MEDICAL STAFF BYLAWS
RULES AND REGULATIONS

MINISTRY SAINT CLARE'S HOSPITAL OF WESTON, INC.

Inaugural (08/01/05)

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The medical staff of Saint Clare's Hospital is organized to promote safety and quality and to improve the quality of care delivered in this institution. Recognizing its responsibility for the overall quality of clinical services provided by its members, the medical staff organizes itself for the purpose of self-governance in conformity with these Bylaws. These bylaws are binding on the medical staff and St. Clare's Hospital. This governing document, and the policies and procedures it implements, will constitute the bylaws directing the Medical Staff and those active members and other providers of Saint Clare's Hospital of Weston, Inc. and other health care programs owned or operated by Saint Clare's Hospital of Weston, Inc. that require a Medical Staff.

The principal functions of the Medical Staff are:

1. Develop and implement policies, procedures, rules and regulations governing the Medical Staff and provision of patient care at the Hospital.

2. Perform all duties required by governmental or private agencies, including Joint Commission and/or other accreditation agencies, and Medicare Conditions of Participation, as are described as functions of the Medical Staff.

3. Determine clinical privileges for individual professionals and provide oversight as to the quality and scope of clinical practice of those professionals affiliated with the Hospital.

4. Monitor on an ongoing basis the scope and quality of patient care provided at Saint Clare's Hospital and account for same on a regular basis to the Hospital's Board of Directors.

DEFINITIONS

For the purposes of these Bylaws, Rules and Regulations, the following words and phrases are defined as:

1. "Admit" or "admission" for purposes of patient care means registration of a patient as a patient of the Hospital for the purpose of treatment on either an outpatient or inpatient basis, but does not include registrations solely for the purpose of outpatient laboratory and diagnostic imaging not requiring the presence or supervision of the ordering professional.

2. "Advanced Practice Clinician" (APC) means an individual, other than a licensed physician, oral surgeon, dentist or podiatrist, who is granted privileges to practice in the Hospital through the Medical Staff Bylaws and who is licensed, certified or registered in the state and who is trained and qualified in a recognized heath care discipline to exercise judgment within the areas of his or her professional competence and who is qualified to render direct or indirect medical care either independently or under the supervision of a practitioner who has been accorded privileges to provide such care in the Hospital. Such professionals are not members of the medical staff but are governed by these bylaws. As used in these Bylaws, the term Advanced Practice Clinician means Advanced Practice Registered Nurse (i.e. Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Advanced Practice Nurse Prescriber, Nurse Practitioner), Physician Assistant, Psychologist, Master Degree Social Worker and Perfusionist.

3. "Authorized Providers" are individuals other than licensed physicians, oral surgeons, dentists, or podiatrists and Advanced Practice Clinicians as defined above. These are providers who are granted privileges to practice in the Hospital under supervision of a licensed physician, oral surgeon, dentist, or podiatrist, and who are approved through an alternative approval process per medical staff policy.

4. "Chief Medical Officer" or "CMO" is an individual who is an MD, DO, DDS, or DPM and is appointed by the governing body to serve as the lead administrative officer in overseeing the medical affairs of the Hospital, to act as a liaison between the Medical Staff and the Hospital and to serve as Chief of Staff.

5. "Clinical privileges" means the authorization granted by the governing body to a practitioner, Advanced Practice Clinicians or Authorized Provider to provide specific patient care services in the Hospital within defined limits, based on the practitioner's license, education, training, experience, competence, health status, and judgment.

6. "Completed application" means a fully-filled out application and mandatory forms, attestations, and releases, accompanied by primary source verification of licensure, education, training, practice history of all hospital affiliations (including department chair verification from each hospital where the applicant held active staff in the past three years), relevant employment, professional liability coverage and claims history, applicable board certifications, National Practitioner Data Bank query and Medical Mediation Panel query, where applicable, and caregiver background check results, Office of the Inspector General (OIG) exclusions and professional references.

7. "Conflict of Interest" may exist if a member of the medical staff requested to perform peer review is unable to provide an unbiased opinion due to either involvement in the patient's care or because of a relationship with the physician involved as a direct competitor or partner. It is the obligation of the practitioner to disclose to the peer review committee the potential conflict and the responsibility of the peer review body to determine if the conflict would prevent the practitioner from participating and the extend of that participation. Practitioners determined to have a conflict may not be present during peer review committee discussions or decisions other than to provide information if requested.

8. "Ex officio" means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

9. "Focused Professional Practice Evaluation" (FPPE) is a process whereby the organization evaluates the privilege- specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. FPPE is a time-limited period during which the organization evaluates and determines the practitioner's professional performance.

10. "Governing body" means the Board of Directors of the Hospital (Board), except that, to the extent authorized in the Hospital's corporate bylaws, the governing body may delegate its authority to act on Medical Staff matters (including but not limited to Medical Staff appointments and the granting of clinical privileges) to special committees appointed by board resolution.

11. **"**Health status" means the physical, emotional, and mental health status of a practitioner.

12. "Hospital" means Saint Clare's Hospital of Weston, Inc.

13. "In good standing" for the purpose of these Bylaws will mean an practitioner who at the time the issue with respect to his or her standing is raised, is current on the payment of dues, has not been suspended in the previous 12 months for any purpose, and is further current and has met for the previous calendar year the meeting attendance requirements set forth in these Bylaws.

14. "Interactive telemedicine" for purposes of these Bylaws consists of responsibility (either total or shared) for patient care, treatment and services (as evidenced by having the authority to write orders and direct care, treatment and services) through a telemedicine link.

15. "Interpretive telemedicine" for purposes of these Bylaws consists of providing official readings of images, tracings, or specimens through a telemedicine link, but not engaging in interactive telemedicine.

16. "Licensed Independent Practitioners" means a licensed physician, oral and maxillofacial surgeon, dentist, or podiatrist who is granted permission to practice in the Hospital through the medical staff bylaws and who is licensed in the State of Wisconsin and trained and qualified to exercise judgment within areas of his/her professional competence and who is qualified to render direct or indirect medical care independently.

17. "Medical Executive Committee" or "MEC" means the executive committee of the Medical Staff unless specific reference is made to the executive committee of the governing body.

18. "Medical Management Team" or "MMT" means a team of physicians that is appointed by the governing body to assist the MEC in the overall management of the Medical Staff.

19. "Medical Staff" means the Hospital's organized component of physicians, podiatrists, oral surgeons and dentists appointed by the governing body of the Hospital and granted specific clinical privileges for the purpose of providing adequate medical, podiatric and dental care for the patients of the Hospital. Medical Staff Membership in itself does not confer the right to vote on medical staff matters.

20. "Medical Staff member" or "Medical Staff membership" allows the opportunity for Medical Staff participation and does not necessarily include any clinical privilege whatsoever.

21. "President" means the individual appointed by the governing body to act on its behalf in the overall management of the Hospital.

22. "Ongoing Professional Practice Evaluation" (OPPE) is an ongoing evaluation of information related to a physician's performance and peer review to assist in determining physician competency including identifying opportunities to improve patient safety and quality of care and services. OPPE information is considered in the decision of maintaining existing privilege(s), revising existing privilege(s), or revoking existing privilege(s) prior to or at time of renewal.

23. "Oral surgeon" means an appropriately licensed dentist or physician who has successfully completed a postgraduate program in oral surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education.

24. "Patient" means an individual who receives preventative, diagnostic or therapeutic services relating to the patient's health from individuals authorized to provide such services by the hospital and utilizing hospital resources in the provision of the services. The term "patient" applies to all individuals described above from the point in time that they begin receiving the services or are admitted for services, whether on an inpatient

or outpatient basis, whichever occurs first, and continues until they are discharged or stop receiving services (whichever occurs last).

25. “Peer” is an individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of an individual's performance will determine what "practicing in the same profession" means on a case-by-case basis. For example, for quality issues related to general medical care, a physician (MD or DO) may review the care of another physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that surgical specialty.

26. “Peer Review” is the ongoing evaluation of a practitioner's professional practice and includes the identification of opportunities to improve patient safety and quality of care and services. Peer review uses multiple sources of information including the review of individual cases, the review of aggregate data for compliance with general rules of the medical staff and clinical standards, and use of rates in comparison with established benchmarks or norms. An individual's evaluation is based on accepted standards of care. Through the peer review process, individuals receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing care.

27. “Peer Review Body” is designated to perform the initial review by the Medical Executive Committee (MEC) or its designee, Medical Management Team (MMT) who serves in the capacity as the Peer Review Steering Committee, will determine the degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of Saint Clare's Hospital. Initial peer review will be at the department level with the service chief. Peer review results including any recommendations will be shared by the service chief with the Peer Review Steering Committee.

28. “Plan” shall mean the Corrective Action Procedures and Fair Hearing Plan Addendum to the Bylaws of the Medical Staff of the Hospital.

29. “Practitioner” means an appropriately licensed medical or osteopathic physician, oral surgeon, dentist or podiatrist and Advanced Practice Clinicians (APC).

30. “Service” means an operating unit with a specific clinical scope incorporating all the stakeholders of the clinical disciplines.

31. “Special notice” means written notification sent by certified or registered mail, return receipt requested, or hand delivered to the addressee.

SECTION 1 – PURPOSES AND RESPONSIBILITIES

1.1 The purposes of the Medical Staff are:

(a) To provide that all patients admitted to or treated in any of the facilities of the Hospital receive appropriate, safe, quality medical care;

(b) To be the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by individual practitioners and the obligations of Medical Staff membership may be fulfilled;

(c) To serve as the primary means for providing assurances as to the appropriateness of the professional performance and ethical conduct of its members, Advanced Practice Clinicians and Authorized Providers and to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available; and

(d) To provide a means through which the Medical Staff may participate in the Hospital's policy-making and planning processes.

1.2 The responsibilities of the Medical Staff are:

(a) To ensure an appropriate level of professional performance for all members of the Medical Staff, Advanced Practice Clinicians and Authorized Providers authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each individual may exercise in the Hospital and through a Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) ;

(b) To provide a continuing education program fashioned, at least in part, on the needs demonstrated through a patient care audit and other quality assessment and improvement programs;

(c) To provide a utilization review program to allocate inpatient medical and health services based upon determinations of patients' medical, social and emotional needs consistent with sound health care resources utilization management;

(d) To provide an organizational structure that allows continuous monitoring and improvement of patient care practices;

(e) To conduct reviews and evaluation of the quality and safety of patient care through quality assessment, risk management and improvement activities;

(f) To recommend to the governing body action to be taken with respect to medical staff appointments, reappointments, staff category, clinical privileges and corrective action;

(g) To assure the governing body that appropriate clinical procedures have been delineated;

(h) To account to the governing body for the appropriateness, quality and efficiency of patient care rendered to patients at the Hospital through regular reports and recommendations;

(i) To initiate and pursue corrective action with respect to members when warranted;

(j) To develop, administer, and seek compliance with these Bylaws, the Rules and Regulations of the Medical Staff, Medical Staff policies and procedures and other patient care related Hospital policies and procedures;

(k) To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs;

(l) To conduct all of its affairs involving the Medical Staff, patients and employees in a willing manner and in an atmosphere of civility, dignity and respect, free of unlawful discrimination because of age, sex, creed, national origin, race, handicap, disability, color, ancestry, religion, sexual orientation, mental status, newborn status, source of payment or any other unlawful basis; and

(m) To carry out such other responsibilities as may be delegated to the Medical Staff by the governing body.

(n) Participate in call coverage needs of the organization as required by MEC

1.3 The basic obligations of A Medical Staff member are:

(a) To provide patients with care at the generally recognized and accepted professional level of safety, quality and efficiency;

(b) To abide by these Bylaws and by all other applicable standards, policies, rules and regulations of the Hospital and the Medical Staff; and

(c) To willingly and in a collegial manner discharge the staff, committee, department and/or Hospital functions for which he or she is responsible, whether by membership category, appointment, election or otherwise.

SECTION 2 – MEMBERSHIP / PRIVILEGES

2.1 Privilege of Membership

Membership on the Medical Staff of Saint Clare's Hospital of Weston, Inc. is a privilege that shall be extended only to those practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Medical Staff shall confer on the practitioner only such prerogatives as the governing body grants in accordance with these Bylaws.

2.2 Qualifications

Medical Staff members shall include practitioners who:

(a) Possess a valid and current license to practice their profession in the State of Wisconsin;

(b) Submit and maintain on file at all times current evidence of continued licensure, DEA registration (if applicable to their profession), and acceptable malpractice insurance coverage in at least the minimum amounts determined by Wisconsin Statutes. Failure to maintain current licensure and malpractice insurance coverage will result in automatic suspension under the Fair Hearing Plan;

(c) Have completed education and graduate training from a medical or osteopathic school meeting the standards of the Accreditation Council of Graduate Medical Education or the American Osteopathic Association, a dental school meeting the standards of the Council on Dental Education of the American Dental Association, or a school of podiatry meeting the standards of the Council on Education of the American Podiatric Medical Association;

(d) Have provided evidence of their background, experience, training and demonstrated current competency in his or her specialty for all privileges requested, sufficient to assure, in the judgment of the governing body, that any patient treated by those in the Hospital will be given appropriate, quality medical care;

(e) Have agreed to submit to proctoring, supervision, and/or practice evaluation as deemed necessary by the MMT and MEC.

(f) Have provided evidence of their good reputation, adherence to the ethical code of their respective professions and ability to work competently and cooperatively with others and to efficiently use resources, to the satisfaction of the governing body;

(g) Are not excluded from participation in any federally-funded health care program;

(h) Are not barred from providing direct patient care in the Hospital under Wisconsin's caregiver misconduct laws;

(i) Have certified that their current health status does not in any way impair their ability to safely exercise the clinical privileges requested or to care for patients. The governing body may precondition appointment, reappointment or the continuing exercise of any or all clinical privileges upon the practitioner undergoing a health examination by a physician acceptable to the governing body or upon submission of any other reasonable evidence of current health status that may be requested by the MEC or the governing body. The MEC may require that a member of the Medical Staff, including an affiliated Medical Staff member, submit to a physical or mental health examination by an appropriate physician at such other times as the committee deems appropriate. A physical or mental condition that can reasonably be accommodated shall not bar the granting of Medical Staff membership or clinical privileges;

(j) Are either: (1) certified by a certifying board that is either a member of the American Board of Medical Specialties (ABMS) or recognized by the American Osteopathic Association (AOA), the American Board of Podiatric Medicine (ABPM) or a Dental Specialty Certifying Board in the practitioner's primary specialty; or (2) have completed all of the residency or other specialized training required for admission to the examination of such a certifying board and have an active application for certification to include meeting any minimum years in practice requirements followed by certification within five years of the date of completion of residency or specialized training. The governing body may waive this requirement in unusual circumstances, based on the favorable recommendation of the MEC, when the practitioner has extensive experience, qualifications and training. Physicians not meeting the above criteria but who are certified in emergency medicine by the American Board of Physician Specialists and have five years of full-time practice in an emergency department may apply for membership and privileges for the limited purposes of staffing the emergency department.

2.3 Governing Body Considerations

(a) The governing body shall be the sole determining entity regarding whether to approve or reject any applicant, based on the limitations of facilities, services, equipment, staff, support capabilities or any combination of these.

(b) The governing body may also decide not to appoint or reappoint or grant privileges to a practitioner, Advanced Practice Clinician or Authorized Provider in accordance with the criteria of a Medical Staff development plan or existence of contracts for provision of clinical services, whether exclusive or not, with other practitioners or affiliated providers, or for other reasons, when consistent with the Hospital's purposes, needs and capabilities, or community need.

2.4 Medical Staff Conditions of Appointment

(a) All practitioners shall participate in and be subject to the quality, competency, and safety assessments and improvement activities of the Hospital and Medical Staff.

(b) Medical Staff appointees have a continuing obligation to promptly, but in no case more than 15 days after the triggering action, notify the CMO of, and to provide such additional information as may be requested regarding each of the following:

(1) The revocation, limitation, voluntary relinquishment, or suspension of his or her professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal government agency relating to his or her professional license, or the imposition of terms of probation or limitation by any state;

(2) voluntary relinquishment or loss of staff membership or privileges at any hospital or other health care facility, whether temporary or permanent, including all suspensions;

(3) cancellation or change of professional liability insurance coverage;

(4) receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation, or the filing of charges regarding health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, the Office of the Inspector General, or any law enforcement agency or health regulatory agency of the United States or State of Wisconsin;

(5) any criminal conviction or pending criminal charge, and any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient, or has misappropriated a patient's property;

(6) any proposed or actual exclusion from any federally-funded health care program, any notice to the individual or his or her representative of proposed or actual exclusion or any pending investigation of the individual from any federally-funded health care program, including Medicare and Medicaid;

(7) receipt of notice of the filing of any suit against the practitioner or submission of adversity to the Wisconsin Patients Compensation Fund alleging professional liability in connection with the treatment of any patient in or at the Hospital; and

(8) settlement of any claim by payment from an insurance company (or by the practitioner or any other party) or any other agreement that results in a release being given by a patient to the appointee relating to the treatment of any patient in or at the Hospital.

(c) Medical Staff appointees agree to honor their continuing obligation to comply with federal and state laws and regulations applicable to the practice of their profession.

(d) Medical Staff appointees agree to honor their obligation to comply with the rules and policies established by the MEC, the standing committees of the Medical Staff or the governing body, including but not limited to the Hospital's and Medical Staff's Code of Conduct, Corporate Compliance Plans and Conflict of Interest Policy.

(e) By accepting membership on the Medical Staff, practitioners specifically agree to abide by the Hospital's mission statement, the Bylaws, Rules and Regulations of the Medical Staff, the Medical Staff's Code of Conduct, the Ethical and Religious Directives for Catholic Health Care Services, as promulgated by the National Conference of Catholic Bishops and the Code of Ethics of the American Medical, Dental, Osteopathic or Podiatry Association or other Code of Ethics applicable to their profession, whichever is applicable. Should there be a conflict between any provisions of the applicable Code of Ethics and the Ethical and Religious Directives, the latter shall prevail.

(f) All members of the Medical Staff must pledge not to receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services. All members of the Medical Staff pledge that their recommendations relating to patient care, treatment plans, and levels of service will not be based solely on the patient's ability to pay for the services provided. All members also must pledge that they will provide continuous care for their patients, and refrain from delegating the responsibility for diagnosis or care of hospitalized patients to an individual who is not qualified to undertake the responsibility and is not adequately supervised. The member must use covering physicians with appropriate privileges, in accordance with departmental policy or practice, or a telephone answering service which can then supply the name of the available alternate, to contract when the practitioner is unavailable.

(g) Medical Staff members granted any clinical privileges to provide patient care in the Hospital acknowledge they participate in the organized health care arrangement (OHCA) comprised of

all clinically integrated settings in which patients receive services at the Hospital (Saint Clare's Hospital OHCA). As a condition of appointment and of the granting of any clinical privileges, all individuals with clinical privileges must follow the privacy practices of Saint Clare's Hospital OHCA, as set forth in its notice of privacy practices, with respect to protected health information received through Saint Clare's Hospital OHCA.

(h) Medical Staff practitioners have a continuing obligation to comply with health requirements established by the MEC.

(i) Medical Staff members willingly undertake a fair share of responsibility for the discharging of Medical Staff responsibilities, at all times treating other practitioners as colleagues, treating all individuals with respect and dignity and maintaining the confidentiality of information obtained through the discharge of these responsibilities, in accordance with Medical Staff policy.

(j) The professional conduct of members of the Medical Staff shall at all times be governed by applicable Wisconsin and federal laws and Saint Clare's Hospital Medical Staff Code of Conduct. In the event the provisions of these Bylaws, Rules and Regulations shall not be in conformity with any Wisconsin or federal law or regulation, these Bylaws and Rules and Regulations shall be deemed automatically superseded to comply with such law or regulation. As soon thereafter as may be practicable, the Bylaws or Rules and Regulations will be amended to comply with the law.

2.4 Term of Appointment

(a) All initial appointments to the Medical Staff shall be made by the governing body of the Hospital upon the recommendation of the MEC. Initial appointment to the Medical Staff will be granted for a period not to exceed two years.

(b) Reappointments of all members of the Medical Staff shall be for a period up to but not more than two years

(c) The governing body shall not act on an application for appointment, reappointment or cancel an appointment previously made without prior conference and consultation with the MEC. However, in the event of unwarranted delay on the part of the MEC in acting upon an application, the governing body may act on the basis of the applicant's professional and ethical qualifications obtained from reliable sources.

(d) Appointments to the Medical Staff shall confer on appointees only such privileges and prerogatives as are specified in the notice of appointment in conformity with these Bylaws, Rules and Regulations.

(e) All Medical Staff who have been granted privileges for the first time by the Hospital will be subject to monitoring or Focused Professional Practice Evaluation (FPPE). Providers who currently have privileges and are requesting new privilege(s) will also be subject to a monitoring/FPPE for the new privilege(s). FPPE is a defined method of determining competency of a provider who is granted privileges at the Hospital and the Hospital does not have first-hand data. MMT will determine either a fixed number of cases and/or a fixed time period, not to exceed 6 months, in which cases will be reviewed, either through review of documentation and/or direct observation of procedures, for the individual provider.

2.6 Dues

(a) The Medical Staff will assess dues annually according to its needs. Staff dues shall be determined by a majority vote of the MEC. Dues will be designated for use by the MEC, consistent with the purposes and responsibilities of the Medical Staff.

2.7 Qualifications for Clinical Privileges for Advanced Practice Clinicians and Authorized Providers

(a) Advanced Practice Clinicians and Authorized providers who apply for privileges at the Hospital shall:

(1) Possess a current unlimited license or certificate to practice his or her professional in the State of Wisconsin and have a privilege form approved by the MMT and supervising physician; if unlicensed or uncertified, have a privilege form approved by MMT and the supervising physician;

(2) Submit and maintain on file at all times current evidence of acceptable malpractice insurance coverage in at least the minimum amounts determined by Wisconsin Statutes.

(3) Submit and maintain on file at all times current evidence of continued licensure, DEA registration (if applicable to their profession);

(4) Be located close enough to the Hospital to provide timely and continuous care for patients in the Hospital;

(5) Are not excluded from participation in any federally-funded health care program;

(6) Have never been criminally convicted of a felony;

(7) Have provided evidence of their background, education experience, training and demonstrated current competency in his or her specialty for all privileges requested, sufficient to assure, in the judgment of the governing body, that any patient treated by those in the Hospital will be given appropriate, quality medical care;

(8) Have agreed to submit to proctoring, supervision, and/or practice evaluation as deemed necessary by the MMT and MEC.

(9) Have provided evidence of their good reputation, adherence to the ethical code of their respective professions and ability to work competently and cooperatively with others and to efficiently use resources, to the satisfaction of the governing body;

(10) Are not barred from providing direct patient care in the Hospital under Wisconsin's caregiver misconduct laws;

(11) Have certified that their current health status does not in any way impair their ability to safely exercise the clinical privileges requested or to care for patients. The governing body may precondition appointment, reappointment or the continuing exercise of any or all clinical privileges upon the practitioner undergoing a health examination by a physician acceptable to the governing body or upon submission of any other reasonable evidence of current health status that may be requested by the MEC or the governing body. The MEC may require that a member of the Medical Staff, including an affiliated Medical Staff member, submit to a physical or mental health examination by an appropriate physician at such other times as the committee deems appropriate. A physical or mental condition that can reasonably be accommodated shall not bar the granting of Medical Staff membership or clinical privileges;

2.7 Governing Body Considerations

(a) The governing body shall be the sole determining entity regarding whether to approve or reject any applicant, based on the limitations of facilities, services, equipment, staff, support capabilities or any combination of these.

(b) The governing body may also decide not to grant privileges to a practitioner, Advanced Practice Clinician or Authorized Provider in accordance with the existence of contracts for provision of

clinical services, whether exclusive or not, with other practitioners or affiliated providers, or for other reasons, when consistent with the Hospital's purposes, needs and capabilities, or community need.

2.9 Advanced Practice Clinicians / Authorized Provider Conditions of Privileges

(a) Advanced Practice Clinicians and Authorized Providers who are not employees of the hospital must apply for privileges and be credentialed through the medical staff processes and approved by the MMT, MEC and Board of Directors. Hospital-employed Physician Assistants (PA's), Certified Registered Nurse Anesthetists (CRNA's), Advanced Practice Nurse Practitioners (APNP's), Nurse Practitioners (NP's) and Nurse Midwives must apply for privileges and be credentialed through the medical staff processes and approved by the MMT, MEC and Board of Directors. Advanced Practice Clinicians are not members of the Medical Staff and have none of the prerogatives of Medical Staff membership, such as any rights under the Plan or rights to attend meetings of the Medical Staff or to vote.

(b) Advanced Practice Clinicians and Authorized Providers may function in the Hospital only so long as they remain employees of the hospital and/or are directly supervised by a Physician currently appointed to the Medical Staff. Should the Medical Staff appointment or clinical privileges of the Staff Physician employing an Allied Health Practitioner be revoked or terminated, the Allied Health Practitioner's permission to practice in the Hospital shall be deemed to be automatically relinquished. If the Medical Staff appointment or clinical privileges of a Physician supervising an Allied Health Practitioner is revoked or terminated, the Medical Management Team may immediately recommend the termination of the Allied Health Practitioner's permission to practice in the Hospital or may recommend that the Allied Health Practitioner be permitted to arrange for supervision by another Physician appointed to the Medical Staff, as permitted by law.

(c) Advanced Practice Clinicians and Authorized Providers shall participate in and be subject to the quality, competency, and safety assessments and improvement activities of the Hospital and Medical Staff.

(d) Advanced Practice Clinicians and Authorized Providers have a continuing obligation to promptly, but in no case more than 15 days after the triggering action, notify the CMO of, and to provide such additional information as may be requested regarding each of the following:

(1) The revocation, limitation, voluntary relinquishment, or suspension of his or her professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal government agency relating to his or her professional license, or the imposition of terms of probation or limitation by any state;

(2) Voluntary relinquishment or loss of privileges at any hospital or other health care facility, whether temporary or permanent, including all suspensions;

(3) cancellation or change of professional liability insurance coverage;

(4) receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation, or the filing of charges regarding health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, the Office of the Inspector General, or any law enforcement agency or health regulatory agency of the United States or State of Wisconsin;

(5) any criminal conviction or pending criminal charge, and any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient, or has misappropriated a patient's property;

(6) any proposed or actual exclusion from any federally-funded health care program, any notice to the individual or his or her representative of proposed or actual exclusion or

any pending investigation of the individual from any federally-funded health care program, including Medicare and Medicaid; and

(7) settlement of any claim by payment from an insurance company (or by the practitioner or any other party) or any other agreement that results in a release being given by a patient to the appointee relating to the treatment of any patient in or at the Hospital.

(e) Advanced Practice Clinicians and Authorized Providers agree to honor their continuing obligation to comply with federal and state laws and regulations applicable to the practice of their profession.

(f) Advanced Practice Clinicians and Authorized Providers agree to honor their obligation to comply with the rules and policies established by the MEC, the standing committees of the Medical Staff or the governing body, including but not limited to the Hospital's and Medical Staff's Code of Conduct, Corporate Compliance Plans and Conflict of Interest Policy.

(g) Approved Advanced Practice Clinicians and Authorized Providers specifically agree to abide by the Hospital's mission statement, the Bylaws, Rules and Regulations of the Medical Staff, the Medical Staff's Code of Conduct, the Ethical and Religious Directives for Catholic Health Care Services, as promulgated by the National Conference of Catholic Bishops and any other Code of Ethics applicable to their profession. Should there be a conflict between any provisions of the applicable Code of Ethics and the Ethical and Religious Directives, the latter shall prevail.

(h) Advanced Practice Clinicians and Authorized Providers must pledge not to receive from or pay to another practitioner, either directly or indirectly, any part of a fee received for professional services. All Advanced Practice Clinicians and Authorized Providers pledge that their recommendations relating to patient care, treatment plans, and levels of service will not be based solely on the patient's ability to pay for the services provided. All Advanced Practice Clinicians and Authorized Providers also must pledge that they will provide continuous care for their patients, and refrain from delegating the responsibility for diagnosis or care of hospitalized patients to an individual who is not qualified to undertake the responsibility and is not adequately supervised.

(i) Advanced Practice Clinicians and Authorized Providers agree to seek consultation of a member of the Medical Staff whenever necessary or as required by the scope of practice or delineation of clinical privileges.

(j) Advanced Practice Clinicians and Authorized Providers acknowledge they participate in the organized health care arrangement (OHCA) comprised of all clinically integrated settings in which patients receive services at the Hospital (Saint Clare's Hospital OHCA). All individuals with clinical privileges must follow the privacy practices of Saint Clare's Hospital OHCA, as set forth in its notice of privacy practices, with respect to protected health information received through Saint Clare's Hospital OHCA.

(k) Advanced Practice Clinicians and Authorized Providers have a continuing obligation to comply with health requirements established by the MEC.

(l) Advanced Practice Clinicians and Authorized Providers are expected to willingly undertake a fair share of responsibility for the discharging of Medical Staff responsibilities under the direction of the sponsoring physician, at all times treating other practitioners as colleagues, treating all individuals with respect and dignity and maintaining the confidentiality of information obtained through the discharge of these responsibilities, in accordance with Medical Staff policy.

(m) The professional conduct of Advanced Practice Clinicians and Authorized Providers shall at all times be governed by applicable Wisconsin and federal laws and Saint Clare's Hospital Medical Staff Code of Conduct. In the event the provisions of these Bylaws, Rules and Regulations shall not be in conformity with any Wisconsin or federal law or regulation, these Bylaws and Rules and Regulations shall be deemed automatically superseded to comply with such law or

regulation. As soon thereafter as may be practicable, the Bylaws or Rules and Regulations will be amended to comply with the law.

(n) Advanced Practice Clinicians and Authorized Providers agree to complete, in a timely manner, the medical and other required records for all patients as required by the Medical Staff bylaws, rules and regulations, and other applicable policies of the Hospital.

2.10 Term of Privileging

(a) All initial privileging decisions shall be made by the governing body of the Hospital upon the recommendation of the MEC.

(b) Renewal of privileges shall be for a period up to but not more than two years.

(c) The governing body shall not act on an application for privileges, renewal or privileges, or previously approved privileges without prior conference and consultation with the MEC. However, in the event of unwarranted delay on the part of the MEC in acting upon an application for privileges, the governing body may act on the basis of the applicant's professional and ethical qualifications obtained from reliable sources.

(d) Permission to practice as an Advanced Practice Clinicians or Authorized Providers shall confer only such privileges and prerogatives as are specified in the notice of approval in conformity with these Bylaws, Rules and Regulations.

(e) Advanced Practice Clinicians and Authorized Providers who have been granted privileges for the first time by the Hospital will be subject to monitoring or Focused Professional Practice Evaluation (FPPE). Providers who currently have privileges and are requesting new privilege(s) will also be subject to a monitoring/FPPE for the new privilege(s). FPPE is a defined method of determining competency of a provider who is granted privileges at the Hospital and the Hospital does not have first-hand data. MMT will determine either a fixed number of cases and/or a fixed time period, not to exceed 6 months, in which cases will be reviewed, either through review of documentation and/or direct observation of procedures, for the individual provider.

2.11 Supervision by Employing or Supervising Physician

(a) Any activities permitted by the Medical Executive Committee to be performed at the Hospital by an Advanced Practice Clinician / Authorized Provider shall be performed only under the direct supervision of the Physician employing or supervising that individual. Except as provided by law or Hospital policy, "direct supervision" shall not require the actual physical presence of the employing or supervising Physician.

(b) The number of Advanced Practice Clinician / Authorized Providers acting as employees of or under the supervision of one (1) Physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulation, the rules and regulations of the Medical Starr, and the policies of the Board.

(c) It shall be the responsibility of the Physician employing or supervising the Advanced Practice Clinician / Authorized Provider to ensure that the individual practices within the scope of their licensure.

(d) It shall be the responsibility of the Physician employing or supervising the Advanced Practice Clinician / Authorized Provider to provide, or to arrange for, professional liability insurance coverage for the practitioner in amounts required by the Board that covers any activity of the practitioner at the Hospital and to furnish evidence of such coverage to the Hospital. The Advanced Practice Clinician / Authorized Provider shall act at the Hospital only while such coverage is in effect.

(e) It shall be the responsibility of the Physician employing or supervising the Advanced Practice Clinician or Authorized Provider to complete performance evaluations of the practitioner in an acceptable format and to submit to the MMT at the time of each re-privileging.

(f) It shall be the responsibility of the Physician employing or supervising the Advanced Practice Clinician or Authorized Provider to ensure that such individual does not exceed the cope of practice or delineation of privileges approved by the Board.

(g) The supervising Physician must co-sign all chart orders and documentation. On the day of discharge, all patients must be evaluated and discharged by the attending Physician.

2.12 Term of Privileging

(a) All initial privileging decisions shall be made by the governing body of the Hospital upon the recommendation of the MEC. Initial privileges shall be granted for a period not to exceed two years.

(b) Renewal of privileges shall be for a period up to but not more than two years.

(c) The governing body shall not act on an application for privileges, renewal or privileges, or previously approved privileges without prior conference and consultation with the MEC. However, in the event of unwarranted delay on the part of the MEC in acting upon an application for privileges, the governing body may act on the basis of the applicant's professional and ethical qualifications obtained from reliable sources.

(d) Permission to practice as an Advanced Practice Clinician or Authorized Provider shall confer only such privileges and prerogatives as are specified in the notice of approval in conformity with these Bylaws, Rules and Regulations.

(e) Advanced Practice Clinicians and Authorized Providers who have been granted privileges for the first time by the Hospital will be subject to monitoring or Focused Professional Practice Evaluation (FPPE). Providers who currently have privileges and are requesting new privilege(s) will also be subject to a monitoring/FPPE for the new privilege(s). FPPE is a defined method of determining competency of a provider who is granted privileges at the Hospital and the Hospital does not have first-hand data. MMT will determine either a fixed number of cases and/or a fixed time period, not to exceed 6 months, in which cases will be reviewed, either through review of documentation and/or direct observation of procedures, for the individual provider.

2.13 Dues

(a) The Medical Staff will assess dues annually according to its needs. Staff dues shall be determined by a majority vote of the MEC. Dues will be designated for use by the MEC, consistent with the purposes and responsibilities of the Medical Staff.

SECTION 3 – CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be divided as follows. All members of every category of the medical staff must fulfill the qualifications listed under Section 2.

3.1 Active Medical Staff

(a) The active Medical Staff shall consist of those practitioners who regularly admit patients to, or are otherwise regularly involved in the care of patients in the Hospital; who are located close enough to the Hospital to provide proper care to their patients; and who assume all of the functions and responsibilities of membership. Active staff may also include those who do not regularly admit but who serve on formal committees, serve on process improvement teams or in other ways approved by the MEC which provide services to the medical staff organization to enhance its mission and purpose.

(b) Applicants requesting Active status will have a one year provisional period. During the provisional period, members will be expected to fulfill the responsibilities and abide by the restrictions applicable to the active staff category, as a condition of advancement upon completion of the provisional term. However, provisional Medical Staff members shall not be eligible to (1) vote on any medical staff issues; (2) serve on the MEC, the MMT; or (3) hold office. A Provisional Medical Staff member shall be assigned to a service line. The provisional Medical Staff member's clinical performance will be monitored through the FPPE process, as previously described.

(c) Emergency specialty call coverage requirements will be determined for each specialty by each department, subject to the approval of the MEC. Each active Medical Staff member must comply with the call coverage requirements so established.

(d) For purposes of this Section, a practitioner will be considered to be located close enough to the Hospital to provide proper care if the practitioner meets the following on call requirements:

(1) Maintains a telephone response time of 15 minutes or less when on call; and

(2) Unless specific arrangements have been made to transfer care responsibilities to an alternative practitioner qualified to cover for the individual, or to appropriately transfer patients to another facility that is equipped to handle the patients' emergency medical conditions, arrives at the Hospital within 60 minutes of being called in; and

(3) Can arrive at the Hospital within 60 minutes of being called in (day and night).

(4) Pediatrics, obstetrics, and anesthesia specialists will arrive within 30 minutes of being called in for emergency C-sections.

(e) Members of the active Medical Staff shall promote the quality and safety of medical care in the Hospital, offer sound counsel to the CMO and the governing body and participate in the internal governance of the Medical Staff according to these Bylaws. The members of the active staff shall, within their scope of privileges, provide care to patients without regard to source of payment or ability to pay.

(f) Members of the active Medical Staff shall:

(1) Be eligible to vote, hold office and serve on the MEC, and the MMT

(2) Be required to serve on Medical Staff committees and process improvement teams and attend and committee meetings as provided in Section 11 of these Bylaws.

3.2 Courtesy Medical Staff

(a) The courtesy Medical Staff shall consist of practitioners who desire to treat patients in the Hospital, but who are unable to participate actively in the functions of the Medical Staff.

(b) Members of the courtesy staff may, but are not required to, attend general Medical Staff meetings or committee meetings.

(c) Members of the courtesy staff are not eligible to vote, hold office or serve on the MEC, or the MMT; however, they may be required to serve on other Medical Staff committees.

(d) Members of the courtesy Medical Staff shall be restricted to admitting 12 patients (inpatient or outpatient) per year. If this number is exceeded at any time during the Medical Staff year, the member will automatically be considered to have applied for advancement to active staff membership.

3.3 Consulting Medical Staff

(a) The consulting Medical Staff shall consist of recognized specialists who are active in their specialties and have indicated a willingness to accept such appointments to the Medical Staff. Members of the consulting staff must be members of specialty boards, diplomates of one of the national boards of medical specialties, or other practitioners who, in the opinion of the MEC and the MMT, are qualified for consultation work in their specialty. Membership on the consulting staff shall not, per se, qualify the member for active staff membership.

(b) Members of the consulting staff shall provide their services in the care of patients in the Hospital at the request of any member of the Medical Staff and in circumstances where consultation is required by the Rules and Regulations of the Medical Staff. Consulting staff members may not admit patients on their own initiative.

(c) Members of the consulting staff shall have no assigned duties and shall not be eligible to vote or hold office, but may serve on Medical Staff committees, except the MEC and the MMT.

(d) Members of the consulting staff may, but are not required to, attend general Medical Staff meetings and committee meetings.

(e) A member of the consulting staff must be a member of the active Medical Staff of another hospital where he or she actively participates in a patient care audit program or other quality assessment and improvement activities similar to those required of the members of the active staff of this Hospital.

3.4 Limited Medical Staff

(a) The limited Medical Staff shall consist of those practitioners whose primary hospital affiliation is the Hospital, who refer and follow patients, or whose professional practice is largely outpatient with infrequent use of Hospital facilities. Limited Medical Staff have an active interest in the operation of the Hospital, and those practitioners who are only applying for history and physical privileges

(b) Members of the limited Medical Staff shall:

(1) Not be eligible to vote at general staff meetings or committee meetings;

(2) Be eligible to serve, without voting rights, on all Medical Staff committees, except for the MEC, and the MMT;

(3) Not be eligible to hold office;

(4) Be allowed, but not required to, attend general Medical Staff meetings or committee meetings, except shall not be eligible to attend and participate in those portions of meetings devoted to peer review of Medical Staff members in other categories of the Medical Staff;

(5) Not have admitting or treating privileges;

(6) Be allowed to order, but not perform, outpatient diagnostic or therapeutic procedures that can be performed without their being present and that are within their scope of practice to order; and

(7) Be allowed to visit patients in the hospital, review medical records, consult with the attending physician, and observe diagnostic or surgical procedures with the approval of the attending physician or surgeon.

(8) Be allowed to provide pre-procedural history and physical examinations.

(c) Review of the office practice of members of the limited Medical Staff may be performed by the appropriate Medical Staff committees to provide a basis for evaluation of the member's current professional competence and judgment.

3.5 Locum Tenens

(a) Practitioners who provide locum tenens coverage may not be members of the Medical Staff and will not have any of the rights and responsibilities conferred upon medical staff members, but may be granted privileges as outlined in the Medical Staff Appointment Process in these Bylaws. If the locum tenens practitioner routinely provides coverage up to and into a reappointment period, s/he must complete the reappointment procedure as outlined in the Procedures for Reappointment in these Bylaws:

(1) The practitioner will notify the Medical Staff Office at least 120 days prior to the anticipated date of service (except in emergencies) and will obtain an application from the Medical Staff Office.

(2) The completed application along with supporting documentation will be returned to the Medical Staff Office at least 90 days prior to the proposed start date.

(3) Because of extensive work experience of locum tenens providers, verification of work experience will include at least the last ten appointments or ten years, whichever is more.

(4) Locum tenens applications will be limited to a maximum privileging term of two years at which time the practitioner must apply for re-privileging if still providing services.

(5) Locum tenens providers will abide by all applicable service, hospital and medical staff policies, procedures, and these Bylaws and may be terminated for any reason when their services are no longer required or if the quality of services provided or their behavior does not meet acceptable standards. Locum tenens providers are not entitled to a fair hearing and provide services only in accordance with their contract or employment agreement.

3.6 Telemedicine Service Providers

(a) Practitioners who provide telemedicine services may not be members of the Medical Staff and will not have any of the rights and responsibilities conferred upon medical staff members, but may be granted privileges as outlined in the Medical Staff Appointment Process in these Bylaws. If the telemedicine practitioner routinely provides coverage up to and into a reappointment period, s/he must complete the reappointment procedure as outlined in the Procedures for Reappointment in these Bylaws

(b) Practitioners who wish or provider consultative, diagnostic, and interactive telemedicine services must complete an application and be fully credentialed according to the Appointment provisions in these Bylaws, except that no verification of identity will be done by the Hospital. Identification verification will be done by the contracting telemedicine agency and provided to the Hospital.

3.7 Non-MD Oral Surgeon, Dentist and Podiatrist Staff Functions

(a) Non-MD oral surgeons, dentists and podiatrists granted membership on the Medical Staff in accordance with the procedures set forth in Section 5 may be members of any category of the Medical Staff for which they qualify and shall be under the direction of the Surgical Service Chief.

(b) Except as provided in Section 1.1(d) below, patients admitted to the Hospital for dental or podiatric care shall be given the same medical appraisal as those admitted for other services. Admission of a dental or podiatric patient shall be the dual responsibility of the dentist or

podiatrist and a physician member of the Medical Staff. The physician shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of a dental or podiatric patient.

(c) Non-MD oral surgeons who have been granted clinical privileges to do so may admit and discharge patients without medical problems without first obtaining the concurrence of a physician member of the Medical Staff, but such oral surgeons must designate a physician member of the Medical Staff with appropriate clinical privileges to be responsible for the care of any medical problem that may arise. If granted clinical privileges to do so, oral surgeons may, in lieu of a physician member of the Medical Staff, perform the admission history and physical examination and assess the medical risks of the proposed surgical procedures on those patients admitted without medical problems.

(d) Non-MD oral surgeons, dentists and podiatrists shall conform to these Bylaws, Rules and Regulations of the Medical Staff with the following additions:

(1) Surgical procedures performed by non-MD oral surgeons, dentists or podiatrists shall be done under the administrative supervision of the chief of surgery or his or her designee;

(2) Podiatrists, dentists, and non-MD oral surgeons may not supervise CRNAs in providing anesthesia services; only physician members of the medical staff may provide this supervision;

(3) At the time of inpatient surgery and at the time of admission, the name of the physician member of the medical staff who will be providing medical care for the patient must appear in the medical record. This provider or his/her designee shall be responsible for pre- and post-operative medical evaluation and care of the patient;

(4) The dentist or podiatrist may discharge the patient after obtaining the concurrence of the consulting physician; and

(5) Complete records, both dental or podiatric and medical, shall be required on each patient and shall be part of the Hospital record.

3.8 Honorary Medical Staff

(a) The honorary Medical Staff shall consist of practitioners who are not active in the Hospital and who are honored by emeritus positions. These may be practitioners who have retired from active hospital service, or who are of outstanding reputation, not necessarily residents of the community.

(b) Honorary Medical Staff members shall have no assigned duties and they shall not have privileges to admit or treat patients in the Hospital. Honorary Medical Staff members are not eligible to vote or hold office, but may serve on Medical Staff committees, except the MEC and the MMT.

(c) Honorary Medical Staff members may, but are not required to, attend general Medical Staff meetings or committee meetings, except they shall not be eligible to attend and participate in those portions of the meetings devoted to peer review of Medical Staff members in other categories of the Medical Staff.

SECTION 4 : FOCUSED PROFESSIONAL PRACTICE EVALUATION AND NEW CLINICAL PRIVILEGES

4.1 At the time of initial appointment to the Medical Staff, when privileges are initially granted to Advance Practice Clinicians and Authorized Providers, or when new privileges are granted to any currently privileged practitioner it will be the responsibility of the Service Chief(s) to establish and oversee the FPPE process.

(a) All Medical Staff, Advance Practice Professionals, and other staff who have been granted privileges for the first time by the Hospital will be subject to monitoring or Focused Professional Practice Evaluation (FPPE). Providers who currently have privileges and are requesting new privilege(s) will also be subject to a monitoring/FPPE for the new privilege(s). FPPE is a defined method of determining competency of a provider who is granted privileges at the Hospital and the Hospital does not have first-hand data. MMT will determine either a fixed number of cases and/or a fixed time period, not to exceed 6 months, in which cases will be reviewed, either through review of documentation and/or direct observation of procedures, for the individual provider.

(b) Focused professional practice evaluation may include chart review, monitoring of clinical practice patterns, direct observation, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient.

(c) The Service Chief may assign a designee(s) to perform the FPPE. The evaluation may be assigned to multiple providers as long as all are members of the Medical Staff.

(d) In addition to the case review process, a New Provider Evaluation form will be completed by the Service Chief or designee and processed by the Medical Management Team

(e) (MMT), Medical Executive Committee, and Board (Refer to New Provider Evaluation Policy). The 6 month evaluation will include:

(1) Patient Care: Treats patients in a caring/respectful manner, availability & thoroughness of care, ER coverage, use of consults when needed.

(2) Medical/Clinical/Technical Knowledge & Skills: Medical knowledge, technical/clinical abilities, judgment.

(3) Practice-Based Learning & Improvement: Patient care outcomes, use of information technology, compliance with practice guidelines.

(4) Interpersonal & Communication Skills: Ability to work with others, listening skills, relationship with patients/peers/staff, communication effectiveness.

(5) Professionalism: Professional ethics, demeanor, quality/timeliness of medical records, participation in staff/department/committee meetings, sensitive to cultural/age/gender/disability issues, adherence to Bylaws.

(6) System-Based Practice: Knowledge of practice & deliver systems, practice cost effective care, advocate for patients generating patient satisfaction.

(f) Based upon the review of available information at the end of the proctoring period, the Service Chief will make a recommendation for the Medical Management Team as to whether additional focused evaluation is required or no additional focused evaluation is required. The Medical Management Team will make its recommendation to the Medical Executive Committee as to whether additional focused evaluation is required or no additional focused evaluation is required.

(g) The evaluation process must be completed no later than 6 months after initial appointment unless the Chief Medical Officer grants an extension if initial concerns are raised that require

further evaluation of there is insufficient activity during the initial period. Such extension will be communicated to the provider and Service Chief.

(h) Anyone granted privileges and undergoing FPPE in their first six months of association with the hospital will be expected to fulfill the responsibilities and abide by the any restrictions imposed by the Board of Directors. Such appointees shall not be eligible to (1) vote on any medical staff issues; (2) serve on the MEC or MMT ; or (3) hold office.

(i) Such appointees shall be assigned to a service. New appointees' clinical performance will be monitored through the FPPE process, as previously described.

(j) If the new appointee has had no activity at the end of the first full reappointment cycle, the practitioner will be sent notification that they shall receive one (1) six-month provisional reappointment period. If at the end of the provisional reappointment the practitioner still has not had any hospital activity, this shall be deemed a voluntary resignation of medical staff membership and/or clinical privileges at the expiration of the practitioner's current term.

(k) If the new appointee is deemed not to meet competency expectations, MMT will recommend termination of privileges to MEC and upon board action, the practitioner will have the right to invoke the fair hearing plan.

(l) Evaluation during the time-limited FPPE is the responsibility of all members of the Medical Staff. FPPE is an aspect of peer review and as such is protected under the same state and federal law protections as other peer review activities. All documents prepared for the purpose of reviewing or monitoring the quality of care and services of the Wisconsin Statutes, Sec. 146.38. The records are prepared for the purpose of reviewing or evaluating the quality of care and services of the individual providers practicing at the hospital. All documentation generated as a result of FPPE shall be secured in the provider's peer review file.

(m) At the conclusion of the cases or period of time established by the MMT the Service Chief(s) shall recommend to the MMT that the FPPE be concluded or that an additional period of monitoring be established. Should the MEC extend the monitoring of a practitioner for an additional period, such may be done with no further action being required by the governing body. Further, the practitioner shall not be entitled to a hearing or review on the decision under the Fair Hearing Plan. Any decision to extend the monitoring protocol beyond the term of the next renewal appointment following the initial appointment or granting of new or increased clinical privileges must be ratified by the governing body. The decision to extend monitoring is not subject to review under the Fair Hearing Plan.

(n) During the new appointment, the FPPE shall afford the Hospital and the practitioner the following:

(1) The ability to establish pretreatment consultation requirements.

(2) A current review of the clinical abilities of the practitioner.

(3) A resource person or committee from whom the practitioner can or must seek voluntary or required consultation.

(4) A basis for recommending privileges at the completion of the new appointment.

SECTION 5 – MEDICAL STAFF APPOINTMENT AND REAPPOINTMENT

5.1 Application for Appointment

(a) Practitioners desiring appointment to the Medical Staff shall request an application and privilege request form from the Medical Staff office. If the applicant meets the established medical staff and Board prerequisites to receive an application, the medical staff office shall provide such application and supporting documentation requirements. In addition to the forms, the medical

staff office will provide the applicant with access to the Medical Staff Bylaws, Rules and Regulations, Medical Staff Code of Conduct and Conflict of Interest Policy and of the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops, the Hospital mission statement, Code of Conduct, and hospital-specific orientation. A copy of the principles of medical ethics of the American Medical, Dental, Podiatric, or Osteopathic Association, as appropriate, shall be made available for practitioner review upon request.

(b) All applications for appointment to the Medical Staff shall be submitted on the current required form(s). The applicant shall sign a statement that he or she agrees to provide continuous care to his or her patients and that the applicant has received and read these Bylaws, Rules and Regulations of the Medical Staff and the Medical Staff Code of Conduct and Conflict of Interest Policy, and agrees to be bound by their terms if granted membership or clinical privileges, and to be bound by their terms relating to consideration of his or her application without regard to whether or not the applicant is ultimately granted membership or clinical privileges.

(c) The application shall include information as to whether the applicant's membership and/or clinical privileges have ever been revoked, suspended, reduced, not renewed, denied, investigated, voluntarily relinquished or subjected to probationary conditions, whether proceedings towards any of those ends have been instituted or recommended; or whether he or she has been subject to any other disciplinary action or sanction at any other hospital or institution, by any specialty board, by any local, state or national medical organization or other professional society, or by any employer of the applicant in a clinical position or practice arrangement. The applicant shall also include information as to whether or not the applicant has ever been refused liability insurance or renewal or had it canceled, or limitations placed on scope of coverage, had coverage rated up because of unusual risk or been notified of any intent by any insurer to do so. The applicant shall also include information as to any involvement in any professional liability action, information as to any past or pending involvement in any quality inquiry, sanction action or formal investigation by Medicaid or a Medicare quality improvement organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or any state, and information as to whether any license or registration of the applicant has ever been suspended or revoked, and whether the applicant has ever been reprimanded or otherwise disciplined by any state or federal governmental agency relating to the practice of his or her profession. The applicant shall also include information as to any currently pending challenges to any licensure or registration of the applicant and as to the applicant's ability to safely exercise the privileges requested. The application shall include information as to whether the applicant has any criminal conviction or pending criminal charge, any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient or has misappropriated the property of any patient. The applicant must provide a fully completed Background Information Disclosure form with the completed application and must cooperate with the Hospital in obtaining any additional information required for the Hospital to comply with the requirements of Chapter HFS 12 of the Wisconsin Administrative Code. The Background Information Disclosure form will be completed by the practitioner at a minimum of every four years to initiate the Wisconsin Caregiver Background Check.

(d) The applicant must submit current evidence of the minimum amounts of malpractice insurance coverage as determined by Wisconsin Statutes.

(e) The application shall identify as references at least two individuals who have recently worked with the applicant and directly observed his or her professional performance over a reasonable period of time, and who can and will provide reliable information regarding the applicant's current clinical ability, ethical character and ability to work with others.

(f) Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated current competence, references and other relevant information, including an appraisal by the Service Chief in which service such

privileges are sought. The applicant shall have the burden of establishing both qualifications and competency in the clinical privileges requested.

(g) The applicant shall have the burden of producing adequate information for a proper evaluation of his or her competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. Failing to adequately complete the application form, withholding requested information, providing false or misleading information (whether intentional or not), or omitting material information necessary for a full picture of the applicant's professional history shall cause the processing of the application to be suspended until such deficiencies are corrected and may be a basis for denial of membership on or removal from the Medical Staff.

(h) Additional details regarding the applicant's health status (including physical, mental and emotional stability) shall be obtained following a favorable recommendation for appointment by the MEC.

(i) The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following:

(1) A current picture hospital ID card

(2) A valid picture ID issued by a state or federal agency (e.g., driver's license or passport)

(j) In the case of telemedicine providers who do not present locally to provide services, the ID verification process must be completed by a representative at the distant site and forwarded to the local Medical Staff Office.

(k) By applying for appointment or reappointment, the applicant signifies a willingness to appear and be interviewed in regard to the application. The applicant by signing the application authorizes the Hospital to consult with any and all members of Medical Staffs of other hospitals or other health care entities with which the applicant has been associated, as well as with others who may have information bearing on the competence, character, health status, and ethical qualifications of the applicant and to inspect such records and documents as shall be material to an evaluation of stated professional qualifications, and competence to carry out the clinical privileges requested as well as the applicant's moral and ethical qualifications and health status. By so applying, the applicant also releases all individuals who submit information, including otherwise privileged and confidential information, at the request of the Hospital to facilitate the assessment of his or her qualifications for staff appointment and clinical privileges from any liability for their statements and releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in connection with evaluating the applicant.

5.2 Administrative Denial

The Medical Staff office may, upon the approval of the CMO, refuse to process an application for appointment or reappointment to the Medical Staff or for clinical privileges without further review, if it determines any of the following about the applicant: (1) he or she does not hold a valid Wisconsin license and no application is pending; (2) he or she does not have adequate professional liability insurance; (3) he or she is not eligible to receive payment from the Medicare or Medical Assistance programs or is currently excluded from any federally-funded health care program; (4) he or she is barred from providing services under Chapter HFS 12 of the Wisconsin Administrative Code; (5) he or she has only requested clinical privileges: (a) in a department that has been closed pursuant to any medical staff development plan adopted by the Hospital or (b) that have been exclusively granted to another practitioner pursuant to a written contract then in effect without notice from either party to the contract of intent to terminate, which contract covers all the clinical privileges being requested by the applicant; or (6) he or she refuses to provide requested or required information to complete the credentialing process. Applicants who are administratively denied under this section do not have a right to a fair hearing under the Plan, but may submit evidence to the Medical Staff office to refute the basis for the administrative denial.

5.3 Automatic Suspension

Please refer to the Fair Hearing Plan approved by MEC and Board of Directors.

5.4 Special Meeting Attendance Requirements

Whenever suspected deviation from standard clinical or professional practice is identified, the Medical Executive Committee (MEC), Service Chief, or applicable committee chair may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the conference at least five (5) days prior to the conference, including the date, time, place, a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such conference after two notices, unless excused by the MEC upon showing good cause, will result in an automatic termination of membership. Such termination will not give rise to a fair hearing, but will automatically be rescinded upon the practitioner's participation in the previously referenced conference. Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of clinical privileges as outlined in the Fair Hearing Plan.

5.5 Appointment Process

(a) The completed application and all supporting and mandatory documents and forms as referenced in the application/application cover letter shall be presented to the CMO. The CMO or his or her designee will obtain verifying information from the National Practitioner Data Bank, the appropriate state licensing boards and other related sources. If required, the applicant will sign any special releases that may be required. The CMO or his or her designee will also obtain primary source verification of the medical license, residency training, or other postgraduate education of the applicant, particularly as it applies to the privileges requested. After collecting the references and other materials deemed pertinent, the CMO shall present the application and all supporting materials to the MMT. The MMT shall simultaneously present the completed application to the appropriate Service Chief(s), as determined by the MMT. The Hospital is responsible for verifying the information provided, but the applicant has a continuing obligation to facilitate the release of information necessary for verification and evaluation of the applicant's credentials.

(b) The MMT:

(1) Shall verify, through references and other sources, that the applicant meets and has established all basic qualifications set forth in these Bylaws. This includes verification of the applicant's current competence.

(2) May request that the applicant arrange for a personal interview with the Service Chief(s) and the CMO or his or her designees, who must be Medical Staff members.

(c) Within 60 days after receipt of the completed application for membership, references, reports and other supporting data requested of the applicant, the MMT shall make a written report of its recommendations. In preparing this report, the MMT shall examine the character, professional competence including quality of patient care and services, qualifications and ethical standing of the applicant and shall verify, through information contained in references given by the applicant and from other sources available to the committee, including the appraisals from the Service Chief(s), that the applicant meets and has established all the necessary qualifications for the category of staff membership and the clinical privileges requested as set forth in Section 3 of these Bylaws. The recommendations of the Service Chief(s) are advisory to the MMT and do not themselves constitute professional review action. While the recommendation and the appointment to the Medical Staff shall be based primarily on professional competence of applicants, the ability of the Hospital to provide adequate facilities and supportive services for the applicant and his or her patients and patient care needs for additional staff members with the applicant's skill and training shall also be considerations in determining Medical Staff membership. To the extent the geographic location of the applicant and his or her practice

affects the ability of the applicant to provide effective continuity of care for hospital patients, it shall also be a consideration.

(d) The governing body, MEC, MMT, or Service Chief may, at any time, request additional information in connection with a completed application, and the processing of the application shall be suspended for 60 days or until the applicant has provided the information requested or satisfactorily explains his or her failure to do so, whichever occurs first.

(e) The MMT shall submit a written report concerning the applicant to the MEC. The report may be in the form of the committee's minutes with attachments, but it must address the following requirements:

(1) The written report shall state the applicant's qualifications, other current hospital affiliations, interest in the Hospital, and the MMT's opinion in regard to the applicant's current professional competence, character, and ability to safely perform the clinical privileges requested, with or without accommodation, and recommend that the application be approved, deferred or rejected.

(2) The MMT report shall include a recommendation as to a delineation of privileges to be extended and any limitations or restrictions, based upon the recommendations from the Service Chief(s). Any recommendations as to limitations or restrictions, if temporary, shall specify the time period and conditions required to remove such limitations or restrictions. If there are differences in privilege recommendations between Service Chiefs, both recommendations shall be submitted with each Service Chief's reasons set forth.

(3) When a recommendation to defer is made, the recommendation shall state the basis for deferral and shall specify the date of meeting at which the application will be recommended for acceptance or rejection.

(4) The recommendations of the MMT are advisory to the MEC and do not of themselves constitute professional review action.

(f) The MEC shall at its next regular meeting after the receipt of the report of the MMT:

(1) Give careful consideration to the new applicant in reference to current professional competence, ethical conduct and willingness to contribute toward meeting the educational and professional needs of the Hospital;

(2) Decide by a majority vote to recommend to approve, defer or reject the application and submit its recommendation to the governing body through the CMO. Any recommendation for appointment may include probationary conditions. A recommendation by the MEC to defer for further consideration or investigation must be followed up within three months by a recommendation for appointment to the Medical Staff with specified privileges or for rejection of staff membership;

(3) Should the recommendation of the MEC be negative or not in accord with the staff status or privileges requested by the applicant, then prior to any referral of the recommendation to the governing body for action, the practitioner involved should be notified of the recommendation pursuant to these Bylaws and given an opportunity either to waive any procedural rights by accepting the recommendations or to exercise such review rights as are set forth in the Plan; and

(4) When the recommendation of the MEC is favorable, additional information regarding the applicant's current health status shall be obtained prior to forwarding the recommendation to the governing body. The MEC at its discretion may require the practitioner to submit to a physical examination by an appropriate physician or psychologist for the purpose of determining the practitioner's current ability to competently and safely exercise the privileges requested, with or without reasonable

accommodation. Upon receipt of the completed health assessment questionnaire, the CMO shall determine whether further investigation and review is warranted.

(i) If the CMO determines that the applicant's health information may affect the MEC's recommendation, the matter will be referred to the MMT for further investigation and review. Following review, the MMT may recommend affirmation or modification of the MEC's recommendation and submit a report to that effect to the MEC for processing in accord with the process above.

(ii) If the CMO determines that the information does not affect the recommendation, the MEC's recommendation shall be forwarded to the governing body and be deemed final unless disapproved by the governing body or authorized committee of the governing body within 60 days of receipt of the MEC's recommendation. This Section shall not preclude referral to the practitioner's advisory committee for recommendation for monitoring.

(g) The governing body, at its next regular meeting after the receipt of the recommendation of the MEC (provided all procedural rights to hearing and appellate review have either been waived or exhausted), shall:

(1) For favorable recommendations, either ratify the final action or refer it back to the MEC, indicating reasons for non-acceptance.

(2) For adverse recommendations, either accept the recommendation or refer it back to the MEC, indicating reasons for non-acceptance.

(h) When the governing body's action is final, it shall send notice of such decision through the CMO to the Service Chief(s) concerned and, by special notice, to the practitioner.

5.6 Medical Staff Procedure for Reappointment

(a) In order to be eligible for reappointment to the medical staff of Saint Clare's Hospital, practitioners must have provided patient care services or had clinical activity at the Hospital in the preceding two years, or be a member of a group in which clinical privileges are obtained for the purpose of providing specialty service cross coverage.

(b) The Medical Staff Office will provide each staff member scheduled for reappointment a reappointment application form no more than 90 days prior to expiration of the member's current appointment.

(c) Each staff member who desires reappointment shall submit his or her completed reappointment application to the Medical Staff Office within 30 days of receipt. Failure without good cause to return the form shall be deemed a voluntary resignation from the staff and shall result in automatic termination of membership at the expiration of the member's current term. A practitioner whose membership is so terminated shall be entitled to the procedural rights provided in the Plan for the sole purpose of determining the issue of good cause.

(d) The reappointment application form shall include all information necessary to update the information contained in the applicant's initial application for appointment since the last time such information was supplied including, without limitation:

(1) Changes in Medical Staff membership or clinical privileges at any other hospital or institution, including, without limitation, any revocation, suspension, reduction, limitation, denial or non-renewal thereof, whether voluntary or involuntary;

(2) Suspension or revocation of licensure or registration (state, district or DEA) or any reprimand or imposition of sanctions related thereto or suspension or revocation of membership or imposition of other sanctions by any local, state or national professional society;

(3) Any malpractice claims, suits, settlements or judgments, whether pending or finally determined and any refusal or cancellation of professional liability insurance;

(4) Any additional training, education or experience relevant to the privileges sought on reappointment;

(5) Any criminal conviction or pending criminal charges;

(6) Current evidence of licensure and DEA registration and of professional liability insurance coverage;

(7) Documentation of the health assessment required under state regulations on persons providing direct patient services in the Hospital and reporting of any adverse findings relevant to the applicant's exercise of clinical privileges;

(8) Any exclusion or pending exclusion from any federally-funded health care program;

(9) Receipt of any sanction notice or notice of proposed sanction or of the initiation of a formal investigation or the filing of charges relating to health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, the Office of the Inspector General, or any law enforcement agency or health regulatory agency of the United States or any state;

(10) Updated information regarding any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient or has misappropriated the property of any patient, and

(11) Such other information about the applicant's ethics, qualifications, and ability as may be relevant to his or her ability to provide quality patient care at the Hospital.

(12) Participation in continuing medical education as required to maintain Wisconsin licensure. Each practitioner must attest to attending CME programs and receiving the majority of required CME credits in his/her area of practice and must be willing to provide proof of attendance and program content upon request.

(e) All promotions in or changes in Medical Staff category or scope of clinical privileges shall be subject to the procedures in the Bylaws applicable to initial appointments.

(f) Prior to the last scheduled governing body meeting before expiration of the practitioner's current appointment, the MMT shall complete its review of all pertinent information available on each applicant for reappointment for the purpose of determining its recommendations for reappointment to the Medical Staff and for the granting of clinical privileges for the ensuing term and shall transmit its recommendations, in writing, to the MEC. In arriving at recommendations for reappointment of each Medical Staff member and the assignment of privileges, specific consideration shall be given to the practitioner's current professional competency and clinical judgment in the treatment of patients, ethics and conduct, compliance with the Medical Staff Code of Conduct and Conflict of Interest Policy, physical and mental capabilities, attendance at Medical Staff meetings and participation in staff affairs, compliance with the Hospital Bylaws and the Medical Staff Bylaws, Rules and Regulations (including timeliness of medical record completion), cooperation with Hospital personnel, appropriate use of the Hospital's facilities for patients, relations with other staff members, and general attitude toward patients, the Hospital and the public, participation in continuing education. Reappointment policies include the periodic appraisal of the professional activities of each member of the Medical Staff and of all other individuals granted clinical privileges in the Hospital through the Medical Staff approval process.

(g) The assessment of the competence of the practitioner by the Service Chief(s) shall be considered.

(h) The evaluation of information obtained during the Ongoing Professional Practice Evaluation (OPPE) that consists of a review of the various dimension of performance including patient care; medical/clinical/technical knowledge and skills; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice. In addition, the FPPE performed during initial appointment shall be considered in the appraisal of the applicant's professional performance, judgment and technical and/or clinical skills.

(i) A written report of all matters considered in each practitioner's periodic reappointment appraisal must be made a part of the permanent files of the Hospital.

(j) Aggregate Data considered in the periodic appraisal may include but are not limited to:

(1) Number of operative and other procedures performed or major diagnoses made;

(2) Rates of undesirable outcomes, such as complications, compared with those of others doing similar procedures; and

(3) Use of blood and blood components

(4) Criteria for autopsies

(5) Findings and conclusions of review by peers (please refer to Medical Staff PI Policy approved by MEC and Board of Directors);

(k) Prior to the last scheduled governing body meeting before the expiration of the practitioner's current appointment, the MEC shall make its recommendations to the governing body, through the CMO, concerning the reappointment or non-reappointment and the continuation or alteration of privileges for the ensuing term of each member of the Medical Staff applying for reappointment. In all cases where non-reappointment or a change in staff status or clinical privileges is recommended, the reasons for the recommendation shall be stated and documented.

(l) When the recommendation of the MEC constitutes a professional review action giving rise to hearing rights as specified in the Plan, then prior to any referral of the recommendation to the governing body for action, the CMO shall give the practitioner involved special notice of the recommendation, and the practitioner shall be given an opportunity either to exercise the procedural rights set forth in the Plan or to accept the recommendation.

(m) Thereafter, the procedure provided in Section 5 relating to recommendations on applications for initial appointments shall be followed.

(n) If, for any reason, the reappointment process has not been fully completed by the end of the current appointment, the applicant's staff appointment and clinical privileges will automatically cease. No temporary privileges will be extended. The burden is on the applicant to provide the necessary documentation and verifications to complete the reappointment process.

(o) Each member of the Medical Staff is responsible for advising the CMO and their Service Chief(s) of any current physical or mental condition that may limit the individual's ability to safely exercise his or her clinical privileges. A referral may be made to the Physician Health Committee. If, as a result of the practitioner's self-reporting of a disability, the Physician Health Committee submits a recommendation for modification of membership status or privileges and the MEC adopts such recommendation, the affected practitioner shall be notified by special notice of the recommendation. The recommendation shall not be considered a professional review action unless and until the practitioner chooses to exercise the right to hearing available under the Plan, and the notice shall so state. If the MEC recommends modification of membership status or privileges due to a condition initially discovered by means other than self-reporting, such recommendation shall constitute a professional review action without regard to whether or not the practitioner exercises the hearing rights available under the Plan. Please refer to the Physician Health Committee Policy (25405).

5.7 Reapplication After Adverse Action

(a) An applicant who has received a final adverse professional review action regarding appointment or clinical privileges or both and who did not exercise any of the hearing rights provided in the Plan shall not be eligible to reapply for the membership status or privileges that were the subject of the adverse action for a period of six months from the date of final adverse action or until he or she completes training identified by the Medical Staff as a prerequisite for the privileges, whichever is longer.

(b) An applicant who has received a final adverse professional review action regarding appointment or clinical privileges or both and who exercised some or all of the hearing rights provided in the Plan shall not be eligible to reapply for the membership status that were the subject of the adverse action for a period of two years from the date of final adverse action.

(c) Any reapplication under this Section shall be processed as an initial application, but the applicant shall submit additional information as the Medical Staff or governing body may require in demonstration that the basis for the earlier adverse action no longer exists.

(d) If the recommendation of the Medical Staff or the action proposed by the governing body upon reapplication continues to be adverse, the scope of the hearing to which the practitioner is entitled shall be limited to consideration of the sufficiency of the additional information submitted in demonstration that the basis for the earlier adverse action no longer exists.

5.8 Time Periods For Processing

(a) Applications for appointment or reappointment shall be considered in a timely and good faith manner by all individuals and groups who are required by these Bylaws to act on such applications and, except for good cause, shall be processed within the time periods specified in Section 5. However, the time periods specified are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the practitioner to have his or her application processed within those periods nor to create a right for a staff member to be automatically reappointed for the coming term.

SECTION 6 – CLINICAL PRIVILEGES AND RE-PRIVILEGING FOR ADVANCED PRACTICE CLINICIANS AND AUTHORIZED PROVIDERS

6.1 Application for Clinical Privileges

(a) Advanced Practice Clinicians and Authorized Providers seeking privileges shall request an application and privilege request form from the Medical Staff office. If the applicant meets the established conditions of privileges to receive an application, the medical staff office shall provide such application and supporting documentation requirements. In addition to the forms, the medical staff office will provide the applicant with access to the Medical Staff Bylaws, Rules and Regulations, Medical Staff Code of Conduct and Conflict of Interest Policy and of the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops, the Hospital mission statement, Code of Conduct, and hospital-specific orientation. A copy of the principles of medical ethics of the American Medical, Dental, Podiatric, or Osteopathic Association, as appropriate, shall be made available for practitioner review upon request.

(b) All applications for clinical privileges shall be submitted on the current required form(s). The applicant shall sign a statement that he or she agrees to provide continuous care to his or her patients and that the applicant has received and read these Bylaws, Rules and Regulations of the Medical Staff and the Medical Staff Code of Conduct and Conflict of Interest Policy, and agrees to be bound by their terms if granted clinical privileges, and to be bound by their terms relating to consideration of his or her application without regard to whether or not the applicant is ultimately granted clinical privileges.

(c) The application shall include information as to whether the applicant's clinical privileges have ever been revoked, suspended, reduced, not renewed, denied, investigated, voluntarily relinquished or subjected to probationary conditions, whether proceedings towards any of those ends have been instituted or recommended; or whether he or she has been subject to any other disciplinary action or sanction at any other hospital or institution, by any specialty board, by any local, state or national medical organization or other professional society, or by any employer of the applicant in a clinical position or practice arrangement. The applicant shall also include information as to whether or not the applicant has ever been refused liability insurance or renewal or had it canceled, or limitations placed on scope of coverage, had coverage rated up because of unusual risk or been notified of any intent by any insurer to do so. The applicant shall also include information as to any involvement in any professional liability action, information as to any past or pending involvement in any quality inquiry, sanction action or formal investigation by Medicaid or a Medicare quality improvement organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or any state, and information as to whether any license or registration of the applicant has ever been suspended or revoked, and whether the applicant has ever been reprimanded or otherwise disciplined by any state or federal governmental agency relating to the practice of his or her profession. The applicant shall also include information as to any currently pending challenges to any licensure or registration of the applicant and as to the applicant's ability to safely exercise the privileges requested. The application shall include information as to whether the applicant has any criminal conviction or pending criminal charge, any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient or has misappropriated the property of any patient. The applicant must provide a fully completed Background Information Disclosure form with the completed application and must cooperate with the Hospital in obtaining any additional information required for the Hospital to comply with the requirements of Chapter HFS 12 of the Wisconsin Administrative Code.

(d) The applicant must submit current evidence of the minimum amounts of malpractice coverage as determined by Wisconsin Statues.

(e) The application shall identify as references at least two individuals who have recently worked with the applicant and directly observed his or her professional performance over a reasonable period of time, and who can and will provide reliable information regarding the applicant's current clinical ability, ethical character and ability to work with others.

(f) Every initial application for clinical privileges must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated current competence, references and other relevant information, including an appraisal by the Service Chief in which service such privileges are sought. The applicant shall have the burden of establishing both qualifications and competency in the clinical privileges requested.

(g) The applicant shall have the burden of producing adequate information for a proper evaluation of his or her competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. Failing to adequately complete the application form, withholding requested information, providing false or misleading information (whether intentional or not), or omitting material information necessary for a full picture of the applicant's professional history shall cause the processing of the application to be suspended until such deficiencies are corrected and may be a basis for denial of clinical privileges.

(h) In the event privileges have been granted prior to discovery of the applicant's withholding, misrepresenting or omitting such material information, this discovery shall result in automatic relinquishment of all clinical privileges or scope of practice and resignation as an Advanced Practice Clinician or Authorized Provider. In either situation, there will be no entitlement to procedural rights provided in these Bylaws.

(i) Additional details regarding the applicant's health status (including physical, mental and emotional stability) shall be obtained following a favorable recommendation for appointment by the MEC.

(j) The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following:

(1) A current picture hospital ID card

(2) A valid picture ID issued by a state or federal agency (e.g., driver's license or passport)

(k) In the case of telemedicine advanced practice clinicians who do not present locally to provide services, the ID verification process must be completed by a representative a the distant site and forwarded to the local Medical Staff Office.

(l) By applying for clinical privileges or re-privileging, the applicant signifies a willingness to appear and be interviewed in regard to the application. The applicant by signing the application authorizes the Hospital to consult with any and all members of Medical Staffs of other hospitals or other health care entities with which the applicant has been associated, as well as with others who may have information bearing on the competence, character, health status, and ethical qualifications of the applicant and to inspect such records and documents as shall be material to an evaluation of stated professional qualifications, and competence to carry out the clinical privileges requested as well as the applicant's moral and ethical qualifications and health status. By so applying, the applicant also releases all individuals who submit information, including otherwise privileged and confidential information, at the request of the Hospital to facilitate the assessment of his or her qualifications for staff appointment and clinical privileges from any liability for their statements and releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in connection with evaluating the applicant.

6.2 Administrative Denial

The Medical Staff office may, upon the approval of the CMO, refuse to process an application for clinical privileges or re-privileging without further review, if it determines any of the following about the applicant: (1) he or she does not hold a valid Wisconsin license and no application is pending, if applicable; (2) he or she does not have adequate professional liability insurance; (3) he or she is not eligible to receive payment from the Medicare or Medical Assistance programs or is currently excluded from any federally-funded health care program; (4) he or she is barred from providing services under Chapter HFS 12 of the Wisconsin Administrative Code; (5) he or she has only requested clinical privileges: (a) in a department that has been closed pursuant to any medical staff development plan adopted by the Hospital or (b) that have been exclusively granted to another practitioner pursuant to a written contract then in effect without notice from either party to the contract of intent to terminate, which contract covers all the clinical privileges being requested by the applicant; or (6) he or she refuses to provide requested or required information to complete the credentialing process. Applicants who are administratively denied under this Section do not have a right to a fair hearing under the Plan, but may submit evidence to the Medical Staff office to refute the basis for the administrative denial.

6.3 Privileging Process

(a) The completed application and all supporting and mandatory documents and forms as referenced in the application/application cover letter shall be presented to the CMO. The CMO or his or her designee will obtain verifying information from the National Practitioner Data Bank, if applicable, the appropriate state licensing boards and other related sources. If required, the applicant will sign any special releases that may be required. The CMO or his or her designee will also obtain primary source verification, if applicable, of the medical license, residency training, or other postgraduate education of the applicant, particularly as it applies to the privileges requested. After collecting the references and other materials deemed pertinent, the CMO shall present the application and all supporting materials to the MMT. The MMT shall simultaneously present the completed application to the appropriate Service Chief(s), as determined by the MMT. The Hospital is responsible for verifying the information provided, but

the applicant has a continuing obligation to facilitate the release of information necessary for verification and evaluation of the applicant's credentials.

(b) The MMT:

(1) Shall verify, through references and other sources, that the applicant meets and has established all basic qualifications set forth in these Bylaws. This includes verification of the applicant's current competence.

(2) May request that the applicant arrange for a personal interview with the Service Chief(s) and the CMO or his or her designees, who must be Medical Staff members.

(c) Within 60 days after receipt of the completed application for clinical privileges, references, reports and other supporting data requested of the applicant, the MMT shall make a written report of its recommendations. In preparing this report, the MMT shall examine the character, professional competence including quality of patient care and services, qualifications and ethical standing of the applicant and shall verify, through information contained in references given by the applicant and from other sources available to the committee, including the appraisals from the Service Chief(s), that the applicant meets and has established all the necessary qualifications for the clinical privileges requested as set forth in these Bylaws. The recommendations of the Service Chief(s) are advisory to the MMT and do not themselves constitute professional review action. While the recommendation and granting of clinical privileges shall be based primarily on professional competence of applicants, the ability of the Hospital to provide adequate facilities and supportive services for the applicant and his or her patients and patient care needs for additional staff members with the applicant's skill and training shall also be considerations in granting clinical privileges. To the extent the geographic location of the applicant and his or her practice affects the ability of the applicant to provide effective continuity of care for hospital patients, it shall also be a consideration.

(d) The governing body, MEC, MMT, or Service Chief may, at any time, request additional information in connection with a completed application, and the processing of the application shall be suspended for 60 days or until the applicant has provided the information requested or satisfactorily explains his or her failure to do so, whichever occurs first.

(e) The MMT shall submit a written report concerning the applicant to the MEC. The report may be in the form of the committee's minutes with attachments, but it must address the following requirements:

(1) The written report shall state the applicant's qualifications, other current hospital affiliations, interest in the Hospital, and the MMT's opinion in regard to the applicant's current professional competence, character, and ability to safely perform the clinical privileges requested, with or without accommodation, and recommend that the application be approved, deferred or rejected.

(2) The MMT report shall include a recommendation as to a delineation of privileges to be extended and any limitations or restrictions, based upon the recommendations from the Service Chief(s). Any recommendations as to limitations or restrictions, if temporary, shall specify the time period and conditions required to remove such limitations or restrictions. If there are differences in privilege recommendations between Service Chiefs, both recommendations shall be submitted with each Service Chief's reasons set forth.

(3) When a recommendation to defer is made, the recommendation shall state the basis for deferral and shall specify the date of meeting at which the application will be recommended for acceptance or rejection.

(4) If the MMT's initial recommendation is adverse to the applicant, when applicable, the practitioner in question and the employing or supervising physician shall be given the opportunity to meet with the MMT before a final recommendation to the MEC.

(i) This meeting shall be informal and shall not be considered a hearing. Following this meeting the, MMT shall make a recommendation to the MEC.

(ii) If the MMT's recommendation to the MEC is adverse, the employing or supervising Physician shall be given the opportunity to meet with the MEC before a decision by the MEC is made. Prior to any referral of the recommendation to the governing body for action, the practitioner involved should be notified of the recommendation pursuant to these Bylaws.

(5) The recommendations of the MMT are advisory to the MEC and do not of themselves constitute professional review action.

(f) The MEC shall at its next regular meeting after the receipt of the report of the MMT:

(1) Give careful consideration to the new applicant in reference to current professional competence, ethical conduct and willingness to contribute toward meeting the educational and professional needs of the Hospital;

(2) Decide by a majority vote to recommend to approve, defer, or reject the application and submit its recommendation to the governing body through the CMO. Any recommendation for clinical privileges may include probationary conditions. A recommendation by the MEC to defer for further consideration or investigation must be followed up within three months by a recommendation for granting or rejecting clinical privileges;

(3) When the recommendation of the MEC is favorable, additional information regarding the applicant's current health status shall be obtained prior to forwarding the recommendation to the governing body. The MEC at its discretion may require the practitioner to submit to a physical examination by an appropriate physician or psychologist for the purpose of determining the practitioner's current ability to competently and safely exercise the privileges requested, with or without reasonable accommodation. Upon receipt of the completed health assessment questionnaire, the CMO shall determine whether further investigation and review is warranted.

(i) If the CMO determines that the applicant's health information may affect the MEC's recommendation, the matter will be referred to the MMT for further investigation and review. Following review, the MMT may recommend affirmation or modification of the MEC's recommendation and submit a report to that effect to the MEC for processing in accord with the process above.

(ii) If the CMO determines that the information does not affect the recommendation, the MEC's recommendation shall be forwarded to the governing body and be deemed final unless disapproved by the governing body or authorized committee of the governing body within 60 days of receipt of the MEC's recommendation. This Section shall not preclude referral to the Medical Management Team for recommendation for monitoring.

(g) The governing body, at its next regular meeting after the receipt of the recommendation of the MEC (provided all procedural rights to hearing and appellate review have either been waived or exhausted), shall:

(1) For favorable recommendations, either ratify the final action or refer it back to the MEC, indicating reasons for non-acceptance.

(2) For adverse recommendations, either accept the recommendation or refer it back to the MEC, indicating reasons for non-acceptance.

(h) When the governing body's action is final, it shall send notice of such decision through the CMO to the Service Chief(s) concerned and, by special notice, to the practitioner.

6.4 Procedure for Re-Privileging

(a) In order to be eligible for re-privileging at Saint Clare's Hospital, practitioners must have provided patient care services or had clinical activity at the Hospital in the preceding two years, or be a member of a group in which clinical privileges are obtained for the purpose of providing specialty service cross coverage.

(b) The Medical Staff Office will provide each staff member scheduled for re-privileging with a re-privileging application no more than 90 days prior to expiration of the member's current privileging term.

(c) Each practitioner who desires re-privileging shall submit his or her completed re-privileging application to the Medical Staff Office within 30 days of receipt. Failure without good cause to return the form shall be deemed a voluntary resignation of privileges and shall result in automatic termination of privileges at the expiration of the practitioner's current term.

(d) The re-privileging application shall include all information necessary to update the information contained in the applicant's initial application for privileges since the last time such information was supplied including, without limitation:

(1) Changes in Medical Staff membership or clinical privileges at any other hospital or institution, including, without limitation, any revocation, suspension, reduction, limitation, denial or non-renewal thereof, whether voluntary or involuntary;

(2) Suspension or revocation of licensure or registration (state, district or DEA) or any reprimand or imposition of sanctions related thereto or suspension or revocation of membership or imposition of other sanctions by any local, state or national professional society;

(3) Any malpractice claims, suits, settlements or judgments, whether pending or finally determined and any refusal or cancellation of professional liability insurance;

(4) Any additional training, education or experience relevant to the privileges sought on re-privileging;

(5) Any criminal conviction or pending criminal charges;

(6) Current evidence of licensure and DEA registration and of professional liability insurance coverage;

(7) Documentation of the health assessment required under state regulations on persons providing direct patient services in the Hospital and reporting of any adverse findings relevant to the applicant's exercise of clinical privileges;

(8) Any exclusion or pending exclusion from any federally-funded health care program;

(9) Receipt of any sanction notice or notice of proposed sanction or of the initiation of a formal investigation or the filing of charges relating to health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, the Office of the Inspector General, or any law enforcement agency or health regulatory agency of the United States or any state;

(10) Updated information regarding any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient or has misappropriated the property of any patient, and

(11) Such other information about the applicant's ethics, qualifications, and ability as may be relevant to his or her ability to provide quality patient care at the Hospital.

(12) Participation in continuing medical education as required to maintain Wisconsin licensure. Each practitioner must attest to attending CME programs and receiving the majority of required CME credits in his/her area of practice and must be willing to provide proof of attendance and program content upon request.

(e) All promotions in or changes in Medical Staff category or scope of clinical privileges shall be subject to the procedures in the Bylaws applicable to initial privileging.

(f) Prior to the last scheduled governing body meeting before expiration of the practitioner's current privileging term, the MMT shall complete its review of all pertinent information available on each applicant for re-privileging for the purpose of determining its recommendations for the granting of clinical privileges for the ensuing term and shall transmit its recommendations, in writing, to the MEC. In arriving at recommendations for re-privileging of each practitioner and the assignment of privileges, specific consideration shall be given to the practitioner's current professional competency and clinical judgment in the treatment of patients, ethics and conduct, compliance with the Medical Staff Code of Conduct and Conflict of Interest Policy, physical and mental capabilities, attendance at Medical Staff meetings and participation in staff affairs, compliance with the Hospital Bylaws and the Medical Staff Bylaws, Rules and Regulations (including timeliness of medical record completion), cooperation with Hospital personnel, appropriate use of the Hospital's facilities for patients, relations with other staff members, and general attitude toward patients, the Hospital and the public, participation in continuing education. Reappointment policies include the periodic appraisal of the professional activities of each member of the Medical Staff and of all other individuals granted clinical privileges in the Hospital through the Medical Staff approval process.

(g) The assessment of the competence of the practitioner by the Service Chief(s) shall be considered.

(h) The evaluation of information obtained through Ongoing Professional Practice Evaluation (OPPE) that consists of the a review of the various dimensions of performance including patient care; medical/clinical/technical knowledge and skills; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice. In addition, the FPPE performed during initial privileging shall be considered in the appraisal of the applicant's professional performance, judgment and technical and/or clinical skills.

(i) A written report of all matters considered in each practitioner's periodic re-privileging appraisal must be made a part of the permanent files of the Hospital.

(j) Aggregate Data considered in the periodic appraisal may include but are not limited to:

(1) Number of operative and other procedures performed;

(2) Rates of undesirable outcomes, such as complications, compared with those of others doing similar procedures; and

(3) Findings and conclusions of review by peers;

(k) Prior to the last scheduled governing body meeting before the expiration of the practitioner's current privileging term, the MEC shall make its recommendations to the governing body, through the CMO, concerning the continuation, alteration, or non-renewal of privileges for the ensuing term of each practitioner applying for re-privileging. In all cases where non-renewal or a change in clinical privileges is recommended, the reasons for the recommendation shall be stated and documented.

(l) When the recommendation of the MEC constitutes a professional review action giving rise to hearing rights as specified in the Plan, then prior to any referral of the recommendation to the governing body for action, the CMO shall give the practitioner involved special notice of the recommendation, and the practitioner shall be given an opportunity either to exercise the procedural rights set forth in the Plan or to accept the recommendation.

(m) Thereafter, the procedure provided in Section 6 relating to recommendations on applications for initial privileges shall be followed.

(n) If, for any reason, the re-privileging process has not been fully completed by the end of the current privileging term, the applicant's clinical privileges will automatically cease. No temporary privileges will be extended. The burden is on the applicant to provide the necessary documentation and verifications to complete the re-privileging process.

(o) Each practitioner is responsible for advising the CMO and their respective Service Chief(s) of any current physical or mental condition that may limit the individual's ability to safely exercise his or her clinical privileges. A referral to the Physician Health Committee may follow. The Physician Health Committee may require the individual to submit evidence of his or her current physical and/or mental status, as determined by a physician acceptable to the Physician Health Committee.

(p) If as a result of the practitioner's self-reporting of a disability, the Physician Health Committee submits a recommendation for modification of clinical privileges and the MEC adopts such recommendation, the affected practitioner shall be notified by special notice of the recommendation. The recommendation shall not be considered a professional review action unless and until the practitioner chooses to exercise the right to hearing available under the Plan, and the notice shall so state. If the MEC recommends modification of clinical privileges due to a condition initially discovered by means other than self-reporting, such recommendation shall constitute a professional review action without regard to whether or not the practitioner exercises the hearing rights available under the Plan.

6.5 Reapplication After Adverse Action

(a) An applicant who has received a final adverse professional review action regarding appointment or clinical privileges or both and who did not exercise any of the hearing rights provided in the Plan shall not be eligible to reapply for the membership status or privileges that were the subject of the adverse action for a period of six months from the date of final adverse action or until he or she completes training identified by the Medical Staff as a prerequisite for the privileges, whichever is longer.

(b) An applicant who has received a final adverse professional review action regarding appointment or clinical privileges or both and who exercised some or all of the hearing rights provided in the Plan shall not be eligible to reapply for the membership status that were the subject of the adverse action for a period of two years from the date of final adverse action.

(c) Any reapplication under this Section shall be processed as an initial application, but the applicant shall submit additional information as the Medical Staff or governing body may require in demonstration that the basis for the earlier adverse action no longer exists.

(d) If the recommendation of the Medical Staff or the action proposed by the governing body upon reapplication continues to be adverse, the scope of the hearing to which the practitioner is entitled shall be limited to consideration of the sufficiency of the additional information submitted in demonstration that the basis for the earlier adverse action no longer exists.

6.6 Time Periods For Processing

(a) Applications for initial privileging or re-privileging shall be considered in a timely and good faith manner by all individuals and groups who are required by these Bylaws to act on such applications and, except for good cause, shall be processed within the time periods specified in Section 5. However, the time periods specified are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the practitioner to have his or her application processed within those periods nor to create a right for a staff member to be automatically re-privileged for the coming term.

SECTION 7 : ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) / PEER REVIEW

7.1 Ongoing Professional Practice Evaluation / Peer Review

(a) The Medical Staff participates in performance improvement activities through assessing the performance of individuals granted clinical privileges and uses those results to improve patient safety and quality of care and services.

(b) All peer review information is privileged and confidential in accordance with medical staff and Saint Clare's Hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability. The involved individual will receive provider-specific feedback on a routine basis. Saint Clare's Hospital will use the provider-specific peer review results in its credentialing and privileging process and, as appropriate, in its performance improvement activities. Saint Clare's Hospital will keep provider-specific peer review and other quality information concerning a practitioner in a secure, locked file.

(c) The criteria used in the ongoing professional practice evaluation may include the following:

(1) Review of operative and other clinical procedure(s) performed and their outcomes

(2) Pattern of blood and/or pharmaceutical usage

(3) Requests for tests and procedures

(4) Length of stay patterns

(5) Morbidity and mortality data

(6) Provider's use of consultants

(7) Provider's role in sentinel events, significant incidents or near misses

(8) Correspondence to the provider regarding commendations, comments regarding practice performance, or corrective action

(9) Other relevant criteria/triggers established by the medical staff

(d) In addition, performance data for all dimensions of performance is evaluated on an ongoing basis and includes the following:

(1) Patient Care: Treats patients in a caring/respectful manner, availability & thoroughness of care, ER coverage, use of consults when needed.

(2) Medical/Clinical/Technical Knowledge & Skills: Medical knowledge, technical/clinical abilities, judgment.

(3) Practice-Based Learning & Improvement: Patient care outcomes, use of information technology, compliance with practice guidelines.

(4) Interpersonal & Communication Skills: Ability to work with others, listening skills, relationship with patients/peers/staff, communication effectiveness.

(5) Professionalism: Professional ethics, demeanor, quality/timeliness of medical records, participation in staff/department/committee meetings, sensitive to cultural/age/gender/disability issues, adherence to Bylaws.

(6) System-Based Practice: Knowledge of practice & delivery systems, practice cost effective care, advocate for patients generating patient satisfaction.

(e) On an annual basis, the criteria used for ongoing professional practice evaluation will be reviewed and revised, as needed, by the medical staff in collaboration with the Quality Department.

(f) Information used in the ongoing professional practice evaluation may be acquired through the following:

(1) Periodic chart review

(2) Direct observation

(3) Monitoring of diagnostic and treatment techniques

(4) Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel

(g) Ongoing professional practice evaluation information is reviewed on a regular, no less than every 6 months, by the Peer Review Steering Committee and Medical Executive Committee. It will be the Service Chief's responsibility to meet with each provider in his/her areas of responsibility to review the individual provider's performance, develop improvement plans, and provide feedback. The Service Chief will also request, when needed, a focused professional practice evaluation for a provider.

(h) Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal. Information will be maintained in each provider's peer review file.

(i) If there is uncertainty regarding the provider's professional performance, the course of action will be followed as defined in the Medical Staff Bylaws for further evaluation of the provider.

(j) Peer review information is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a medical staff leader or hospital employee. Access to information will be to the extent necessary to carry out assigned responsibilities. Only the following individuals will have access to provider-specific peer review, risk management, and quality information and only for purposes of performance improvement and ongoing professional practice evaluation of practitioners granted privileges at Saint Clare's Hospital:

(1) Chief Medical Officer

(2) Service Chiefs

(3) Members of the Medical Executive Committee and Medical Management Team

(4) Saint Clare's Vice President of Quality and Safety

(5) Saint Clare's Director of Medical Staff Support and Clinical Quality

(6) Medical Staff support staff to the extent access to the information is necessary for recredentialing or formal corrective action

(7) Surveyors for accrediting bodies with appropriate jurisdiction (Joint Commission or state/federal regulatory bodies

(8) Individuals with a legitimate purpose for access as determined by Saint Clare's Hospital Board of Directors

(9) Saint Clare's Hospital COO when information is needed to take immediate formal corrective action for purposes of summary by the CMO

(k) No copies of peer review documents will be created and distributed unless authorized by hospital management or policy.

(l) Peer review is conducted on an ongoing basis and reported to the appropriate committee for ongoing professional practice evaluation and action, as appropriate. Additional evaluation will be conducted when there is a sentinel event or near miss identified during concurrent or retrospective review; or an unusual individual case or clinical pattern of care identified during a quality review.

(m) The Medical Management Team acting as the Peer Review Steering Committee will make recommendations on the need for external peer review to the Medical Executive Committee. External peer review will take place under the following circumstances if deemed appropriate by the MEC or Board of Directors. No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the MEC or Board of Directors. Circumstances requiring external peer review include:

(1) Litigation – when dealing with a potential lawsuit

(2) Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly impact a practitioner's membership or privileges

(3) Lack of internal expertise – when no one on the medical staff has adequate expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as described above. External peer review will take place if the potential for conflict of interest cannot be appropriately resolved by the MEC or Board of Directors.

(4) New technology – when a medical staff member requests permission to use new technology or perform a procedure new to Saint Clare's and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.

(5) Miscellaneous issues – when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the MEC or Board of Directors may require external peer review in any circumstances deemed appropriate by either bodies.

(n) Participants in the peer review process will be selected according to the Medical Staff Bylaws. The work of all practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate by the department or service chair. Additional support staff will participate if such participation is included in their job responsibilities. The peer review body will consider and record the views of the person whose care is under review. Recommendations and outcomes will be submitted by the service chief for review by the MMT, acting as the Peer Review Committee, before a final report is made to the MEC.

(o) In the event of a conflict of interest or circumstances would suggest a biased review, the MMT or MEC will replace, appoint, or determine who will participate in the process so that bias does not interfere in the decision-making process.

(p) If the results of individual case reviews for a physician exceed thresholds established by the Medical Staff described below, the service chief will review the findings to determine if further intensive review is needed to identify a potential pattern of care. Thresholds are:

(1) Any single egregious case

(2) Within any 12 month period of time, any one of the following criteria:

(3) 3 cases rated care physician inappropriate

(4) 5 cases rated either physician care controversial or inappropriate

(5) 5 cases rated as having documentation issues regardless of care rating

(q) In the event a decision is made by the Board of Directors to investigate a practitioner's performance or circumstances warrant the evaluation of one or more providers with privileges, the MEC or its designee shall appoint a panel of appropriate medical professionals to perform the necessary peer review activities.

(r) Peer review will be conducted by the medical staff in a timely manner. The goal is for routine cases to be completed within 90 days of the data the chart is reviewed by Quality Improvement Specialist and/or Care Coordinators. Complex cases are to be completed within 120 days. Exceptions may occur based on case complexity or review availability.

(s) Direct oversight of the peer review process is delegated by the MEC to the MMT, acting as the Peer Review Committee. The responsibilities of the MMT related to peer review are described in the Medical Staff Bylaws. The MMT will report to the MEC and the Board of Directors at least annually.

(t) All matters relating to the peer review process are treated in strict confidence. All activities relating to the performance improvement process will be held in confidence to the extent permitted by law. Peer review case study activities are conducted pursuant to Sections 146.37 & 146.38 of the Wisconsin Statutes regarding the peer review of health care providers. All St. Clare's Hospital employees receive the corporate confidentiality policy and are required to sign a confidentiality agreement annually.

SECTION 8 – PRIVILEGES

8.1 Delineation of Clinical Privileges

(a) A practitioner Advanced Practice Clinician or Authorized Providers providing clinical services in the Hospital by virtue of the Medical Staff Bylaws process shall be entitled to exercise only those clinical privileges specifically granted by the governing body or the CMO pursuant to the procedures set forth in these Bylaws and other applicable Medical Staff policies.

(b) All Medical Staff, Advance Practice Clinicians and Authorized Providers who have been granted privileges for the first time by the Hospital will be subject to Focused Professional Practice Evaluation (FPPE) as defined in these Bylaws.

(c) Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the criteria set forth in Section 7, which includes but is not limited to the observation of care provided, the health status of the practitioner, review of the records of patients treated in this or other hospitals or clinical practice setting and review of the records of the Medical Staff documenting the member’s participation in the delivery of medical care, including training, experience, current competence and satisfactory exercise of clinical privileges to date.

(d) Privileges granted to oral surgeons, dentists and podiatrists should be based on their training, experience and demonstrated current competence and judgment and will be subject to FPPE. The scope and extent of surgical procedures that each oral surgeon, dentist or podiatrist may perform must be specifically defined and recommended in the same manner as all other surgical privileges. The oral surgeon, dentist or podiatrist is responsible for the oral surgery, dental or podiatric care of the patient, including the oral surgery, dental or podiatric history and physical examination, discharge summary and all appropriate elements of the patient’s record.

(e) Oral surgeons, dentists and podiatrists may write orders within the scope of their license, as limited by the applicable statutes and as consistent with the Medical Staff regulations. Oral surgeons, dentists and podiatrists shall agree to comply with all applicable Medical Staff Bylaws, Rules and Regulations at the time of application for clinical privileges.

(f) All individuals who are not members of the Medical Staff but who are granted clinical privileges through the Medical Staff process shall, as a condition of the grant of clinical privileges, be subject to the conditions set forth in Section 2.4(e).

8.2 Temporary Privileges

(a) The granting of temporary privileges is not encouraged and shall be limited to:

(1) Periods of time pending review and approval of a completed application, or

(2) Where it is deemed necessary or beneficial to the Hospital to meet important patient care needs.

(b) Practitioners applying for temporary privileges under this section must be licensed in Wisconsin and have a sponsor on the Medical Staff who is willing to assume responsibility for the practitioner. Additionally, the practitioner must satisfy the requirements regarding professional liability insurance, health status and the Wisconsin caregiver background check as described in these Bylaws.

(c) Upon the basis of information then available which may reasonably be relied upon as to the current competence and ethical standing of the applicant, temporary clinical privileges (non-membership) may be granted by the President upon recommendation of the CMO or his or her designee, for the care of a specific patient, to a practitioner who is not an applicant for membership, provided that the practitioner first acknowledges in writing that he or she has received and read copies of the Medical Staff Bylaws, Rules and Regulations, Medical Staff Code of Conduct and applicable policies and agrees to be bound by their terms in all matters relating to temporary clinical privileges. Temporary privileges for a non-applicant practitioner shall be limited to situations where there is an important patient care need that mandates an immediate authorization to practice before all credentials information can be verified and approved. Temporary privileges for a non-applicant practitioner shall be restricted to the treatment of not more than two patients in any one year by any practitioner, after which the practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

(d) Temporary clinical privileges for up to 120 days are available for applicants with a completed application awaiting review and approval of the governing body. Before temporary privileges can be granted under this section, the applicant must have submitted a completed application showing no current or previously successful challenges to a licensure or registration; no involuntary termination of Medical Staff membership at another organization; and no prior involuntary limitation, reduction, denial or loss of clinical privileges elsewhere. Additionally, temporary privileges cannot be granted under this section without first obtaining at least telephone verification of current licensure, relevant training or experience, current competence, demonstration of ability to perform the privileges requested, proof of insurance, absence of any bar from providing direct patient care under Wisconsin's caregiver misconduct laws, absence of exclusion from any federally-funded health care program, and receipt of the results of the National Practitioner Data Bank inquiry. The governing body shall complete processing such applications in accordance with these Bylaws.

(e) The CMO may permit a practitioner serving as a "Locum Tenens" for a member of the Medical Staff to attend patients without applying for membership on the Medical Staff for a period not to exceed 45 days per year, provided all credentials have first been approved by the CMO and the member engaging the locum tenens has filed a letter requesting temporary privileges for the locum tenens, acknowledging responsibility for his or her actions and quality of practice.

(f) Special requirements of supervision and reporting may be imposed by the CMO on any practitioner granted temporary privileges. Temporary privileges may be immediately terminated by the CMO, upon notice of any failure by the practitioner to comply with the special conditions.

(g) The CMO may at any time, upon the recommendation of the service chief concerned, terminate a practitioner's temporary privileges effective as of the discharge of the practitioner's patient(s) then under his or her care in the Hospital. However, when it is determined that the life or health of the patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a suspension pursuant to the Plan, and the same shall be effective immediately. The appropriate committee chairperson or, in his or her absence, the CMO shall assign a member of the Medical Staff to assume responsibility for the care of the practitioner's patient(s) until they are discharged from the Hospital. The wishes of the patient(s) shall be considered when feasible in the selection of a substitute practitioner. The termination or modification of temporary privileges shall not entitle the practitioner involved to the procedural rights set forth in the Plan.

(h) Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested. Before temporary privileges are granted, the practitioner must acknowledge in writing that he or she received and read the Bylaws, Rules and Regulations, Medical Staff Code of Conduct and applicable Medical Staff policies, and that he or she agrees to be bound by the terms thereof in all matters relating to his or her temporary privileges.

(i) No practitioner is entitled to temporary privileges as a matter of right. A practitioner shall not be entitled to the procedural rights afforded by the Plan because of his or her inability to obtain temporary privileges or because of any termination, modification or suspension of temporary privileges.

8.3 Emergency Privileges

In the case of any emergency, any practitioner, to the degree permitted by his or her license, and regardless of department or staff status, or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such practitioner must then request the privileges necessary to continue to treat the patient, or in the event such privileges are denied or he or she does not desire to request the privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this Section, an "emergency" is defined as a condition which could result in serious permanent damage to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

8.4 Disaster Credentialing

(a) The CMO, or in his or her absence, a Service Chief, and/or President shall have the power to grant emergency privileges to physicians, physician extenders, ancillary and nursing staff, and will assign them to work under the general direction of an identified Medical Staff member when the Emergency Management Plan has been activated and the organization is unable to meet immediate patient needs.

(b) Privileges may be granted to these individuals in areas of their individual expertise to assist in times of disasters such as public health threats and emergencies that involve mass casualties, pursuant to protocols and conditions set forth in Medical Staff policy approved by the MEC. Any practitioner providing patient care must be granted privileges prior to providing patient care, even in a disaster situation. The following information must be available and presented to the administrative person in charge of the disaster control center when the practitioner first reports to Hospital:

(1) Valid professional license, registration, or certification to practice in the United States and valid picture ID issued by a state or federal agency (passport or driver's license) and at least one of the following:

(2) Identification indicating that the individual is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professional (ESAR-VHP), or other recognized state or federal response organization or group, or

(3) Identification indicating that the individual has been granted authority by a government entity to render patient care, treatment, and services in a disaster circumstances, or

(4) Primary source verification of licensure, certification, or registration (required by laws and regulation in order to practice, or

(5) Current picture identification card from a health care organization that clearly identifies professional designation, or

(6) Confirmation by a current hospital or medical staff member with personal knowledge regarding the practitioner's identity and ability to act as a qualified volunteer during a disaster, or

(7) State Medical Society Response Team Membership

(8) Identification indicating that the individual is a credentialed physician at another hospital participating in the Ministry Health Care credentialing network where the standardized credentialing process is followed.

(c) A list of practitioners granted privileges through this process will be maintained throughout the disaster.

(d) The hospital will review the records of patients cared for by practitioners granted disaster privileges to ensure professional performance.

(e) Except in an emergency warranting the extension of emergency privileges as allowed by the Medical Staff Bylaws, before the practitioner is granted temporary disaster privileges St. Clare's Hospital staff should attempt to verify that the practitioner is not listed as an excluded provider by the Office of Inspector General and verify licensure through the applicable state's license verification website (unless the disaster has disrupted computer service at Hospital or the agencies involved, such that verification cannot be obtained on a same day basis).

(f) Primary source verification of the above information should be done as soon as possible by the medical staff office but will begin as soon as the situation is under control but will be completed no later than 72 hours. Records of this information should be retained. It is recommended that the practitioner be paired with a currently credentialed medical staff member and should act only under the direct supervision of a medical staff member. Within 72 hours, the hospital will make a decision based on information obtained regarding the professional practice of the volunteer practitioner whether or not to continue to allow this practitioner to provide care. If primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice) cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the following will be documented:

(1) Reason(s) why it could not be performed within 72 hours of the practitioner's arrival;

(2) Evidence of the practitioner's demonstrated ability to continue to provide adequate care, treatment, and services;

(3) Evidence of the hospital's attempt to perform primary source verification as soon as possible.

If, due to extraordinary circumstances, primary source verification cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible.

(g) It is recommended that the practitioner be paired with a currently credentialed medical staff member (in the same specialty or as close of specialty as can be matched under the circumstances) and should act only under the direct supervision of medical staff member. Within 72 hours, the hospital will make a decision based on information obtained regarding the professional practice of the volunteer practitioner whether or not to continue to allow this practitioner to provide care. If primary source verification cannot be obtained within 72 hours, the provider will be evaluated and granted privileges every 24 hours or until primary source verification can be completed.

(h) Approved practitioners should be issued temporary identification badges which clearly indicate the practitioners are temporarily approved to provide disaster assistance.

(i) When the disaster situation no longer exists, these temporary disaster privileges terminate and no notice of such termination need be provided.

8.5 Leave of Absence and Reappointment

Individuals appointed to the Medical Staff or practitioners granted clinical privileges may, for good cause, be granted leaves of absence by the Board for a definite, stated period of time. A leave of absence is an excused absence from responsibilities, duties, and privileges for a specified period of time of sixty (60) days but not exceeding twelve (12) months or beyond the present term of the practitioner's appointment / privileging term.

(a) Absence for longer than the period of time granted or longer than twelve (12) months shall constitute voluntary resignation of clinical privileges and Medical Staff appointment, if applicable, unless an extension is requested in writing at least thirty (30) days prior to the end of the leave and granted by the Board upon recommendation of the Medical Executive Committee.

(b) Extensions will be considered only in extraordinary cases of hardship and when extension of a leave is found to be in the best interest of the Hospital.

(c) Requests for leave of absence shall state the start and anticipated end date of the requested leave and the reasons for the leave (such as military duty, additional training, family matters or personal health). Failure of a practitioner to return or apply for an extension of leave shall constitute a voluntary resignation of clinical privileges and Medical Staff appointment, if applicable, and shall not be subject to any hearing or appellate review. A request for Medical Staff membership or clinical privileges subsequently received from a staff member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for reappointment / re-privileging.

(d) If the leave of absence was for medical reasons, then upon return the practitioner must submit a report from his or her attending physician indicating that the practitioner is physically and/or mentally capable of resuming a hospital practice and exercising the clinical privileges requested competently and safely. The practitioner shall also provide such other information as may be requested by the MMT or MEC at that time. All information shall be forwarded by the CMO to the MMT. After considering all relevant information, the MMT shall then make a recommendation regarding reinstatement to the MEC which shall make recommendation to the governing body for final action.

(e) If a leave of absence is requested to take remedial training as a result of corrective action or probation, the practitioner, after completion of the training, must present to the appropriate Service Chief and to the MMT satisfactory evidence that the special education/training corrected the deficiencies in clinical performance. The MMT shall evaluate the evidence presented and shall make a recommendation to the MEC. The MEC will act upon that recommendation and forward its recommendation to the governing body for final approval. Any monitoring, review or similar processes affecting the practitioner prior to the leave of absence shall resume upon return of the practitioner from the leave.

(f) A practitioner in good standing who is granted a leave of absence for special training in his or her specialty to acquire new knowledge and/or skills shall present evidence of competence in the new or different procedure(s) to the department chair and the MMT. After review, the recommendations of the MMT shall be forwarded to the MEC and the governing body for appropriate action.

(g) Subject also to the conditions set forth above for specific types of leave, at the conclusion of the leave of absence, the practitioner may request reinstatement by filing a written statement with the CMO summarizing any relevant professional activities undertaken during the leave of absence. The practitioner shall also provide such other information as may be requested by the MMT at that time. Notice of the practitioner's intent to return from leave must be received a minimum of 30 days before the termination of the leave of absence. The MMT will review the request and make a recommendation to the MEC and to the governing body regarding reinstatement. Reinstatement after a leave of absence is a matter of courtesy, not of right.

(h) During the period of leave, the practitioner shall not exercise clinical privileges at the Hospital and membership rights and responsibilities shall be inactive but the obligation to pay dues, if any, shall continue unless waived by the MEC.

(i) The practitioner shall be responsible for obtaining coverage for his or her patients during the leave.

(j) A leave of absence may not extend beyond the term of the practitioner's current term of appointment / privileging. If the practitioner is not ready to return from leave before his or her current appointment / privileging term is set to expire, any application for reappointment / re-privileging will be held in abeyance for up to two years until the practitioner identifies with reasonable certainty the date of anticipated return from leave. The practitioner will then be required to supply interval data through the date of the notice of anticipated return from leave to begin the reappointment / re-privileging process. The practitioner's clinical privileges and Medical Staff membership, if applicable, shall be considered expired between the time of the expiration of the term in which the leave began and the date of reappointment / re-privileging.

8.6 Orders From Individuals Without Clinical Privileges or Medical Staff Membership

The Hospital may accept and execute orders for outpatients from health care professionals who are not members of the Medical Staff or the Advanced Practice Clinician staff and who have not been granted any clinical privileges at the Hospital only if all the following conditions are met:

(a) The order is within the scope of practice, as established by state law, of the ordering professional.

(b) The ordering professional is currently licensed, certified or registered in any state in a field of practice recognized by Wisconsin law and, upon the Hospital's request, provides evidence satisfactory to the Hospital of such current licensure, certification or registration.

(c) The ordering professional is not excluded from any federally-funded health program (such as Medicare or Medicaid).

(d) The order can be executed within the standards of the applicable disciplines under which the order is to be performed without the presence or supervision of the ordering professional, e.g. radiology exams, lab tests, therapies.

(e) The ordering professional does not hold himself or herself out to be associated or affiliated with the Hospital or its Medical Staff.

(f) Refer to the procedure on Verification of Non-Affiliated Providers approved by the MEC and Board of Trustees.

SECTION 9 – IMMUNITY FROM LIABILITY

9.1 The following shall be express conditions to any individual's application or reapplication for, or exercise of, clinical privileges or Medical Staff membership at the Hospital:

(a) Any act, communication, report, recommendation or disclosure, with respect to any individual, performed or made for the purpose of achieving and maintaining quality patient care and patient safety in this or any other health care facility, shall be privileged to the fullest extent permitted by law;

(b) Such privileges shall extend to members of the Medical Staff, administration and the governing body, the CMO and any of their designated representatives and to third parties who supply information to or receive information from any of the foregoing authorized to receive, release, or act upon the same. For the purposes of this Section, the term "third parties" means both individuals and organizations who have supplied information to or received information from an authorized representative of the Hospital (including the governing body, the Medical Staff, or administration) and includes but is not limited to individuals, health care facilities, governmental agencies, quality improvement organizations and any other person or entity with relevant information;

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

(d) Such immunity shall apply to all acts, communications, reports, or disclosures performed or made in connection with this or any other health care institution's activities related to, but not limited to:

(1) Applications for appointment or clinical privileges;

(2) Monitoring of new members of the staff or of any other practitioner or affiliated provider;

(3) Ongoing Professional Practice Evaluation for reappointment or clinical privileges;

(4) Corrective action, including suspension;

(5) Hearings and appellate reviews;

(6) Medical care evaluations;

(7) Utilization reviews;

(8) Profiles and profile analysis;

(9) Malpractice loss prevention; and

(10) Other hospital, departmental, service or committee activities related to quality, safe, and efficient patient care and professional conduct.

(e) The acts, communications, reports, recommendations and disclosures referred to in this Section may relate to a practitioner's professional qualifications, clinical competency, character, health status, ethics, or any other matter that might directly or indirectly have an effect on patient care;

(f) Each practitioner who exercises clinical privileges or performs any service that is monitored as a condition of exercising the clinical privileges or performing the service, shall indemnify and hold harmless all members of the Medical Staff and governing body, the CMO and their designated representatives from any liability arising from or out of the services performed by the practitioner being monitored, including but not limited to claims of malpractice, negligent supervision, and any other basis. The exercise of clinical privileges or performance of any service that is

monitored constitutes the practitioner's acceptance of the terms of this indemnification agreement;

(g) To reaffirm the immunity intended by this Section, each practitioner shall, upon request of the Hospital, execute releases acknowledging the immunity and protections set forth in this Section in favor of the individuals and organizations specified in Section 1.1(b). Execution of such releases is not a prerequisite to the effectiveness of this Section; and

(h) The consents, authorizations, releases, rights, privileges and immunities provided by Section 9 of these Bylaws for the protection of this Hospital's practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointments / clinical privileges, shall also be fully applicable to the activities and procedures covered by this Section. All provisions in these Bylaws and in other forms used in the credentials process relating to authorizations, confidentiality of information and immunity from liability are in addition to and not in limitation of other immunities provided by law.

SECTION 10 – INTERVIEWS, HEARINGS AND APPELLATE REVIEW

10.1 Interviews

(a) When the MEC or the governing body is considering initiating a professional review action concerning a practitioner (other than immediate suspension) and the practitioner has not previously been afforded an opportunity for an interview with any preliminary investigating body as to the subject matter forming the basis of the professional review action, the practitioner shall be afforded an interview with the body initiating the professional review action. Such interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The practitioner shall be informed of the general nature of the circumstances and may present information relevant thereto. A record of this interview shall be made.

(b) For the purposes of this section, a preliminary investigating body may be a Service Chief, a committee or committee chair, the MMT, or the CMO or any other designees acting in the official capacities who provided information or a recommendation to the MEC or governing body upon which the MEC's or governing body's professional review action is based.

10.2 Hearings and Appellate Review

(a) When any practitioner receives notice of a professional review action of the MEC, the practitioner shall be entitled, upon request, to a hearing before a hearing committee of the Medical Staff, as outlined in the Plan. If the recommendation of the MEC following such hearing is still adverse to the practitioner, the practitioner shall then be entitled, upon request, to an appellate review by the governing body before a final decision is rendered.

(b) When any practitioner receives written notice of a professional review action by the governing body taken contrary to a favorable recommendation by the MEC where no right to a hearing existed, such practitioner shall be entitled, upon request, to a hearing before a hearing committee appointed by the governing body, as outlined in the Plan. If such hearing does not result in a favorable recommendation, the practitioner shall then be entitled, upon request, to an appellate review by the governing body before a final decision is rendered.

10.3 Procedure and Process

All hearings and appellate reviews shall be in accordance with the procedures set forth in the Plan appended to these Bylaws as Appendix A and incorporated into these Bylaws by reference. The MEC shall have the authority to recommend amendments to the Plan, which amendments shall become effective when approved by the governing body.

10.4 Exceptions

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

10.5 Removal of Hospital Employed Physician

Removal from office of a Hospital employed physician or termination of a contract for exclusive privileges may be accomplished in accordance with the terms of such practitioner's contractual agreement. Removal or termination of a contract that provides for the exclusive exercise of clinical privileges by the contracting entity shall terminate the clinical privileges covered by the contract and the termination shall not create any right to a hearing under the Plan. If the termination of an exclusive contract terminates all the clinical privileges held by the practitioner, the practitioner's Medical Staff membership shall also be considered terminated but such termination shall not create any right to a hearing under the Plan.

SECTION 11 – MEDICAL STAFF STRUCTURE

11.1 Medical Executive Committee

(a) Composition. The MEC shall be composed of no fewer than nine and no greater than 15 voting members, five of which will be the Service Chiefs and the CMO. In addition, the President, VP of Nursing, VP of Quality & Safety, and Medical Staff Coordinator or their specified designees shall meet with the MEC as a non-voting member.

(b) Nomination and Selection of Members:

(1) Five of the members of the MEC will consist of the CMO and the employed medical directors who shall also serve as Service Chiefs and are actively participating in the hospital. These five members shall be selected and directly appointed by the governing body, shall have full voting rights, and shall be called the Medical Management Team (MMT). The remaining members of the MEC shall be selected from a slate of actively participating Medical Staff members nominated pursuant to Section 1.1(b)(2).

(2) The MMT shall serve as the Hospital's nominating committee. The MMT shall consider the authority, duties and responsibilities of the MEC, as outlined by these Bylaws, when considering active staff members for nomination as an at-large member of the MEC. The MMT shall develop a process of solicitation and input into potential candidates for nomination and recommend to the governing body by September 1st yearly at least four active staff members to be nominated for election by the active Medical Staff to serve as at-large members of the MEC. If the governing body rejects any recommended nominee, the MMT shall propose one or more replacement candidates until at least four candidates have been approved. Prior to October 1st yearly, the MMT also will develop a slate of potential candidates for any anticipated vacancies of the elected members of the MEC.

(c) Membership Requirements. Active Medical Staff members may be considered eligible for appointment or election to the MEC. Also eligible for appointment or election to MEC are Medical Staff who do not regularly admit but who serve on formal committees, serve on process improvement teams or in other ways approved by the MEC which provide services to the medical staff organization to enhance its mission and purpose. All practitioners eligible for appointment or election to the MEC must:

(1) Demonstrate ability to establish professional and collegial relationships;

(2) Be committed to the mission, vision, values and strategic plan of the Hospital;

(3) Demonstrate commitment to the continuous performance improvement activities of the Medical Staff and the Hospital;

(4) Be respected by their peers; and

(5) Be aware of and willing to enforce compliance with these Bylaws, the Medical Staff Code of Conduct and Conflict of Interest Policy and the Ethical & Religious Directives for Catholic Health Care Services. This enforcement applies only to the Hospital proper and not to other locations and programs not under the Hospital's control or ownership.

(d) Selection of At-Large Members. The Medical Staff shall select from among the medical staff members nominated by the MMT a minimum of four and no more than ten individuals to serve as at-large members of the MEC. They shall be selected by means of a written ballot from the slate nominated by the MMT and approved by the governing body. During election years, the official ballot will be emailed on or before October 1st. If there is no available email address, the official ballot will be mailed to the preferred mailing address identified by the active staff member and supplied to the Medical Staff office. If an active staff member has not indicated a preferred address, the ballots will be sent to the active staff member's office address currently on record. The elected members of the MEC shall be selected by majority vote of the official ballots returned to the Medical Staff office by October 21st or if this dates falls on the weekend, the preceding Friday.

(e) Replacement of Members. In the event of any vacancy, for any reason, on the MMT, the Chair of the governing body, or his or her designee, shall promptly fill the position with a qualified physician after consultation with the President (and the CMO, if it is not the CMO position). MEC members appointed in this fashion shall have a term equal to the remainder of the term of the member they are replacing.

(f) Removal of Members. The governing body also retains the prerogative to remove an elected member of the MEC at any time. The MEC will recommend to the governing body and Medical Staff, subject to ratification of the Medical Staff, a replacement to complete the remainder of the term for elected members of the MEC removed in this manner and for other vacancies in the elected members of the MEC.

(1) The Active staff members may also remove any at large member of the MEC, if 15% of the Active staff members sign a petition calling for the removal of an MEC member, and a two-thirds majority of all the Active staff members vote for removal. Any resulting vacancy shall be filled by an election or appointment of a replacement in a manner as determined by the MMT, subject to governing body approval. A person so removed shall not be eligible for re-election for a period of two years following removal.

(2) Reasons for removal of a member of the MEC include but are not limited to:

(i) failure to adequately discharge or carry out with good faith objectivity the duties of the position;

(ii) actions contrary to the philosophies, policies or mission of the Hospital; and

(iii) failure to meet the conditions of and qualifications for membership on the active Medical Staff.

(3) The CMO shall serve as Chair of the MEC and the MMT. The CMO must fulfill the contractual obligations and duties as stipulated by the governing body, in consultation with the President and the MEC, and consistent with these Bylaws.

(4) The appointed and elected MEC members shall contract with the Hospital to perform the duties required for the proper operation of the MEC and MMT. Such contracts shall be for the length of the term of office of the MEC member, as stipulated in the Bylaws.

(5) The terms of the elected MEC members shall be two years unless the members are selected to fill a vacancy. Office terms also may be shorter than two years to achieve appropriate staggering of terms as determined by the MMT and the governing body.

Prior to the end of the contracted term of office of the appointed members of the MEC, the governing body shall authorize the MMT to review the performance of these members and supply recommendations to the governing body regarding renewal of the contracts of the appointed MEC members.

(6) All members of the MEC, whether elected or appointed, shall be required to sign the Hospital's Conflict of Interest Statement and Confidentiality Agreement.

11.2 Duties and Responsibilities of the MEC

(a) The elected and appointed members of the MEC shall meet as often as necessary (which generally will be monthly), shall have full voting authority on matters presented to the MEC, and shall perform other duties and functions as the MEC and the governing body shall so determine from time to time. The members of the MEC will be expected to participate in training and fulfill the additional expectations and requirements of MEC membership as outlined under Section 1.1(c) above. The Hospital shall provide MEC members with training and leadership skill development in order to permit MEC members to perform their required tasks. The appointed members of the MEC shall have additional duties as outlined under Sections 11.2(c) of these Bylaws.

(b) The MEC shall be delegated sufficient authority and responsibility by the governing body to fulfill the requirements set forth in these Bylaws or as may be otherwise assigned by the governing body.

(c) The MEC shall be responsible for:

(1) assuring that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital receive appropriate, safe and quality medical care;

(2) serving as the primary means for providing assurances to the governing body as to the appropriateness of the professional performance and ethical conduct of its members and to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available;

(3) providing a means through which the Medical Staff may participate in the Hospital's policy-making and planning process;

(4) developing and implementing policies, procedures, rules and regulations governing the Medical Staff;

(5) developing, administering and monitoring compliance with these Bylaws, the rules and regulations of the Medical Staff, Medical Staff policies and other patient care related Hospital policies;

(6) making recommendations to the governing body related to the appointment of medical staff members

(7) making recommendations to the governing body related to the granting and re-granting of the clinical practice privileges of each medical staff member and Advanced Practice Clinicians / Authorized Providers;

(8) taking appropriate corrective or disciplinary action regarding medical staff members and Advanced Practice Clinicians / Authorized Providers;

(9) implementing the hearing and review process as outlined in the Plan;

(10) reviewing the Focused Professional Practice Evaluation for Medical Staff and those staff granted privileges for the first time or adding a new privilege(s) and making recommendations, as needed, for improving a provider's performance;

(11) reviewing Ongoing Professional Practice Evaluation, which includes peer review, and making recommendations, as needed, for improving a provider's performance.

(12) participating in formulation of performance improvement plans, including effective implementation, maintenance and annual review of these plans;

(13) formulation, effective implementation, maintenance and annual review of the Hospital's utilization and case management plans;

(14) establishing and maintaining a physician health committee;

(15) evaluating for quality and utilization of the provider based and contracted services, including but not limited to radiation therapy, radiology, pathology, hospitalist, anesthesiology, emergency and outpatient services;

(16) working with the Hospital in obtaining and maintaining all accreditations, including radiation safety;

(17) assisting the governing body in identifying community health needs, in setting appropriate institutional goals and in implementing programs to meet these needs.

(18) acting on behalf of the organized Medical Staff between Medical Staff meetings.

(19) making recommendations directly to the governing body on at least the following:

(i) Medical staff membership

(ii) Organized Medical Staff structure

(iii) Process used to review credentials and delineate privileges

(iv) Delineation of privileges for each practitioner privileged through the Medical Staff process

(v) Reviews and acts on reports of Medical Staff Committees, Departments and other assigned activity groups

(d) The MEC may create regular or special committees of medical staff members and staff as required to perform department functions. The resolution creating such committees shall include the purpose of the committee, the reporting responsibility of the committee, and the authorized duration of the committee not to exceed 12 months. All committees so authorized will be reviewed at least once yearly and may be authorized for additional duration at the discretion of the MEC. Standing committees identified in these Bylaws are not subject to this provision.

(e) The MEC shall implement a program of regular communication with the medical staff members and staff of the Hospital. This can include, but is not limited to scheduled periodic meetings of all staff members, e-mail communications, distribution of reports, minutes and meetings of the department sections.

(f) When outside federal or state agencies or governing law define activities and responsibilities as functions which are to be provided or performed by a Medical Staff as a whole or a medical MEC, or other committee of a Medical Staff of a hospital, absent action by the governing body assigning such functions to another committee or entity of the Hospital, the MEC shall be authorized to, and will undertake to perform or arrange for the performance of all such functions.

11.3 Meeting and Procedural Rules of the MEC

(a) The MEC shall meet as often as necessary, which generally will be monthly. The MEC may take action at any meeting if six of the voting members are present.

(b) The majority of the members present will constitute the action of the MEC, unless otherwise stipulated in these Bylaws.

(c) The MEC may take action without a meeting if a written consent which sets forth the action to be taken is unanimously approved and signed by all members of the MEC. Any or all members of the MEC may participate in a meeting of the MEC by or through the use of any means of communication by which either of the following occurs: (a) all Active members may simultaneously hear each other during the meeting, or (b) all communication during the meeting is immediately transmitted to each Active member, and each Active member is able to immediately send messages to all other Active members. A member Active in such a meeting is deemed to be present in person at the meeting.

(d) Special meetings of the MEC can be called at any time by the CMO or any three members. A 48-hour notice is required.

(e) The MEC shall establish and adhere to regular meetings, maintain complete minutes of its activities, and provide or make written reports available to the governing body.

(f) An Active staff member can arrange, upon notice to the CMO, to meet and confer with the MEC at any regularly scheduled meeting, contingent upon CMO approval and with at least 48 hours advance notice to the MEC.

(g) The following actions require MEC participation and cannot be delegated to another committee or subcommittee:

(1) Amendments to the Bylaws

(2) Approval of Medical Staff Policies and Procedures

(3) Recommendations concerning individual practitioners with respect to corrective action or quality/utilization review activities

(4) Recommendation of denial or approval of affiliation and clinical privileges of individual practitioners

(h) Policies and procedures adopted by the MEC shall be forwarded to the President for approval and will be shared with the medical staff for information purposes only. Policies involving appointment, reappointment, and clinical privileges and suspension, restriction, or termination of membership or privileges require governing body approval.

11.4 Duties & Responsibilities of the MMT

(a) The Medical Management Team (MMT) shall be composed of the CMO and the four other appointed members of the MEC. Each of the appointed members of the MMT, other than the CMO, shall also serve as a Service Chief. The Service Chief shall be certified or otherwise qualified in an appropriate medical specialty and exhibit clinical skills and professional judgment suitable to the expectations of the position. The MMT shall also include other administrators chosen by the CMO, as non-voting members.

(b) The MMT shall meet as a subcommittee of the MEC, or in conjunction with the full MEC. Additional meetings may be called at the discretion of the CMO or as determined by the MEC.

(c) The MMT may take action at any meeting as long as three voting members are present.

(d) The MMT shall be responsible for and recommend to MEC the following actions:

(1) coordinating activities of the hospital departments and Service Chiefs and addressing any interdepartmental issues;

(2) credentialing functions, including reviewing and recommending to the MEC the appointment of all new applicants, and coordinating with the Service Chiefs in the reappointment / re-privileging process;

(3) developing and implementing FPPE for Medical Staff, Advanced Practice Clinicians and other staff granted privileges for the first time or adding a new privilege(s) at Hospital;

(4) developing and implementing OPPE, as part of the peer review process, for providers and evaluating on an ongoing basis any concerns regarding provider competency that are raised by the Service Chiefs, appropriate committees, quality process or peer review process;

(5) identifying the need for focused professional practice evaluation on any provider with existing privileges when questions arise regarding a provider's ability to provide safe, high quality patient care as a result of a single incident or during the course of an ongoing professional practice evaluation or because of infrequent use of specific privileges. The type of monitoring to be conducted may include chart review, monitoring clinical practice patterns, direct observation, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient. The number of cases for evaluation and measures employed to resolve performance issues will be individualized for each practitioner as determined by the Medical Management Team;

(6) reviewing and revising of credentialing and privileging criteria as are recommended by the Quality Department and Service Chiefs;

(7) implementing performance improvement plans for the Medical Staff as approved by the MEC and the governing body;

(8) establishing committees as required to perform functions;

(9) working with the Hospital's Medical Staff and Clinical Quality Department to review the quality data and assign specific concerns to the appropriate departments for further investigation and recommendation including focused review, when necessary, as defined in these Bylaws.

(10) reviewing the yearly plan for performance improvement recommended by each hospital department and Service Chief before final approval by the MEC and the governing body, and receiving periodic progress reports from the departments concerning these quality action plans;

(11) serving as the Medical Staff Peer Review Committee;

(i) Peer review issues and issues identified through OPPE will be reviewed by the MMT after review by the appropriate Service Chief or hospital department or when the appropriate Service Chief fails or refuses to address a peer review issue after being given the opportunity to do so;

(ii) The recommendations of the department and/or Service Chief will then be reviewed by the MMT before a final report is made to the MEC;

(12) assuring the quality and timely completion of medical records;

(13) assuring that the Education & Development Shared Service Operation, which manages continuing medical education functions, is aware of issues of special concern identified by the CMO and Quality Management Department, the MMT, the MEC or Service Chiefs which might benefit from specific CME programs;

(14) reviewing the Bylaws periodically;

(15) making recommendation for revisions in the Bylaws to the MEC;

(16) working with the Hospital leadership to ensure the coordinated, safe, and effective operations of the Hospital and all related patient care services; some of these functions may be delegated to specific standing committee or to ad hoc committees as determined by the MEC, MMT, President or CMO.

11.5 Officers of the Medical Staff

(a) The officers of the Medical Staff shall be the CMO, who serves as the Chief of Staff and Chair of the MEC. The duties of the Chair of the MEC are as listed below. Any Medical Director/Service Chief shall assume the duties of the Chair in his or her absence. These duties will be delegated by the CMO in his or her capacity as Chair of the MEC.

(b) The Chair of the MEC is the Medical Staff's advocate and representative in its relationships to the governing body of the Hospital and the administration of the Hospital. The Chair of the MEC, jointly with the MMT, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff. Specific responsibilities and authority are to:

(1) call and preside at all general and special meetings of the Medical Staff;

(2) serve as chair of the MEC and MMT, and as a non-voting member of all other Medical Staff committees;

(3) participate, without voting privileges on the governing body and its committees;

(4) enforce bylaws, rules and regulations, policies and procedures of the Medical Staff and Hospital;

(5) appoint committee chairpersons and all members of the Medical Staff standing and ad hoc committees, in consultation with the President and MMT. Committee chairpersons will be asked for their input concerning membership before final recommendations are made. Committee memberships shall be subject to MMT review and final approval;

(6) support and encourage Medical Staff leadership in and participation on interdisciplinary clinical performance improvement teams;

(7) report to the governing body on the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges, and corrective action with respect to practitioners and Advanced Practice Clinicians who are applying for appointment or privileges, or who are granted privileges or providing services in the Hospital;

(8) continuously evaluate and annually report to the MEC, MMT and the governing body regarding the effectiveness of the credentialing and privileging processes;

(9) review compliance with and enforcement of the Ethical & Religious Directives for Catholic Health Care Services among the members of the Medical Staff in their relations with each other, the governing body, the Hospital leadership, other professional and support staff, and the community the Hospital serves;

(10) communicate and represent the opinions and concerns of the Medical Staff and its individual members on matters affecting the Hospital operations to the President, the MEC and the MMT;

(11) ensure that the decisions of the governing body are communicated to and implemented by the Medical Staff; and

(12) perform such other duties and exercise such authority commensurate with the office as are set forth in these Bylaws.

11.6 Service Structure

(a) The Medical Staff shall be non-departmentalized. Leadership and coordination of required activities within and between services and hospital departments will be responsibility of the Chief Medical Officer and Service Chiefs: Surgical/Anesthesia, Women and Families, Emergency/Diagnostics & Therapeutics, Medicine/Hospitalist.

(b) The Chief Medical Officer shall be responsible for:

(1) Overseeing and managing the functions of the Medical Staff and associated committees. Ensures adherence to Medical Staff processes.

(2) Overseeing medical quality initiatives and programs for Saint Clare's Hospital. Assesses the quality of medical care to patients, identifies areas that need improvement, and develops and implements systems for improvement. Participates in clinical practice guideline development and implementation.

(3) Directing utilization management efforts for Saint Clare's Hospital, including prospective, concurrent, and retrospective assessment of patient care. Makes recommendations as to the dissemination of medical resources.

(4) Serving as liaison between the various hospital medical directors and medical staff and administrative personnel. Serves as liaison between the various systems inside and outside the organization, including other medical organizations in the community, consumers, and other systems that may affect the business of the group.

(5) Developing in conjunction with Chief Operating Officer and implementing a quality management and risk management program. Reviews information collected and passes along to appropriate parties for feedback to physicians.

(6) Managing the process for dealing with impaired professionals.

(7) Mediating professional disputes and interdepartmental problems involving physicians, as needed and presents issues(s) to the appropriate governing body of the hospital.

(8) Resolving grievances from or involving physicians through the medical staff governance structure. Ensures appropriate processes are in place for handling grievances against physicians, nurses, other staff, etc. Responds to complaints in a timely fashion and in accordance with established guidelines.

(9) Monitoring patient care and standards of care in the hospitals throughout the organization in order to ensure that the medical staff efforts meet or exceed the standards of the various accrediting organizations. Responsible for seeing that the organization is prepared for all audits or accreditation visits by any state, federal, or accrediting bodies.

(10) Monitoring medical compliance programs.

(c) The Service Chiefs shall be responsible for:

(1) Clinically related activities of the service.

(2) Administratively-related activities of the service, unless otherwise provided by the hospital.

(3) Ongoing surveillance of the professional performance of all individuals exercising privileges within the service including evaluation of OPPE information.

(4) Recommending to the MMT the criteria for clinical privileges that are relevant to the care provided in the service.

(5) Recommending clinical privileges for each member within the service including FPPE for Medical Staff, Advance Practice Clinicians, and other staff granted privileges for the first time or adding a new privilege(s) at Hospital.

(6) Assessing and recommending to the MEC and President off-site sources for needed patient care, treatment, and services not provided by the service or the organization.

(7) The integration of the service into the primary functions of the organization.

(8) The coordination and integration of hospital interdepartmental and intradepartmental services.

(9) Intraservice and interservice coordination and integration.

(10) The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

(11) The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

(12) The determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

(13) The continuous assessment and improvement of the quality of care, treatment, and services.

(14) The maintenance of quality control programs, as appropriate.

(15) The orientation and continuing education of all persons within the service.

(16) Recommending space and other resources needed by the service.

(17) Participating in the peer review process as related to the members exercising privileges within the service as directed by the MMT or CMO, the MEC.

(d) The Service Chief shall recommend to the MEC those other committee assignments needed to comply with the assigned functions of the service.

11.7 Medical Staff/Hospital Board Liaison Committee

Disagreements between the MEC and the governing body shall be referred to the Medical Staff/Hospital Board Liaison Committee for further discussion and action. The Committee shall meet on an as needed basis and shall consist of the three MEC members chosen by the CMO and three members of the governing body chosen by the chair of the governing body. The members of the governing body shall include the chair of the governing body, or designee. The President shall also be invited as a non-voting member. The Committee shall review all the pertinent information and make a recommendation to the governing body for final action.

11.8 Standing Committees

(a) The MEC, at its discretion, may establish committees of staff members as indicated in Section 311. Furthermore, the MEC shall establish the Infection Prevention and Control Committee, Pharmacy and Therapeutics Committee, Performance Improvement Committee, Blood Transfusion Committee, Peer Review Committee, Physician Health Committee, as Standing Committees of the Medical Staff. The Chairs of the Standing Committees shall be appointed by the CMO, in consultation with the President. The members of the Committees shall be selected by the Chair of the Committees, in consultation with the CMO and the President. Appointment of a staff member to a Standing Committee is for a two-year term which can be renewed at the discretion of the Committee Chair and the CMO. Committee members may be removed at any time, at the discretion of the Chair of the Committee or the CMO. The Standing Committees shall meet on a regularly scheduled basis and as necessary to carry out their responsibilities, shall record minutes of all meetings, and shall provide reports to the MEC. All Standing Committees are responsible for participating in and monitoring quality improvement activities. The composition and function of each Standing Committee is detailed in a policy statement. All members are eligible to vote.

(b) The MEC, the Medical Staff/Hospital Board Liaison Committee, the MMT and the Standing Committees are major components of the Hospital's program, organized and operated to help improve the quality of health care in the Hospital, and their activities will be conducted in a manner consistent with the provisions of §§ 146.37 and 146.38 of the Wisconsin Statutes. The peer review protections of these statutes, including the protection of the confidentiality of committee records and proceedings, are intended to apply to all activities of the committees relating to improving the quality of health care and include activities of the individual members of the committees, as well as other individuals designated by the committees to assist in carrying out the duties and responsibilities of the committees, including but not limited to participating in monitoring plans.

(c) Infection Prevention and Control Committee shall:

(1) Be responsible for surveillance of the Hospital for potential and actual infections, promotion of preventive or process improvement programs designed to minimize the risk of infection and the supervision of infection control processes in all areas of the Hospital, including the operating rooms, delivery rooms, recovery rooms, and special care units; and

(2) Supervise sterilization procedures, isolation procedures, procedures aimed at reducing cross infection by anesthesia apparatus or inhalation therapy, procedures for testing the Hospital or its personnel for carrier status, procedures and processes for disposal of infectious materials, and any other infection related processes as requested by the President or the MEC.

(d) Pharmacy and Therapeutics Committee shall:

(1) Be responsible for the development of a formulary and policies and procedures concerning drug utilization within the Hospital in order to obtain the best clinical results at the least potential for hazard; and

(2) Work with the Hospital leadership to develop a process, which includes ongoing monitoring and process improvement activities, to reduce medication errors, especially adverse drug reactions.

(e) Performance Improvement Committee. The Performance Improvement Committee shall:

(1) Be responsible for the formulation, effective implementation, maintenance, and annual review of the performance improvement and patient safety plan.

(2) Create reports to assist practitioners and hospital staff in determining the quality and safety of patient care provided by the Hospital.

(f) Blood Transfusion Committee. The Blood Transfusion Committee shall:

(1) Review transfusion results related to the transfusion process, qualification of transfusion requisitions, and transfusion reactions. Results are shared with medical staff and the MEC.

(2) Promote effective communication between clinicians and the blood bank.

(g) Peer Review Committee. Refer to Section 7.

(h) Physician Health Committee. The Physician Health Committee shall be composed of at least three members of the Medical Staff appointed by the CMO. The Committee's role is to provide compassionate assistance to Medical Staff members and those concerned about these members because of problems of health which might impair the member's ability to practice medicine. The policy governing the function and scope of the Committee will be reviewed by the MMT on an annual basis and be approved by the governing body.

SECTION 12 – MEETINGS

12.1 Staff Meetings

Meetings of the Medical Staff shall be convened as deemed necessary by the MEC. Such meetings may include general meetings of the full medical staff, medical staff forums, and advisory groups.

12.2 Special Meetings

(a) Special meetings of the Medical Staff may be called at any time by the CMO, and shall be called at the written request of the governing body, the MEC or at least 25% of the Active Medical Staff. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Notice of a special meeting shall be given to each member of the Active Medical Staff in writing, electronically or by telephone at least 48 hours before the time set for the special meeting. The special meeting shall be held within 10 business days after the written request is presented to the CMO.

(b) Attendance at Meetings.

(1) Active Medical Staff members are expected to attend all meetings of the general Medical Staff.

12.3 Quorum

Thirty percent of the total membership of the Active Medical Staff shall constitute a quorum for general meetings of the Medical Staff. A quorum for committee and department meetings shall consist of 50% of the members of such committee or department who are eligible to vote. A quorum is necessary in order to hold a meeting.

12.4 Eligibility to Vote

(a) Medical Staff Matters. To vote at a Medical Staff meeting on Medical Staff business, a Medical Staff member must be a member of the Active staff.

(b) Committee Matters. Except as otherwise stated in these Bylaws, only Active Medical Staff members appointed in accord with these Bylaws to the committee that is conducting the business at issue shall be entitled to vote upon matters before that committee.

(c) Good Standing. In addition to the eligibility requirements set forth above, a Medical Staff member must be in good standing at the time of the vote for such vote to be counted.

12.5 Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of attendance of members and the vote taken on each matter. The minutes shall be filed electronically with review available to medical staff members on the hospital intranet. The minutes shall thereafter be forwarded to the MEC. Each committee shall maintain a permanent electronic file of the minutes of each meeting. All Medical Staff members may have access to meeting minutes that are not otherwise privileged and confidential, by accessing them on the hospital intranet.

SECTION 13 – RULES AND REGULATIONS

13.1 Staff Rules and Regulations

The Medical Staff shall adopt such Rules and Regulations that are recommended by the MEC as may be necessary for the proper conduct of the work of the Medical Staff and to implement more specifically the general principles set forth in these Bylaws. Such Rules and Regulations shall be appended to these Bylaws as Appendix B. Rules and Regulations may be amended or repealed at any regular meeting of the Medical Staff upon the recommendation of the MEC by a majority vote of a quorum of the Medical Staff, provided at least ten days notice, accompanied by the proposed Rule or Regulation and/or alterations has been given of the intention to take such action. Such changes shall become effective when approved by the governing body.

Members of the active medical staff may challenge any rule or policy established by the MEC. In the event that a rule, regulation, or policy is thought to be inappropriate, the medical staff member(s) may submit a petition signed by 25% of the members of the active category. On presentation of such a petition, the physician(s) submitting the petition shall be invited to meet with the MEC. If following the meeting there is no resolution between the petitioners and the MEC, the petitioners may submit language for a revised or new rule or policy to the Medical Staff, the adoption procedure outlined in Section 14.2 will be followed.

13.2 History and Physical (H&P) Examination Requirements

(a) A H&P must be recorded by a member of the active, courtesy, limited or consulting Medical Staff (or provisional members in these categories), or by licensed health care provider granted privileges to do so. Completion of the H&P may be delegated to a non-privileged provider when a privileged provider reviews the document, assesses the patient to confirm the information and findings, updates information and findings as necessary and signs and dates the H&P as attestation to it being current.

(b) An H&P must be performed and documented for all patients admitted to the Hospital within 24 hours of admission. An H&P is required for both inpatient and medical observation-type (ambulatory) admissions. An H&P must be performed and documented prior to patients undergoing inpatient or outpatient surgical or other high-risk procedures requiring anesthesia services.

(c) The H&P may be completed no more that 30 days before admission or surgical or other high-risk procedure requiring anesthesia services. An update to the patient's condition is required at the time of admission when using an H&P that was performed before admission. A copy of the H&P as well as the H&P update must be present in the record within 24 hours of admission or prior to surgery or high-risk procedure requiring anesthesia services.

(d) The content of complete and focused history and physical examinations is delineated in the rules and regulations.

13.3 Administrative Procedures

(a) Administrative procedures which involve peer review, scope of practice by specialty or type of practitioner, and categories of practitioners who will be granted privileges all require review and approval by MMT, MEC and the Board of Directors.

(b) Clinical policies and procedures not related to privileges or scope of practice require review and approval by MMT and MEC.

(c) Administrative procedures and forms, including applications, reappointments, privileges and consent forms and procedures relating to Medical Staff Office administrative functions require only MMT approval.

SECTION 14 – ADOPTION AND AMENDMENT OF BYLAWS

14.1 Medical Staff Responsibility

The MEC shall have the initial responsibility to formulate the Medical Staff Bylaws, Rules and Regulations and any amendments, and to present them to the Medical Staff for adoption and recommendation to the governing body. Such Medical Staff Bylaws, Rules and Regulations, and amendments shall be effective when approved by the governing body.

Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, so as to have Bylaws, Rules and Regulations of generally recognized quality, to provide a basis for acceptance by accreditation agencies, to comply with supervising licensing authorities, and to provide a system of ongoing effective professional review.

14.2 Methodology

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

(a) The affirmative vote of two-thirds of the active staff eligible to vote on this matter as set forth in Section 11, who are present at a meeting at which a quorum is present, provided at least ten days written notice, accompanied by the proposed Bylaws and/or alterations, has been given of the intention to take such action;

(b) In the event that a quorum is not present to act on an amendment or in the event that it is necessary for the staff to act on an amendment without being able to meet, the voting staff may be presented with the proposed amendment by email (or mail, if necessary) and their votes returned to the CMO by email (or mail, if necessary).

(1) Ballots will be distributed via email to the Medical Staff and include the proposed amendment, a section to indicate their vote, instructions for return and a deadline for return of 14 days after the date of ballot distribution. If there is no available email address, the official ballot will be mailed to the preferred mailing address identified by the active staff member and supplied to the Medical Staff office.

(2) A minimum of 30% of the Active Staff, eligible to vote, shall be required to return ballots before votes will be tallied for amendments recommended by the MEC and a minimum of 60% for amendments not recommended by the MEC.

(3) To be adopted, a two-thirds affirmative vote from the ballots received shall be required.

(4) If the minimum percentage specified of the Active Staff ballots are not received by the deadline, the deadline shall be extended seven days. If by that deadline the minimum return threshold is not achieved, then the amendment shall be deemed adopted for amendments recommended by the MEC and shall be deemed rejected for amendments not recommended by the MEC.

(i) Amendments adopted by the Medical Staff shall be effective when approved by the governing body.

(ii) These Bylaws may not be unilaterally amended. In the event that the Medical Staff shall fail to exercise its responsibility and authority as required by this section, and after notice from the governing body to such effect, including a

reasonable time for response, the governing body may, upon its own initiative, formulate amendments to these Bylaws. In such event, Medical Staff recommendations and views will be carefully considered by the governing body during its deliberations and in its actions.

14.3 Effective Date

These Bylaws, together with the appended Rules and Regulations, shall be adopted at any regular meeting of the Active Medical Staff, shall replace any previous Bylaws, Rules and Regulations, and shall become effective when approved by the governing body of the Hospital. They shall, when adopted and approved, be equally binding on the governing body and the Medical Staff.

14.4 Review and Revision

The Medical Staff Bylaws, Rules and Regulations, and policies shall be reviewed periodically and revised as necessary. The review shall be undertaken through a procedure designated by the CMO and any proposed amendments and revisions of the Bylaws shall be adopted by the Medical Staff and governing body as provided in Section 14.

ADOPTED by the active Medical Staff of Saint Clare's Hospital of Weston, Inc.

Date _____ Chief Medical Officer _____

APPROVED by the governing body of Saint Clare's Hospital of Weston, Inc.

Date _____ Chair of Governing Body of Directors _____