to such notice, shall be deemed equivalent to the giving
of such notice. The attendance of a Director at a meeting shall constitute a
waiver of notice of such meeting except where a Director attends the
meeting for the express purpose of objecting to the transaction of any
business because the meeting is not lawfully called or convened.

4.14 **Quorum.** Eight (8) Directors, or, if there are vacancies, fifty-one percent (51%) or
more of the Directors then in office shall constitute a quorum for the transaction of
business at any meeting of the Corporation Board. If fewer/less than such
number/percentage are present at a meeting, a majority of the Directors present may
adjourn the meeting from time to time without further notice.

4.15 **Manner of Acting.** The act of a majority of the Directors present at a meeting at
which a quorum is present shall be the act of the Corporation Board, unless the act
of a greater number is required by the Wisconsin Statutes or by the Articles of
Incorporation or Bylaws of the Corporation.

4.16 **Informal Action by Directors.** Except as required by the Wisconsin Open
Meetings Law, the Corporation Board may take action by two-thirds (2/3) written
consent of the Directors. The consent must be in a writing signed by all of the
Directors with respect to the subject matter thereof, and it must set forth the action
to be taken. Such consent may be for any action that the Articles of Incorporation
or Bylaws of the Corporation or any provision of applicable law requires to be taken
at a meeting, or any other action that might be taken at a meeting. Such consent shall have the same force and effect as a unanimous vote.

4.17 Presumption of Assent. A Director of the Corporation, who is present at a meeting of the Corporation Board, or a committee thereof, at which action on any corporate matter is taken, is presumed to have assented to the action taken. This presumption will stand unless the Director’s dissent is entered in the minutes of the meeting or the Director files a written dissent to the action with the person acting as the Secretary of the meeting. Such dissent shall be filed before the adjournment of the meeting or shall be forwarded by registered mail to the Secretary of the Corporation immediately after the adjournment of the meeting. Such right to dissent shall not apply to a Director who voted in favor of such action.

4.18 Compensation. Directors may only receive reimbursement for reasonable expenses incurred in connection with corporate matters, provided that such reimbursement policy is authorized by the affirmative vote of a majority of the Directors at a meeting at which a quorum is present.

4.19 Meetings by Telephone or by Other Communication Technology. Except as required by the Wisconsin Open Meetings Law, meetings of the Corporation Board or committees of the Corporation Board may be conducted by telephone or other communication technology in accordance with Chapter 181.0820(3) of the Wisconsin Statutes or any successor statute thereto. If such a meeting is conducted, all participating Directors shall be informed at the time the meeting is to begin that a meeting is taking place at which official business may be transacted and that any Director participating in such meeting is deemed present in person at the meeting. At the beginning of such a meeting, and again at the time any vote is taken at such a meeting, each of the Directors shall first verify his or her identity and ability to hear each other simultaneously and have communication immediately transmitted to each and all participating directors. Meetings may be held pursuant to § 4.19 to address and to vote on any matter which properly comes before the Directors pursuant to these Bylaws.
(EXHIBIT D)

POLICY ON NOMINATION AND ELECTION

OF FACULTY DIRECTORS

(A) Nominations. The Council of Faculty, with the oversight of the Executive/Governance Committee, shall be responsible for sending a written notice to all Faculty requesting self-nominations or Faculty nomination for Faculty Directors. A nomination will require a completed application.

(B) Selection of Candidates. The Council of Faculty will receive all nominations for the open Faculty Director seats and from those nominations shall choose a slate of up to six (6) candidates based on the Selection Criteria noted in Paragraph C below, subject to approval of the candidates by the Authority Board of Directors.

(C) Selection Criteria. The Council of Faculty will choose a slate of candidates following a consideration of the following Selection Criteria in order to ensure diversity among Faculty Directors serving on the Corporation Board. The Selection Criteria include:

1. Departmental Diversity. The Council of Faculty will consider whether or not an individual is nominated from a Clinical Department which has had little or no historical representation on the Corporation Board.

2. Experience. The Council of Faculty will consider a nominee’s experience, including his or her length of service, the academic track chosen by nominee, and the nominee’s academic rank.

3. Practice Location. The Council of Faculty will consider a nominee’s practice location and hospital affiliation.

4. Academic Interests. The Council of Faculty will consider a nominee’s academic interests in practice, whether it is clinical, research, teaching or a blend of all three.

5. Type of Practice. The Council of Faculty will consider the nominee’s type of practice, including whether or not it is primary care, specialty or hospital-based.

6. Service Record. The Council of Faculty will consider a nominee’s record of service to the Corporation through participation on committees to the Corporation Board, whether or not he or she is a current Corporation Board member, or other through other administrative or community activities that support the Corporations’ corporate purposes.

7. Demographic Balance. In choosing a slate of candidates, the Council of Faculty may consider if the slate supports gender, ethnic, and age diversity and balance among Faculty Directors.
(D) **Administration.** The Council of Faculty will direct and the Corporation’s administration shall compile any and all information in the form required by the Council of Faculty and as necessary for the Council of Faculty to consider the nominations it has received.

(E) **Elections.** The Council of Faculty shall compile a slate of up to six (6) candidates, and direct the Corporation’s administration to create ballots and send the ballots to eligible Faculty, directing that each Faculty member shall vote on the open Faculty Director seats. The Corporation Board shall afford the Faculty a reasonable period of time to return their ballots. The candidates who receive the most votes shall be elected to the open Faculty Director seats. The candidate that receives the highest number of vote(s) cast shall be named the Director from the faculty at large. If there is a tie, the Council of Faculty shall recommend to the Executive/Governance Committee the final candidate to serve as a Faculty Director member.
Resolution

UW Health ACO, Inc.
Shared Savings Distribution Methodology
RESOLUTION OF
THE BOARD OF DIRECTORS OF
UNIVERSITY OF WISCONSIN HOSPITALS AND CLINICS AUTHORITY
REGARDING
UW HEALTH ACO, INC.
SHARED SAVINGS DISTRIBUTION METHODOLOGY

September 23, 2020

WHEREAS, University of Wisconsin Hospitals and Clinics Authority ("Authority") is the sole corporate Member of UW Health ACO, Inc. ("ACO");

WHEREAS, Authority, as sole corporate Member, has reserve powers under Section 3.1(g) of the ACO Bylaws to approve the ACO shared savings or loss methodology; and

WHEREAS, the ACO has received approximately $8,998,774.00 from the Centers for Medicare and Medicaid Services in recognition of its performance under the financial and quality measures utilized by the Next Generation ACO program (the “2019 Shared Savings Payment”);

WHEREAS, the ACO’s Board has considered potential uses of the 2019 Shared Savings Payment and has recommended to the Authority a proposed savings/loss methodology for the 2019 Shared Savings Payment; and

WHEREAS, the Authority’s Board of Directors has determined that it is in the best interest of the Authority to approve the ACO’s recommended methodology for utilizing the 2019 Shared Savings Payment.

NOW, THEREFORE, BE IT RESOLVED, that pursuant to its rights under ACO’s Bylaws, the Authority hereby approves the 2019 shared savings payment methodology recommended by the ACO’s Board, that is consistent with the following:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL Shared Savings</td>
<td>$8,998,774.00</td>
</tr>
<tr>
<td>SNF Gainsharing</td>
<td>($72,751.00)</td>
</tr>
<tr>
<td>Care Model Pilots (10%)</td>
<td>($892,602.00)</td>
</tr>
<tr>
<td>ACO Operations</td>
<td>($1,037,141.00)</td>
</tr>
<tr>
<td>Reserves</td>
<td>($1,246,280.00)</td>
</tr>
<tr>
<td>Distributions to Participants based on attribution (this includes remaining Care Model Pilot funds from 2018 distribution):</td>
<td>($6,183,741.00)</td>
</tr>
<tr>
<td>UWHCA (88%)</td>
<td>$5,441,692.00</td>
</tr>
<tr>
<td>UPH-M (12%)</td>
<td>$742,048.00</td>
</tr>
</tbody>
</table>
FURTHER, RESOLVED, that the UW Health CEO, and his delegates ("Authorized Officers") are hereby authorized, empowered and directed to take all such actions as may be considered proper and convenient to carry out the foregoing resolution and any and all acts heretofore taken by the UW Health CEO, or his delegates in connection with the foregoing resolutions are hereby ratified and confirmed.

FURTHER, RESOLVED, that any and all lawful actions previously taken by any Authorized Officers and representatives on behalf of and in furtherance of the matters contemplated by the foregoing resolutions are hereby ratified, confirmed and approved in all respects.
Attachment

Executive Summary

Department of Anesthesiology
Addendum for Chronic Pain Management
Clinical Compensation Plan
EXECUTIVE SUMMARY

TO:        UWHCA and UWMF Board of Directors
FROM:      Cristopher Meyer, MD, Chair, UWMF Compensation Development Committee
DATE:      September 23, 2020
RE:        Department of Anesthesiology –
            Addendum for Chronic Pain Management Clinical Compensation Plan

The Department of Anesthesia presented a report to the UWMF Compensations Development Committee (CDC) on July 7, 2020. From feedback received at the July 7, 2020 CDC meeting, the Department of Anesthesiology prepared an addendum to the compensation plan that implements a chronic pain management clinical compensation plan. Attached, for your reference, is the Department of Anesthesiology Chronic Pain Clinical Compensation Report (presented to CDC on July 7, 2020) and the CDC Sub-Group Committee’s Executive Summary/Review.

The Department of Anesthesiology, Addendum for Chronic Pain Management Clinical Compensation Plan was submitted to CDC via written and majority endorsed on September 15, 2020. On September 23, 2020, the UWHCA and UWMF Board of Directors will approve the Department of Anesthesiology, Addendum for Chronic Pain Management Clinical Compensation Plan.
Department of Anesthesiology Chronic Pain Clinical Compensation

Situation

The Department of Anesthesiology lacks a clinical compensation plan designed specifically for the practice of chronic pain management. Currently, faculty practicing chronic pain management are compensated similar to faculty in the OR void of any internal (points) or external (wRVU) production expectation. Specifically, chronic pain management is rooted in a salary-based compensation model. Total compensation is comprised of a clinical salary that is aligned with OR faculty (respective of track), academic salary (respective of track and rank) and merit. Given the lack of a production expectation, the current model does not include a formal year-end true-up process.

Department of Anesthesiology leadership believes that the creation of a chronic pain management clinical compensation plan is integral to the sustainability, growth and development of the program.

Background

In order to implement a chronic pain management clinical compensation plan, department faculty must submit a two-thirds majority vote in favor of the proposal, followed by review and approval of the Compensation Development Committee (CDC), UWMF Board, UWMSMPH Dean and the Compensation Review Committee (CRC). A previous attempt to implement a production/collections-based chronic pain management compensation plan in 2016 plan was not approved by the faculty.
Over the past year, department administration has consulted multiple peer organizations within the Morton group, in addition to the UWSMPH Department of Orthopedics and Rehab in order to understand their chronic pain management compensation models. The department has observed a spectrum of compensation models amongst these various institutions and departments, ranging from salary-based to collections-based with multiple hybrid models in between. Figure 1 provides a basic overview of pros and cons associated with both ends of the spectrum.

<table>
<thead>
<tr>
<th></th>
<th>Salary-Based</th>
<th>Production/Collections-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pros (+)</strong></td>
<td>Maintain uniformity in clinical base salary across the department</td>
<td>Encourages and rewards extra work effort</td>
</tr>
<tr>
<td></td>
<td>“Worry free”; therefore sense of security in knowing your salary</td>
<td>Aligns with a chronic pain practice where an anesthesiologist can/does have control over their assignments and workloads (contrary to the OR, where an internal work unit/point is more applicable)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Institutional precedence and support in the Dept. of Orth/Rehab, Ophthalmology and Urology</td>
</tr>
<tr>
<td><strong>Cons (-)</strong></td>
<td>Lacks a financial and production incentive</td>
<td>Potential to foster unhealthy intra-specialty competition amongst physicians</td>
</tr>
<tr>
<td></td>
<td>Potential to discourage growth and may support minimum work effort standards</td>
<td>*Potential to foster unethical practices (over-production)</td>
</tr>
</tbody>
</table>

*The department understands institutional policies and procedures are in place in order to safeguard and protect providers and patients from excessive or inappropriate production, treatment and billing (e.g. prior-authorizations, compliance and coding review, fair-market compensation analysis, etc.).

By way of the institution’s Compensation Development Committee (CDC), department administration has been directly involved in the review of various UWSMPH academic clinical department compensation plans. Institutional precedence and support exists for production-based compensation models in similar ambulatory/procedural practices (i.e. Ortho/Rehab pain management, Ophthalmology and Urology). In such instances, the CDC has shown support for, and fostered adoption of, production-based clinical compensation that is allocated on 50/50 wRVU/collections (professional revenue) basis; the intent of which is to address discrepancies in payor mix and practice. Recent information from UW Health Practice Plan indicates that production-based clinical compensation should be allocated on a 100% wRVU basis; thus removing any allocation based on payments.
UW Health Practice Plan supports clinical compensation at the benchmark rate given production at the benchmark level “benchmark pay for benchmark work”. The benchmark is a blend of academic and private practices on the national level. Specifically, this benchmark references the weighted, median compensation and production from the MGMA, Sullivan Cotter and AMGA surveys on a specialty basis.

The Department of Anesthesiology Compensation Plan considers a full-time clinical CHS faculty physician as working 4 clinical days and 1 academic day per week. The plan also provides a mechanism in which faculty physicians can earn merit compensation based on their academic and clinical accomplishments. On average, for a CHS Assistant Professor, the combined annual academic salary and merit compensation is approximately $85,000 ($60,000 merit and $25,000 academic salary); which can be attributed to their 1 academic day per week.

The blended benchmark clinical compensation is based on a full time clinical physician working 5 days per week. Therefore, a full time clinical CHS physician in the Department of Anesthesiology would be measured against 80% of benchmark clinical compensation and production (i.e. 4/5 clinical days = 80%). Considering the current Anesthesiology Pain Management compensation and production benchmarks of $437,709 and 6,621 wRVU respectively, a chronic pain management physician in the department would be measured against a clinical compensation of $350,167 (80%) and production of 5,297 wRVUs (80%) for 4 days of clinic per week. Total annual compensation for the physician in this scenario, assuming benchmark production and considering an average academic/merit salary of $85,000 for the 5th day of the week, would equal $435,125 or ($435,167 / $437,709 = 99% of the blended benchmark. In essence, there is alignment with “benchmark pay for benchmark work”.

Building from the foundation outlined above, department administration sought counsel from the UWSMPH Departments of Ophthalmology and Urology to understand their practice of budgeting and allocating clinical compensation; such that there was alignment with the benchmark, as well as, accordance with institutional funds flow.

What follows are two scenarios of a production-based clinical compensation plan taking into account the blended benchmark and allocation of clinical compensation based solely on wRVU production. These scenarios are based on the following key elements:

- The benchmark chronic pain clinical compensation pool is calculated by multiplying the provider’s chronic pain clinical FTE by the benchmark compensation pool (e.g. $437,709 * 0.8 = $350,167).
- The benchmark chronic pain clinical compensation pool is allocated to the individual physician on a wRVU basis; which results in their clinical incentive (or clinical compensation)
  - A chronic pain physician’s clinical compensation percent of benchmark is equal to their chronic pain clinical percent FTE assuming a proportionate level of production (e.g. 60% clinical FTE results in a clinical compensation that is 60% of the benchmark as long as the physician produced wRVUs at 60% of the benchmark)
Compensation from other sources (e.g. academic salary, merit, admin, etc.) are added to the clinical compensation to arrive at the Total Compensation.

- In theory, a full time clinical (80% in the case of DoA, 4/5 clinical days) CHS Associate Professor should realize a total compensation equal to 100% of the benchmark considering a clinical compensation of approximately $350,000 (based on wRVU production at 80% of benchmark), an academic salary of approximately $29,000 and an average merit compensation of $60,000.
Scenario 1 is a representation of a new, full time clinical CHS Assistant Professor assuming FY20 benchmarks, an Academic salary of $22,500 aligned with our compensation plan, and funding for new hires of $32,500.

### Scenario 1: Assistant Prof CHS Year 1

<table>
<thead>
<tr>
<th>1.0 Total FTE</th>
<th>FY20 Benchmark’s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full time is 4 days per week CHS Track</td>
</tr>
</tbody>
</table>

- FY2020 Blended Benchmark wRVU: 6,621
- FY2020 Blended Benchmark Comp: 437,709
- % Pain Clinical FTE: 0.8
- Benchmark Chronic Pain Comp Pool (Pain FTE % x Benchmark Comp): 350,167

<table>
<thead>
<tr>
<th>Chronic Pain Clinical FTE</th>
<th>0.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>wRVU Target</td>
<td>5,297</td>
</tr>
<tr>
<td>WRVU % of Benchmark</td>
<td>80%</td>
</tr>
</tbody>
</table>

- Clinical Incentive Allocation based on wRVU: 350,167
- Total Clinical Incentive: 350,167
- Total Clinical Incentive % of Benchmark: 80%

<table>
<thead>
<tr>
<th>Total Chronic Pain Comp</th>
<th>350,167</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Comp from Other Sources</td>
<td></td>
</tr>
<tr>
<td>Clinical OR Comp</td>
<td>0</td>
</tr>
<tr>
<td>Academic Salary</td>
<td>22,500</td>
</tr>
<tr>
<td>Academic &amp; Clinical Merit/New Hire Funding</td>
<td>32,500</td>
</tr>
<tr>
<td>Regional Services Per Diem</td>
<td>0</td>
</tr>
<tr>
<td>Admin (Med. Dir, SMPH-Teaching, DYAD)</td>
<td>0</td>
</tr>
<tr>
<td>Total Comp from Other Sources</td>
<td>55,000</td>
</tr>
</tbody>
</table>

| Total Comp (Clinical Incentive + Non-Pain Comp) | 405,167 |
| Total Comp % of Benchmark                       | 93%     |
| Salary Guarantee                                | 382,700 |

- Salary Guarantee % of Benchmark: 87%
Scenario 1 highlights the following key points:

- If the new physician produced at 80% of benchmark (5,297/6,621) level in FY20, the physician’s clinical compensation would equal 80% of benchmark ($350,167/$437,709)
  - 4 clinical days = 80% of the benchmark. (4/5 days)

- Total compensation is projected to be 93% of benchmark ($405,167/$437,709).
  - Assuming an academic salary of $22,500 for a CHS Assistant Professor with 1 year of service and funding for new hires of $32,500 (not yet merit eligible).
  - $55,000 academic salary and funding for new hires for the 5th day of the week.

- Given the current initialization rate of $382,700 is 87% of benchmark, and the likelihood that a new physician will not produce at benchmark levels for the first years, continuing the practice of initializing new faculty with a minimum guarantee of $382,700 for three years seems appropriate.
**Scenario 2** is a representation of full time clinical CHS Associate Professor assuming FY20 benchmarks, an Academic salary of $29,375 aligned with our compensation plan, and an average merit of $60,000.

<table>
<thead>
<tr>
<th>Scenario 2: Associate Prof CHS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.0 Total FTE</strong></td>
</tr>
<tr>
<td>FY20 Benchmark’s</td>
</tr>
<tr>
<td>Full time is 4 days per week CHS Track</td>
</tr>
<tr>
<td>FY2020 Blended Benchmark wRVU</td>
</tr>
<tr>
<td>FY2020 Blended Benchmark Comp</td>
</tr>
<tr>
<td>% Pain Clinical FTE</td>
</tr>
<tr>
<td>Benchmark Chronic Pain Comp Pool (Pain FTE x Benchmark Comp)</td>
</tr>
<tr>
<td><strong>Chronic Pain Clinical FTE</strong></td>
</tr>
<tr>
<td>wRVU Target</td>
</tr>
<tr>
<td>WRVU % of Benchmark</td>
</tr>
<tr>
<td>Clinical Incentive Allocation based on wRVU</td>
</tr>
<tr>
<td><strong>Total Clinical Incentive</strong></td>
</tr>
<tr>
<td><strong>Total Clinical Incentive % of Benchmark</strong></td>
</tr>
<tr>
<td><strong>Total Chronic Pain Comp</strong></td>
</tr>
<tr>
<td>Comp From Other Sources</td>
</tr>
<tr>
<td>Clinical OR Comp</td>
</tr>
<tr>
<td>Academic Salary</td>
</tr>
<tr>
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</tr>
<tr>
<td>Regional Services Per Diem</td>
</tr>
<tr>
<td>Admin (Med. Dir, SMPH -Teaching, DYAD)</td>
</tr>
<tr>
<td>Total Comp from Other Sources</td>
</tr>
<tr>
<td><strong>Total Comp (Clinical Incentive + Non-Pain Comp)</strong></td>
</tr>
<tr>
<td><strong>Total Comp % of Benchmark</strong></td>
</tr>
</tbody>
</table>
**Scenario 2 highlights the following key points:**

- Production at 80% of benchmark (5,297/6,621) level in FY20 results in the physician’s clinical compensation equaling 80% of benchmark ($350,167/$437,709)
  - 4 clinical days = 80% of the benchmark. (4/5 days)

- Total compensation is projected to be 100% of benchmark ($439,542/$437,709)
  - Assuming an academic salary of $29,375 for a CHS Associate Professor who earned an average merit amount of $60,000.
  - $89,375 academic salary and merit for the 5th day of the week.

**Recommendation**

The current Department of Anesthesiology Compensation Plan is a production (shifts) and merit based plan. The department recognizes that the operating room and intensive care unit represent different clinical settings in which anesthesiologists do not control their own case assignments or daily workload. Therefore, an internal measure (i.e. a work unit or a point) was developed to estimate the relative value of the numerous clinical assignments according to a common work expectation, a day in the operating room – which is valued at 1.0 point.

In a chronic pain practice, an anesthesiologist can/does have more control of their assignments and workloads. In these environments a clinical performance benchmark is an appropriate measure to utilize in the calculation of clinical compensation. The institution supports benchmark clinical compensation for benchmark work, in this case production of wRVUs.

In an effort to implement a chronic pain management clinical compensation plan that incentivizes appropriate production; fosters the growth and development of this critical service; and enhances retention and recruitment of pain management physicians; department leadership recommends the implementation of a production-based clinical compensation model for chronic pain management. This model should align clinical compensation with the benchmark rate and be driven by production of wRVUs at the benchmark level. Existing compensation mechanisms for academic salary and merit would remain in place for chronic pain management.

To this end, it is recommended that the department present the model outlined above at the November 21, 2019 faculty meeting and cast a subsequent vote for implementation effective the start of the next fiscal year, July 1, 2020.
Attachment

Compensation Development Committee
Sub-Group Committee Report

Department of Anesthesiology
(Chronic Pain Addendum)
Committee Executive Summary:

The Chronic Pain addendum to the Department of Anesthesiology Physician Compensation Plan pays for clinical work based on Work RVU’s. Because this compensation is completely tied to productivity, it will be important for the department to closely monitor these faculty and ensure they have equal opportunity to generate Work RVU’s. Clinical Compensation Guidelines that are currently under development for UW Health may require the Department to revise this addendum in the future.

SUB-GROUP COMMITTEE REVIEW:

Reviewed by Dr. Bennett, Dr. Giles, Dr. Meyer, Steve Hall, Kelsie Doty, Lisa Kurth, Daniel Rhiner

The Department of Anesthesiology Physician Compensation Plan pays for clinical work using a shift model. Chronic Pain doctors have a different type of practice – scheduled office visits that generate hospital/ASC procedures. Department leadership felt a productivity model would be more appropriate for these doctors. The Department developed and voted on an addendum for Clinical FTE devoted to Chronic Pain. This impacts three physicians, only for their clinical time devoted to Chronic Pain.

Plan Overview

The Chronic Pain addendum only impacts clinical pay, for Chronic Pain work. All other compensation elements follow the overall department plan reviewed previously by CDC (Clinical OR Comp, Academic Salary, Academic Merit, Clinical Merit, Regional Services Per Diem, Administrative Comp). We noted that Clinical Merit is not based on productivity, so is not redundant.

The Clinical Compensation for Chronic Pain is calculated as:

- Individual Work RVU’s divided by UWMF Blended WRVU Benchmark (median) multiplied by UWMF Blended Compensation Benchmark (median)

The benchmarks are specific to the Chronic Pain subspecialty. A 10% withhold is applied to expected compensation and “trued-up” at the end of the fiscal year.

Strengths

- Clear
- Rewards clinical productivity
- Correlation with revenue
• Market-based pay
• Withhold

Opportunities (weaknesses)
• This compensation is 100% variable
• No ceiling or floor
• May create competition among Chronic Pain faculty

Recommendations
• Monitor individual productivity for unexpected fluctuations
• Consider ways to introduce more stability or shared goals into future iterations
Resolution

UWHCA Resolution of Approval of Department Anesthesiology Chronic Pain Plan
RESOLUTION OF
THE BOARD OF DIRECTORS OF
UNIVERSITY OF WISCONSIN HOSPITALS AND CLINICS AUTHORITY

Approval of Department of Anesthesiology –
Addendum for Chronic Pain Management
Clinical Compensation Plan

September 23, 2020

WHEREAS, the University of Wisconsin Hospitals and Clinics Authority ("UWHCA") is the sole corporate member of University of Wisconsin Medical Foundation, Inc. ("UWMF"), with such powers over the governance of UWMF as are provided in the bylaws of the University of Wisconsin Medical Foundation, Inc., as amended and restated effective July 1, 2015, and as further amended effective July 1, 2020 ("UWMF Bylaws"); and

WHEREAS, UWMF is in the process of updating and reviewing each University of Wisconsin School of Medicine and Public Health ("UWSMPH") clinical department compensation plan (the "Plan" or "Plans") in accordance with Exhibit A, the UWMF "Compensation Principles & Procedures Policy" ("Policy") of the UWMF Bylaws. The Policy requires that each Plan be reviewed and approved by the UWMF Compensation Development Committee ("CDC"), the UWMF Board of Directors ("UWMF Board"), the Dean of UWSMPH ("Dean"), and the UWMF Compensation Review Committee ("CRC");

WHEREAS, on September 15, 2020 the UWMF Compensation Development Committee endorsed the Department of Anesthesiology – Addendum for Chronic Pain Management Clinical Compensation Plan; and

WHEREAS, on September 23, 2020 the UWMF Board approved the Department of Anesthesiology – Addendum for Chronic Pain Management Clinical Compensation Plan; and

WHEREAS, the Plan has been presented to the UWHCA Board of Directors ("Authority Board") for approval, and the Authority Board has determined that the Plan is in the best interests of UWHCA and UWMF;

NOW, THEREFORE, BE IT RESOLVED, that the Plan is hereby approved by UWHCA, and UWMF is authorized and empowered to seek such further approvals as required by the UWMF Bylaws and to take all other actions necessary or appropriate to effectuate the Plan.
EXECUTIVE SUMMARY

TO: UWHCA Board of Directors

DATE: September 23, 2020

RE: Motion W Industrial, LLC Warehouse Lease

Dear UWHCA Board Member:

Background

UW Health is negotiating the terms of a new 15-year warehouse lease with Motion W Industrial, LLC for leased premises located at 3819 John Wall Drive, Madison, WI (“Proposed Lease”). The Proposed Lease has an aggregate base rent over its term of $13,993,143 (with the estimated aggregate additional rent, $20,324,155).

The Proposed Lease will have several immediate benefits, including the following:

- UW Health will locate semi-permanent COVID-19 drive-through testing and vaccination services at the new warehouse. UW Health will stand down the AOB testing site, eliminating tent and trailer rental costs for those locations.

- The new warehouse testing site will increase energy efficiency and supply needs. The new warehouse drive-through lanes will be located inside the climate-controlled warehouse, which is more energy efficient than the tents and trailers outside at AOB. Climate-controlled environment ensures fewer cancellations due to weather, and consistency of supply needs, too.

- The new warehouse is not in a flood plain. UW Health will move PPE stored at AOB (in flood-plain space). UW Health will optimize AOB as consolidated administrative and training space only.

- UW Health will flex space use dependent upon testing/vaccination needs. As needs change, UW Health will utilize warehouse for highest use storage and/or operational needs.

- Investing in one site reduces cost compared to duel/distributed models.
In addition, the Proposed Lease will have longer-term benefits, including the following:

- UW Health will utilize new warehouse to resolve outstanding space challenges and enable University Hospital First Floor Master Plan implementation:
  - Moving storage from AFCH 6th Floor to allow highest and best use of AFCH for revenue generating clinical or inpatient space.
  - Moving support service functions from University Hospital 1st Floor to resolve Reprocessing Center code compliance concerns.
  - Moving Materials Management, Transportation and Facilities & Support Service functions from high-cost University Hospital space to consolidated, cost-efficient Integrated Service Center.

- UW Health will reduce East Campus construction costs. UW Health leadership plans to utilize warehouse as staging space for newly arriving equipment and furniture as we operationalize East Campus.

- UW Health will increase use of the new warehouse as two existing space leases terminate, resulting in approximately $13,169,770 of savings.

Thank you for your consideration.

Claire Finando
Corporate Counsel, UW Health
Resolution

Motion W Industrial, LLC
Warehouse Lease
WHEREAS, University of Wisconsin Hospitals and Clinics Authority ("Authority") leadership has entered into discussions with Motion W Industrial, LLC on a potential warehouse 15-year warehouse lease ("Proposed Lease"), consistent with the description provided to the Authority’s Board of Directors ("Board"); and

WHEREAS, Authority’s executive management has determined that the Proposed Lease is in the best interests of the Authority, and recommend that the Board approve the Proposed Lease on substantially the terms presented to the Board;

WHEREAS, based on the recommendation of Authority executive management, and upon consideration of other relevant factors, the Board has determined that it is in the best interest of Authority execute and deliver the Proposed Lease;

NOW, THEREFORE BE IT RESOLVED, that the Authority hereby approves the Proposed Lease and authorizes UWHCA management to proceed with finalizing the Proposed Lease;

FURTHER RESOLVED, that the UW Health CEO or his delegates are hereby authorized and directed to execute, deliver and perform any and all agreements and other documents in connection with the Proposed Lease as he or his delegates deem necessary or desirable;

FURTHER, RESOLVED, that the UW Health CEO, and his delegates ("Authorized Officers") are hereby authorized, empowered and directed to take all such actions as may be considered proper and convenient to carry out the foregoing resolution and any and all acts heretofore taken by the UW Health CEO, or his delegates in connection with the foregoing resolutions are hereby ratified and confirmed.
Presentation

Weaving Equity in the Board Retreat
Weaving Equity in the Board Retreat

Board Retreat Staff Steering Committee
Inclusion of DEI VP/CDO

Board Prep Materials
Short video on DEI plans and key term definitions

Patient Voice
Intentional inclusion of patients of colors’ voices

Break Out Session
Equity focused questions
<table>
<thead>
<tr>
<th></th>
<th>UWH-Madison/ACO/Isthmus</th>
<th>SAHS/RDI</th>
<th>Total *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>0.5%</td>
<td>0.1%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Budget</td>
<td></td>
<td>0.2%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Prior Year</td>
<td></td>
<td>-7.0%</td>
<td>-1.5%</td>
</tr>
</tbody>
</table>

UW Health Current Month Operating Margin – August 31, 2020
### Summary of Enterprise-wide August 31, 2020 Operating Results

<table>
<thead>
<tr>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>Var. %</th>
<th>Actual</th>
<th>Variance</th>
<th>Var. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>August- FY21</td>
<td>August- FY21</td>
<td>vs. Budget</td>
<td>vs. Budget</td>
<td>August- FY20</td>
<td>vs. PY</td>
<td>vs. PY</td>
</tr>
</tbody>
</table>

#### TOTAL OPERATING REVENUE

- **Net patient service revenue**
  - Actual: 294,765,345
  - Budget: 296,538,698
  - Variance: -1,773,353
  - Var. %: -1%

- **Other operating revenues**
  - Actual: 6,857,769
  - Budget: 7,608,428
  - Variance: -750,659
  - Var. %: -10%

- **Total operating revenues, net**
  - Actual: 301,623,114
  - Budget: 304,147,126
  - Variance: -2,524,012
  - Var. %: -1%

#### TOTAL OPERATING EXPENSES

- **Salaries and benefits**
  - Actual: 167,281,444
  - Budget: 172,468,112
  - Variance: -5,186,668
  - Var. %: -3%

- **Other expenses**
  - Actual: 3,285,985
  - Budget: 3,125,243
  - Variance: 160,742
  - Var. %: 5%

- **Purchased services and agency costs**
  - Actual: 22,442,597
  - Budget: 23,370,705
  - Variance: -928,108
  - Var. %: -4%

- **Medical materials and supplies**
  - Actual: 49,860,400
  - Budget: 47,130,705
  - Variance: 2,728,095
  - Var. %: 6%

- **Pharmaceuticals**
  - Actual: 22,442,597
  - Budget: 23,370,705
  - Variance: -928,108
  - Var. %: -4%

- **Interest expense**
  - Actual: 1,894,804
  - Budget: 2,125,048
  - Variance: -230,244
  - Var. %: -11%

- **Depreciation and amortization**
  - Actual: 9,577,223
  - Budget: 9,307,529
  - Variance: 269,694
  - Var. %: 3%

- **Public aid assessment**
  - Actual: 5,206,420
  - Budget: 5,160,502
  - Variance: 45,918
  - Var. %: 1%

- **Facilities and equipment**
  - Actual: 16,808,178
  - Budget: 17,859,565
  - Variance: -1,051,387
  - Var. %: -6%

- **Nonoperating expenses - academic support**
  - Actual: 5,734,806
  - Budget: 5,711,988
  - Variance: 22,818
  - Var. %: 0%

- **Net Operating Expenses**
  - Actual: 300,432,759
  - Budget: 308,822,292
  - Variance: -8,389,533
  - Var. %: -3%

- **Income from operations**
  - Actual: 1,190,355
  - Budget: 1,475,166
  - Variance: 5,865,521
  - Var. %: 125%

#### NON-OPERATING REVENUE/EXPENSES

- **Net increase/decrease in fair value of investments**
  - Actual: 36,801,615
  - Budget: 0
  - Variance: 36,801,615
  - Var. %: 100%

- **Investment income**
  - Actual: 2,166,237
  - Budget: 2,889,234
  - Variance: -722,997
  - Var. %: -25%

- **Equity interest in income/loss of joint ventures**
  - Actual: 2,298,454
  - Budget: 1,227,909
  - Variance: 1,070,545
  - Var. %: 87%

- **Net inc/dec in fair value of derivative instrument**
  - Actual: 213,364
  - Budget: 0
  - Variance: 213,364
  - Var. %: 100%

- **Other, net**
  - Actual: 286,004
  - Budget: 355,075
  - Variance: -69,071
  - Var. %: -19%

- **Net Non Operating Revenue/Expenses**
  - Actual: 41,765,674
  - Budget: 4,472,218
  - Variance: 37,293,456
  - Var. %: 834%

- **Net Profit**
  - Actual: 42,956,029
  - Budget: 43,158,977
  - Variance: 212,948
  - Var. %: 21266%
## Summary of Enterprise-wide YTD August 31, 2020 Operating Results

<table>
<thead>
<tr>
<th></th>
<th>Actual Aug_YTD-FY21</th>
<th>Budget Aug_YTD-FY21</th>
<th>Variance vs. Budget</th>
<th>Var. %</th>
<th>Actual Aug_YTD-FY20</th>
<th>Variance vs. PY</th>
<th>Var. %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL OPERATING REVENUE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net patient service revenue</td>
<td>612,552,172</td>
<td>596,583,270</td>
<td>15,968,902</td>
<td>3%</td>
<td>590,147,060</td>
<td>22,405,112</td>
<td>4%</td>
</tr>
<tr>
<td>Other operating revenues</td>
<td>13,707,746</td>
<td>14,347,420</td>
<td>(1,239,674)</td>
<td>-8%</td>
<td>12,415,204</td>
<td>2,922,542</td>
<td>10%</td>
</tr>
<tr>
<td>Total operating revenues, net</td>
<td>626,259,918</td>
<td>611,530,690</td>
<td>14,729,228</td>
<td>2%</td>
<td>602,562,264</td>
<td>23,697,654</td>
<td>4%</td>
</tr>
<tr>
<td><strong>TOTAL OPERATING EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and benefits</td>
<td>336,218,493</td>
<td>343,669,421</td>
<td>(7,450,928)</td>
<td>-2%</td>
<td>310,460,921</td>
<td>25,757,572</td>
<td>8%</td>
</tr>
<tr>
<td>Other expenses</td>
<td>6,147,155</td>
<td>6,165,039</td>
<td>(17,884)</td>
<td>0%</td>
<td>12,318,933</td>
<td>(3,171,778)</td>
<td>-50%</td>
</tr>
<tr>
<td>Purchased services and agency costs</td>
<td>37,566,059</td>
<td>44,261,504</td>
<td>(6,695,445)</td>
<td>-15%</td>
<td>40,710,128</td>
<td>(3,144,069)</td>
<td>-8%</td>
</tr>
<tr>
<td>Medical materials and supplies</td>
<td>44,774,378</td>
<td>46,875,999</td>
<td>(2,101,621)</td>
<td>-4%</td>
<td>43,743,062</td>
<td>1,031,316</td>
<td>2%</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>98,218,711</td>
<td>94,189,366</td>
<td>4,029,345</td>
<td>4%</td>
<td>93,051,606</td>
<td>5,167,105</td>
<td>6%</td>
</tr>
<tr>
<td>Interest expense</td>
<td>3,836,291</td>
<td>4,250,097</td>
<td>(413,806)</td>
<td>-10%</td>
<td>4,320,270</td>
<td>(483,979)</td>
<td>-11%</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>19,152,105</td>
<td>18,599,057</td>
<td>513,048</td>
<td>3%</td>
<td>19,836,866</td>
<td>(6,677,761)</td>
<td>-2%</td>
</tr>
<tr>
<td>Public aid assessment</td>
<td>10,412,832</td>
<td>10,321,004</td>
<td>91,828</td>
<td>1%</td>
<td>9,599,254</td>
<td>813,578</td>
<td>8%</td>
</tr>
<tr>
<td>Facilities and equipment</td>
<td>33,065,520</td>
<td>35,789,482</td>
<td>(2,723,962)</td>
<td>-8%</td>
<td>32,321,330</td>
<td>744,190</td>
<td>2%</td>
</tr>
<tr>
<td>Nonoperating expenses - academic support</td>
<td>11,787,754</td>
<td>11,423,976</td>
<td>363,788</td>
<td>3%</td>
<td>12,114,050</td>
<td>(346,296)</td>
<td>-3%</td>
</tr>
<tr>
<td>Net Operating Expenses</td>
<td>601,519,298</td>
<td>615,544,945</td>
<td>(14,025,647)</td>
<td>-2%</td>
<td>578,476,420</td>
<td>23,042,878</td>
<td>4%</td>
</tr>
<tr>
<td><strong>NON-OPERATING REVENUE/EXPENSES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net increase/decrease in fair value of investments</td>
<td>78,302,018</td>
<td>0</td>
<td>78,302,018</td>
<td>100%</td>
<td>(5,814,916)</td>
<td>84,116,934</td>
<td>1447%</td>
</tr>
<tr>
<td>Investment income</td>
<td>5,776,813</td>
<td>5,778,468</td>
<td>(1,655)</td>
<td>0%</td>
<td>1,763,293</td>
<td>4,013,530</td>
<td>228%</td>
</tr>
<tr>
<td>Equity interest in income/loss of joint ventures</td>
<td>3,307,426</td>
<td>2,455,817</td>
<td>851,609</td>
<td>35%</td>
<td>10,699,887</td>
<td>(7,392,461)</td>
<td>69%</td>
</tr>
<tr>
<td>Net incl/dec in fair value of derivative instrument</td>
<td>156,455</td>
<td>0</td>
<td>156,455</td>
<td>100%</td>
<td>(710,445)</td>
<td>866,900</td>
<td>122%</td>
</tr>
<tr>
<td>Other, net</td>
<td>367,464</td>
<td>774,576</td>
<td>(407,112)</td>
<td>-50%</td>
<td>339,799</td>
<td>(32,335)</td>
<td>-10%</td>
</tr>
<tr>
<td>Net Non Operating Revenue/Expenses</td>
<td>87,850,176</td>
<td>9,008,861</td>
<td>78,841,315</td>
<td>875%</td>
<td>6,277,608</td>
<td>81,572,568</td>
<td>1299%</td>
</tr>
<tr>
<td><strong>Net Profit</strong></td>
<td>112,590,796</td>
<td>4,994,606</td>
<td>107,596,190</td>
<td>2154%</td>
<td>30,363,452</td>
<td>82,227,344</td>
<td>271%</td>
</tr>
<tr>
<td></td>
<td>Favorable Direction</td>
<td>FY 20</td>
<td>S&amp;P &quot;AA-&quot; Rated (1)</td>
<td>Moody's &quot;Aa3&quot; Rated (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------</td>
<td>-------</td>
<td>---------------------</td>
<td>------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Margin (including Academic Support)</td>
<td>↑</td>
<td>4.0%</td>
<td>3.0%</td>
<td>3.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Margin</td>
<td>↑</td>
<td>15.8%</td>
<td>5.5%</td>
<td>6.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days Cash on Hand * (including Academic Support)</td>
<td>↑</td>
<td>265</td>
<td>259</td>
<td>264</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days in Accounts Receivable **</td>
<td>↓</td>
<td>47</td>
<td>46</td>
<td>47</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long Term Debt to Capitalization</td>
<td>↓</td>
<td>21.3%</td>
<td>27.4%</td>
<td>24.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Cash Flow</td>
<td>↑</td>
<td>7.7%</td>
<td>7.2%</td>
<td>9.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash-to-Debt</td>
<td>↑</td>
<td>332.3%</td>
<td>224.7%</td>
<td>237.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* excludes provision for bad debt and retiree health insurance
** average for 12 months
(1) S&P’s 2019 financial ratios based on 36 obligators rated "AA-" by S&P. Based on 2018 audited financials.
(2) Moody’s 2019 financial ratios based on 32 "Aa3" rated hospitals. Based on 2018 audited financials.
^ The significant increase to DCOH is related to the advanced received from Medicare, which is over 25 days and some rebounds in the investment portfolio.
### Balance Sheet – Preliminary August 31, 2020

<table>
<thead>
<tr>
<th>Category</th>
<th>UWHCA</th>
<th>UWMF</th>
<th>Total UWHCA and UWMF</th>
<th>Discrete Components</th>
<th>UW Health Consolidated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash &amp; Investments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted</td>
<td>1,436,861,570</td>
<td>504,374,766</td>
<td>1,941,236,336</td>
<td>436,978,935</td>
<td>2,378,215,271</td>
</tr>
<tr>
<td>Restricted by Trustee &amp; Donors</td>
<td>21,069,936</td>
<td>-</td>
<td>21,069,936</td>
<td>54,755,989</td>
<td>75,825,925</td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td>301,574,373</td>
<td>136,536,284</td>
<td>438,110,657</td>
<td>59,745,453</td>
<td>497,856,110</td>
</tr>
<tr>
<td>Property, Plant &amp; Equipment, Net</td>
<td>768,422,313</td>
<td>67,904,656</td>
<td>836,326,969</td>
<td>410,894,759</td>
<td>1,243,257,507</td>
</tr>
<tr>
<td>Other Assets &amp; Deferred Outflows of Resources</td>
<td>1,393,817,313</td>
<td>481,231,671</td>
<td>849,898,420</td>
<td>41,204,385</td>
<td>695,189,867</td>
</tr>
<tr>
<td><strong>Total Assets &amp; Deferred Outflows of Resources</strong></td>
<td><strong>3,921,745,505</strong></td>
<td><strong>1,190,047,377</strong></td>
<td><strong>4,086,642,318</strong></td>
<td><strong>1,003,579,522</strong></td>
<td><strong>4,890,344,681</strong></td>
</tr>
<tr>
<td>Current Liabilities</td>
<td>922,301,228</td>
<td>754,204,971</td>
<td>1,676,506,199</td>
<td>176,312,573</td>
<td>635,931,996</td>
</tr>
<tr>
<td>Long-term Debt &amp; Deferred Inflows of Resources</td>
<td>1,122,821,963</td>
<td>51,143,344</td>
<td>1,173,965,307</td>
<td>257,216,769</td>
<td>1,431,182,076</td>
</tr>
<tr>
<td>Net Position</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted</td>
<td>1,707,202,533</td>
<td>384,699,062</td>
<td>2,091,901,595</td>
<td>561,151,800</td>
<td>2,644,912,448</td>
</tr>
<tr>
<td>Restricted</td>
<td>169,419,781</td>
<td>-</td>
<td>169,419,781</td>
<td>8,898,380</td>
<td>178,318,161</td>
</tr>
<tr>
<td><strong>Total Liabilities, Deferred Inflows of Resources &amp; Net Position</strong></td>
<td><strong>3,921,745,505</strong></td>
<td><strong>1,190,047,377</strong></td>
<td><strong>4,086,642,318</strong></td>
<td><strong>1,003,579,522</strong></td>
<td><strong>4,890,344,681</strong></td>
</tr>
</tbody>
</table>

Elimination Entries are not displayed but are part of the Consolidated Numbers
○ Quarterly Updates to Work Plan
○ OIG HCCA Measuring Compliance Program Effectiveness
  • Standards, Policies, and Procedures
  • Compliance Program Administration
  • Screening and Evaluation of Employees, Physicians, Vendors, and other Agents
  • Communication, Education, and Training on Compliance Issues
  • Monitoring, Auditing, and Internal Reporting Systems
  • Discipline for Non-Compliance
  • Investigation and Remedial Measures
Standards, Policies, and Procedures

• Integration of Compliance & Privacy Policies with Affiliates and Joint Ventures
• Review and Redraft of Conflict of Interest Provider, Non-Provider, & Gift Policies

Compliance Program Administration

• On-Boarding of Compliance Committee Chair and Members
• Participating in Steering Committee Regarding Data Exchange with UW Madison
• Integration of Pharmacy Compliance Reporting to Compliance Committee
• Integration of Enterprise Risk Management (ERM) Committee Into Work Plan
• Updates and Prioritization
• Staffing and Cross Training
• Survey the use of UW Health Reporting Line
Screening & Evaluation
- Transition of Providers Interaction with Industry to Business Integrity (Continuation from 2020)
- Survey of High-Risk Vendors for Compliance With Security and Privacy Requirements

Communication, Education, & Training
- Implement a Pre-Test Option
- Collaborate with Revenue Cycle to Create Computer Based Training for Staff
- Continue Appropriate On-Boarding & Annual Training
Business Integrity – 2021 Work Plan

Monitoring, Auditing, and Internal Reporting Systems

- Systematic Annual Audits - Provider, Coder, HIPAA Audits, Compliance Analyst, Pharmacy Compliance, Research Billing Compliance
- Focused Audits – Office of Inspector General, Recovery Audit Contractor, Supplemental Medical Review Contractor, Office of Civil Rights, DEA
  - Cures Act – Information Blocking
  - Organ Procurement Organization Hybrid Status
  - Drug Diversion
  - 340b
- Hotline Monitoring
Discipline for Non-Compliance

- Continue Quarterly Discipline Reviews with Human Resources
- Review Promotion and Annual Evaluations and Integration of Compliance Concerns (Continued From 2020)

Investigation and Remedial Measures

- Drafting of an Integrated Investigations Policy
2021 Work Plan Questions?
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V. Communication, Education, and Training on Compliance Issues ......................................................... 4  
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I. Introduction

UW Health has a long history as a leader in providing remarkable healthcare and service to its patients. As part of our mission to deliver excellence to our patients, UW Health is committed to maintaining a work environment that assures our physicians and staff can perform their daily tasks with high ethical standards, honesty, and integrity, while in compliance with applicable laws and regulations.

To prioritize the projects and objectives of the Business Integrity Office and facilitate the oversight by the UW Hospital and Clinics Authority (UWHCA) of the UW Health Compliance Committee, this Work Plan is produced and distributed for their review. The Work Plan sets forth various projects to be addressed during the Fiscal Year 2021 but will be updated quarterly based on the identified risk of UW Health. The Business Integrity Office moved to these quarterly updates due to the fluidity of the regulatory environment especially in the days of the pandemic. This structure allows the Office more mobility to address the risks that emerge. In addition, the use of a quarterly work plan coincides with the work of the Enterprise Risk Management Workgroup and will allow greater collaboration.

The Work Plan is structured in the order of the Office of Inspector General’s (OIG) and Health Care Compliance Association (HCCA) Measuring Compliance Program Effectiveness and includes projects within those elements:

- Standards, Policies, and Procedures
- Compliance Program Administration
- Screening and Evaluation of Employees, Physicians, Vendors, and other Agents
- Communication, Education, and Training on Compliance Issues
- Monitoring, Auditing, and Internal Reporting Systems
- Discipline for Non-Compliance
- Investigation and Remedial Measures

The Work Plan uses various resources, such as the US Department of Justice Criminal Division Evaluation of Corporate Compliance Programs, the OIG Work Plan, Recovery Audit Contractor (RAC) issue list, Supplement Medical Review Contractor issues list, industry best practices, and UW Health risk assessment to determine the activities that will be undertaken. Some of the projects described in the Work Plan are standard activities that will be completed each year, such as the physician coding reviews, while others will vary depending on the latest compliance risks. Due to the ever-changing regulatory environment, work plans are often altered to address new risks that need immediate attention.

II. Standards, Policies, and Procedures:

To effectively communicate the organization's commitment to and expectation of compliant conduct to the providers and staff, practice standards and procedures must be developed and implemented. The federal government expects that all providers have compliance policies and procedures that are accessible, viewed by their workforce, and reviewed by leadership on a regular basis. These documents must include foundational compliance items like the Compliance Plan and the Code of Conduct. Based
on these fundamental principles, the Business Integrity Office will be working on the following initiatives:

A. Update and maintenance of the Integrated UW Health Compliance Plan, including review and approval by the Compliance Committee and the Audit Committee. All material changes will be forwarded to the UWMF and UWHCA Board of Directors for review and approval.

B. Continued inventory of all privacy and compliance related policies to determine gaps and integration opportunities between UWMF, UWHC, UW Madison and Swedish-American.


D. Develop a policy and standards that outlines the Drug Diversion Investigation and reporting process.

E. Draft and implement an integrated Record Retention Policy.

F. Completion of a draft Media Capture Policy.

G. Draft and implement a Providers Interaction with Industry Policy.

H. Draft of staff and Board Members Conflict of Interest Policy to include gifts from vendors.

III. Compliance Program Administration:

This section of the Work Plan focuses on whether the compliance program is administered in a way that is appropriate for the size, resources, and scope of UW Health. This section determines whether governing bodies are actively engaged in the compliance program and promote a culture of compliance across all business functions. Additionally, this section asks whether the compliance program is appropriately resourced, whether the compliance officer has other operational responsibilities, and whether the compliance officer’s reporting structure is sufficiently independent of other operational functions. The Business Integrity Office will be working on the following initiatives:

A. Draft of Annual Report to be reviewed and approved by the Compliance Committee and presented to the Audit Committee and the UWHCA and UWMF Board of Directors.

B. On-Boarding of Compliance Committee Chair and Members

C. Integrate the Enterprise Risk Management and the Business Integrity Quarterly Work Plan process.

D. Participate in Steering Committee regarding data exchange with UW Madison and SMPH

E. Establish routine reporting of drug diversion detection and prevention initiatives to the Compliance Committee.

F. Assess staffing needs for professional and facility billing and the potential of cross training Analysts.

G. Survey the use of UW Health Reporting Line to ensure staffs knowledge of this reporting mechanism and non-retaliation.

H. Expand the current physician and coder audit tracking database.
IV. Screening and Evaluation of Employees, Physicians, Vendors, and Other Agents

This section of the Work Plan and the OIG Guidance focuses on whether all employees, physicians, vendors, and other agents are adequately screened against the OIG Exclusion List and other relevant government sanctions lists prior to their engagement. Another area of review is whether a process is in place to identify and disclose conflicts of interest and whether employees, physicians, vendors, and other pertinent agents receive appropriate education on these conflicts. These metrics emphasize that the provider should remain vigilant regarding employee, physician, vendor, and other agent eligibility both at the time of initial engagement and thereafter. Based on these principles, the Business Integrity Office will be working on the following initiatives:

A. Continue to monitor the current processes and frequency for exclusion screening for Board of Directors, employees, providers, and volunteers.

B. Complete the transition of the interactions with industry process to the Business Integrity Office.

C. Continue surveying high-risk business associates and evaluating their compliance with privacy and security requirements and transition coordination to the Privacy Team.

V. Communication, Education, and Training on Compliance Issues

This section of the Work Plan reviews whether the compliance program has established appropriate lines of communication throughout UW Health. Education and training are the components of a compliance program that demonstrates a proactive approach to the rules and regulations that govern our business. Education and training can take on many forms and assists in creating a common understanding for all individuals. It is especially important for those involved in the governance, documentation, coding, and revenue cycle processes. Furthermore, education clarifies what is required by regulation, in addition to the expectations of the organization. Proactive education and training can prevent future problems if physicians and employees have a foundational understanding of the rules and regulations. This process is what makes all individuals within the organization compliance extenders. Based on these principles, the Business Integrity Office will be working on the following initiatives:

A. Develop a pretest option for compliance and privacy testing. This option would show proficiency in the subject matter and would require individual to review sections they did not fully understand.

B. Complete integration of compliance and privacy content for SAHS and Chartwell educational programs.

C. Continue to complete annual compliance training for all employees and the Board of Directors.

D. Continue to complete New Employee and Provider Orientations.

E. Continue individual physician and department in-person education regarding privacy, documentation, coding, and billing standards.

F. Research Compliance will continue to attend Revenue Cycle huddles providing clarification and education as needed.

G. Work with Revenue Cycle Department to develop Computer Based Training (CBT) for various billing processes and topics helping to ensure billing compliance.
VI. Monitoring, Auditing, and Internal Reporting Systems

The purpose of internal auditing and monitoring is to provide an independent appraisal activity that systematically reviews UW Health’s adherence to regulatory requirements of the documentation, coding, and billing processes of both facility and professional services, identification of potential regulatory risk, and recommendations to mitigate the identified risks or deficiencies. This function is completed by various offices within the Business Integrity Office and in conjunction with the quality assurance efforts of the Revenue Cycle Department. In addition, this section of the Work Plan and the OIG guidance include the establishment of confidential reporting mechanisms such as a hotline.

A. Audit Plan:

1. Systematic Annual Audits: All Systematic audits will be adjusted in scope and duration based on the risk to UW Health. These audits will include SAHS.
   a. Provider Services: The Business Integrity Office, Professional Services Office completes reviews of physicians and advanced practitioner-based services. These reviews focus on the documentation, coding, and billing of these services. The provider audits will include SAHS and Chartwell services for the first time this fiscal year. To concentrate resources to the highest risk areas, the Professional Services Office uses software to identify providers that are considered outliers in their billing practices. Examples of outliers include high levels of evaluation and management services, number of hours billed, and modifier usage.
   b. Coder Audits: The Professional Services Office performs annual reviews of the proficiency and accuracy of the Professional Coding staff. The Facility Coding staff are reviewed by an external consultant.
   c. HIPAA Audits: The Privacy Office completes systematic audits as follows:
      i. Quarterly Reports of employees who had recent clinic, emergency department, and inpatient visits.
      ii. Monthly Reports of demographics (e.g. same last name, same address, emergency contact, etc.) access, for outside organizations with access to Health Link.
      iii. Weekly Reports of Care Link reviews.

2. Focused Issue Audits: Each year specific audits are identified due to the high-risk nature of the service being provided. These audits are based upon both external risk factors, such as the RAC Issues list, OIG Work Plan, Supplemental Medical Review Contractor, the Office of Civil Rights, and internal sources such as hotline trends, exit interviews, and routine results. Due to the dynamic nature of reimbursement due to the pandemic this process has moved to a more continuous process of updating audit issues on a weekly basis.
   a. Cures Act Information Blocking
   b. Organ Procurement Organization Hybrid Status

3. External Audits: UW Health receives routine audits from external Federal and State Agencies. The Business Integrity Office coordinates the response to these audits. This year a new reporting system will be established to provide standard and consistent reports to the Compliance Committee for review.
4. **Research Billing Compliance Audit**: The Research Billing Compliance Office will be conducting Medicare Coverage Analysis to ensure appropriate billing of services. The goal is to do two audits per quarter for Fiscal Year 2021. The Research Billing Compliance Office will engage the Senior Director and Chief Clinical Research Officer to understand the auditing and review process for research activities.

5. **Pharmacy Auditing**: Continue drug diversion surveillance and auditing programs and creating an oversight plan with the Drug Diversion Prevention and Oversight Task Force. Work with Pharmacy Department to create an oversight and auditing function for the new UW Health 340B Program.

6. **Hotline**: UW Health maintains a hotline for individuals to send concerns. All concerns are investigated and if necessary, audits are completed to ensure UW Health’s compliance with the rules and regulations. The Business Integrity Office reserves this section as a placeholder for resources to complete these ad hoc projects.

7. **Conflict of Interest Monitoring**: Continue to monitor the annual reporting of Board Members, Key Employees, and staff. Reinstate a provider Interactions with Industry process housed with Business Integrity and implemented in collaboration with the Office of General Counsel and UW Madison School of Medicine and Public Health. This monitoring will include downloading and analyzing of the Sunshine Act data.

8. **For-Cause Audits**: These audits are normally requested by a department or individual and are not planned at the beginning of the audit year. This entry in the Work Plan is to serve as a placeholder for resources to complete these ad hoc projects.

**VII. Discipline for Non-Compliance**

This section of the Work Plan addresses whether UW Health’s policies on corrective action are effective and are followed consistently throughout the organization. The Business Integrity Office works closely with the Human Resources Department for any compliance or privacy investigations that lead to disciplinary action. The OIG guidance is that employees and associates are aware of the corrective action procedures, and whether incentive and promotion criteria are appropriately aligned with compliance priorities. Based on these principles, the Business Integrity Office will be working on the following initiatives:

A. Continue quarterly meetings with Department of Human Resources reviewing disciplinary action for compliance issues and consistent discipline action.

B. Work with Department of Human Resources to review promotion of staff and how non-compliance is evaluated into this process.

**VIII. Investigation and Remedial Measures**

This section of the Work Plan relates to whether UW Health has responded appropriately to reported compliance concerns. The OIG expects that providers are prompted to evaluate their guidelines on conducting investigations, including those done through legal counsel under the attorney-client privilege and/or work product doctrine, and determine whether investigations are consistently conducted. Also, determination of whether investigations lead to appropriate and effective remedial responses, including corrective action plans based on a root-cause analysis, and whether the providers follow through on
these corrective action plans. Based on these principles, the Business Integrity Office will be working on the following initiatives:

A. Develop a policy and standards that outlines the Drug Diversion Investigation and reporting process.

IX. Conclusion

This Work Plan is submitted by the Business Integrity Office for approval by the UW Compliance Committee and the UW Health Audit Committee. Please note that due to the ever-changing regulatory environment, work plans are often altered to address new risks that need immediate attention.