CENTRACARE - RICE MEMORIAL HOSPITAL

301 BECKER AVENUE SW
WILLMAR, MINNESOTA

MEDICAL STAFF BYLAWS

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Definitions

1. AUTHORIZED REPRESENTATIVE or HOSPITAL'S AUTHORIZED REPRESENTATIVE means the individual designated by the hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws. Unless otherwise specified by the Medical Executive Committee, the individual will be the Physician Director-Acute Care of the hospital, or designee.

2. BOARD or BOARD OF DIRECTORS means the governing body having overall responsibility for the Hospital. Referred to as Willmar Area Advisory Committee with the Finance Committee serving as the designated governing body on alternate months.

3. CHIEF OF STAFF means the chief officer of the medical staff elected by members of the medical staff.

4. CORRECTIVE ACTION means the termination of medical staff membership or a restriction, reduction, modification or termination of clinical privileges for reasons of clinical incompetence or unprofessional conduct.

5. IN GOOD STANDING means, at the time of the assessment of standing, his/her membership and/or privileges are not involuntarily limited, restricted, suspended, or otherwise encumbered for disciplinary reasons (excluding leaves of absence).

6. INPATIENT means patients admitted to inpatient level of care requiring complex medical care with the expectation of the need for two or more midnights of medically necessary hospital care.

7. INVESTIGATION means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the medical staff.

8. MEDICAL STAFF, STAFF or MEMBER means those physicians (MD or DO or their equivalent as defined in Article 2.2-2A), oral surgeons (as defined in Article 2.2-2B), or podiatrists (as defined in Article 2.2.-2C) holding a current license to practice within the scope of his or her license who have been granted recognition as members of the medical staff pursuant to the terms of these bylaws.

9. PHYSICIAN DIRECTOR-ACUTE CARE means the lead local physician executive with responsibility for Rice Memorial Hospital with frequent conversation with the lead administrator in Willmar.

Article I - General

1.1 Name

The name of this organization is the Medical Staff of CentraCare - Rice Memorial Hospital.

1.2. Definitions

The definitions that apply to terms used in all the Medical Staff documents are set forth in these Bylaws as well as in the Credentials Policy.

1.3. Time Limits

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

1.4. Delegation of Functions

Functions assigned to an identified individual or committee may be delegated to one or more designees.

1.5. Medical Staff Dues or Assessments

1.5-1 Annual dues or assessments may be as recommended by the Medical Executive Committee and may vary by category. Dues will be payable annually upon request.

A. Annual dues of members of the Active Medical Staff of CentraCare - Rice Memorial Hospital shall be determined by the MEC on an annual basis in May of each year and shall be payable before September 1st. Individuals becoming members of the staff after December 31st, shall pay one-half the established dues.

B. Special assessments for any cause may be approved by a majority of the Active Staff present at any regular staff meeting. Special assessments shall apply only for the year in which the assessment is levied.

C. Original or re-application for any category of Medical Staff membership may have a nonrefundable fee, paid to the Hospital as an offset against the cost of the Credentialing process, which is billed semi-annually. The categories of Medical Staff membership to which a fee applies, and amount of the fee for the various categories, may be suggested by the Chief Executive Officer, but shall only take effect upon approval by the Medical Executive Committee.

1.5-2 The Medical Executive Committee will have the power to determine the manner of expenditure of such funds received.

1.5-3 The Secretary-Treasurer is the signatory on the Hospital's Medical Staff account.

Article II - Membership

2.1 Nature of Membership

No practitioner shall be entitled to membership on the medical staff or to clinical privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

No physician, oral surgeon, or podiatrist, including those in a medical administrative position by virtue of a contract with the hospital, shall admit or provide medical or health-related services to patients in the hospital unless he/she is a member of the medical staff or has been granted telemedicine, locum tenens or temporary privileges in accordance with the procedures set forth in these bylaws. Appointment to the medical staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

2.2 Qualifications for Membership and/or Privileges

To be eligible to apply for initial appointment or reappointment to the Medical Staff/APP/AHP, or for the granting of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials Policy.

2.2-1 General Qualifications

Appointment to the Medical Staff is a privilege, which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in these Bylaws, in the Credentials Policy and in such policies as are adopted from time to time by the Board.

Only physicians, oral surgeons, and podiatrists who:

A. Meet requirements for Board certification identified as Threshold Eligibility Criteria in the Credentials Policy;

B. Document their (1) current Minnesota licensure, (2) Current DEA registration (if applicable) with a Minnesota address (3) adequate experience, education and training, (4) current (within the last two years) professional competence, (5) good judgment, and (6) ability to safely and competently perform the clinical privileges requested, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

C. Are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship or business strategies discussed during administrative conversations, (4) to be willing to participate in and properly discharge those responsibilities determined by the medical staff;

D. Maintain in force professional liability insurance in amounts not less than $1,000,000/$3,000,000 or as from time to time may be jointly determined by the Board of Directors in consultation with the Medical Executive Committee;

shall be deemed to possess basic qualifications for membership in the medical staff, except for the honorary staff categories in which case these criteria shall only apply as deemed individually applicable by the medical staff.

2.2-2 Particular Qualifications

A. Physicians

An applicant for physician membership in the medical staff, except for the honorary staff, must hold an MD or DO degree or their equivalent and a valid and unsuspended license to practice medicine issued by the Minnesota Board of Medical Practice. For the purpose of this Article, "or their equivalent" shall mean any degree (e.g. foreign) recognized by the licensing boards in the State of Minnesota to practice medicine. These individuals will have a graduate degree from an approved institution and will have completed an approved residency or will have passed appropriate foreign medical school exams with Educational Commission for Foreign Medical Graduates (ECFMG) certification.

B. Oral Surgeons

An oral surgeon must be licensed to practice by the Minnesota Board of Dentistry and must have completed an approved residency in oral and maxillofacial surgery.

C. Podiatrists

A podiatrist must be licensed to practice by the Minnesota Board of Podiatric Medicine and must have completed a podiatric residency approved by the Council on Podiatric Medical Education (CPME) or another recognized accrediting body accepted by the CPME.

2.3 Effect of Other Affiliations

No person shall be entitled to receive an application, be appointed or reappointed to the Medical Staff, APP or AHP staff for the reasons delineated in the Credentials Policy. Similarly, one who is otherwise qualified may not be denied membership solely because he/she is not a member of a particular professional society.

2.4 Basic Responsibilities of Medical Staff Membership

As a condition of appointment, reappointment, and/or the granting of clinical privileges, every applicant and member of the Medical Staff, APP or AHP Staff specifically agrees to the Basic Responsibilities and Requirements delineated in the Credentials Policy and to the following, as applicable:

A. Maintaining the confidentiality, privacy and security of all protected health information (PHI) maintained by CentraCare - Rice Memorial Hospital or by any business associates of the Hospital. Confidentiality is maintained in accordance with all privacy and security policies and procedures adopted by Rice Memorial Hospital to comply with current Federal, State and local laws and regulations, including, but not limited to, the HIPAA Privacy Regulations. PHI will not be requested, accessed, used, shared, removed, released or disclosed except in accordance with CentraCare's health information privacy policies and applicable law. Information about a patient whom a Medical Staff member is treating may be shared by the member with any other Medical Staff member who has responsibility for that patient's care. Information can also be shared with any other non-Medical Staff member provider who will be participating in the patient's care.

   Passwords used by a member of the Medical Staff to access PHI from CentraCare - Rice Memorial Hospital records will be used only by said member, who will not disclose the password to any other individual (except authorized staff if needed for investigative purposes). The use of the member's password is equivalent to the member's electronic signature. Any misuse of a Hospital computer system or information from a system may, in addition to any sanctions approved by the CentraCare – Rice Memorial Hospital Board of Directors regarding security measures, be a violation of State and Federal law and may result in denial of payment under Medicare;

B. Abiding by the lawful ethical principles of the American Medical Association (or equivalent professional related to the member's professional discipline);

C. Making appropriate arrangements for coverage for his or her patients as determined by the medical staff;

D. Providing information to and/or testifying on behalf of the medical staff or an accused practitioner regarding any matter under an investigation and those which are the subject of a hearing pursuant to these bylaws;

E. Responding to a call from a patient care area regarding one of their patients as per all applicable CentraCare policies. Individual departments may set stricter response requirements. When appropriate, response to such calls may be made by a physician covering call for the physician's group.

2.5 Leave of Absence

2.5-1 Initiation

A. Except for requests related to physical or mental health (as addressed in (d) below), any leave of absence that is expected to last for 90 days or more must be requested in writing and submitted to the Physician Director-Acute Care. The request must state the beginning and ending dates of the leave, the reasons for the leave, and the arrangement that has been made for patient coverage. The leave of absence may not exceed six months. A single renewal for an additional six months leave of absence may be submitted to the Medical Executive Committee via written request specifying the reason.

B. Except in extraordinary circumstances, this request should be submitted at least 30 days prior to the anticipated start of the leave.

C. The Physician Director-Acute Care will determine whether a request for a leave of absence will be granted, after consulting with the Chief of Staff, the Chair of the Privileging Committee, and the relevant department chairperson. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

D. Members of the Medical Staff or APP/AHP Staff must report to the Physician Director-Acute Care anytime they are away from the Hospital or patient care responsibilities for longer than 30 days and the reason for the absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the Physician Director-Acute Care, in consultation with the Chief of Staff and the Chair of the Privileging Committee, may trigger an automatic medical leave of absence.

E. Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

2.5-2 Duties of Member on Leave

During the leave of absence, the individual will not exercise any clinical privileges and will be excused from all Medical Staff or APP/AHP Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations, and payment of dues). All medical records must be completed as soon as reasonably possible.

2.5-3 Reinstatement

A. Individuals requesting reinstatement will submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant department chairperson, the Chair of the Privileging Committee, the Chief of Staff, and the Physician Director-Acute Care, and in accordance with the Practitioner Health Policy, if applicable.

B. If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Privileging Committee; if the Privileging Committee recommends reinstatement without question, the individual may immediately resume clinical practice. However, if the Privileging Committee has questions, those questions will be forwarded to the Medical Executive Committee, and Board.

C. If any request for reinstatement is not granted for reasons related to clinical competence or professional conduct, and if a report to the National Practitioner Data Bank is determined to be required, the individual will be entitled to request a hearing and appeal.

D. If an individual's current appointment is due to expire during the leave, the individual may elect to apply for reappointment PRIOR to the start date of their leave of absence. The individual may also complete the reappointment process while on leave of absence in order to avoid having their appointment and clinical privileges expire at the end of the current appointment period. If their appointment and clinical privileges expire, the individual will be required to reapply for appointment simultaneously with the request for reinstatement.

2.5-4 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in these bylaws for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Article III - Categories of Membership

3.1 Overview

Qualifications and conditions for appointment to the Medical Staff are outlined in the Credentials Policy. The qualifications for appointment to the specific categories are outlined below.

Appointments will be made by the Board, upon recommendation of the Medical Executive Committee, to one of the following categories: Active, Courtesy, Honorary and CentraCare Credentialed Staff. Upon initial appointment to the Medical Staff and at each time of reappointment, the member's staff category shall be determined.

3.2 Active Staff

3.2-1 Qualifications

The active staff shall consist of members who:

A. Meet the general qualification for membership set forth in these bylaws and the credentials policy;

B. Are active within the hospital either by having a practice which requires regular use of the hospital facilities or by being active on committees.

3.2-2 Prerogatives

Except as otherwise provided, the prerogatives of an active staff member shall be to:

A. Admit patients and exercise such clinical privileges as are granted pursuant to these bylaws;

B. Attend and vote on matters presented at general and special meetings of the medical staff and of the department and committees of which he or she is a member;

C. Hold staff or department office and serve as a voting member of committees to which he or she is duly appointed or elected by the medical staff or duly authorized representative thereof; and

D. Possess medical staff membership without requesting specific privileges.

3.2-3 Transfer of Active Staff Member

After two consecutive years in which a member of the active staff fails to regularly care for patients in this hospital or be regularly involved in medical staff functions as determined by the medical staff, that member may be transferred to another appropriate category, if any, for which the member is qualified.

3.3 Courtesy Staff

3.3-1 Qualifications

The courtesy medical staff shall consist of members who:

A. Meet the general qualification for membership set forth in these bylaws;

B. Have limited hospital activity and who have an ongoing interest in serving patients in our area;

C. At the time of initial appointment, at each reappointment time thereafter, and upon request provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for membership (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

3.3-2 Prerogatives

Except as otherwise provided, the courtesy medical staff member shall be entitled to:

A. Admit patients in accordance with their medical staff privileges;

B. Serve on medical staff committees in a voting capacity, and attend open committee meetings and educational programs; and

C. Possess medical staff membership without requesting specific privileges.

3.3-3 Limitations

A. Courtesy medical staff members shall not be eligible to hold office in the medical staff, except courtesy medical staff members may serve as a department chair consistent with these bylaws.

B. Courtesy medical staff members may be required to attend staff/quality review meetings upon request.

C. Any courtesy medical staff member who attends, admits, or is involved in the care of more than fifteen (15) inpatients per year at the hospital shall be reviewed by the Medical Executive Committee. The Medical Executive Committee may choose to require active medical staff membership on a case-by-case basis.

D. After two consecutive years in which a member of the courtesy staff with clinical privileges fails to care for patients in the hospital or be involved in medical staff functions at least minimally as determined by the Medical Executive Committee, that member may be transferred to the honorary medical staff, if qualified, or may be asked to resign from the courtesy medical staff.

3.4 Honorary Staff

3.4-1 Qualifications

The honorary medical staff shall consist of physicians, oral surgeons or podiatrists (whether or not retired) who do not actively practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital, and who continue to exemplify high standards of professional and ethical conduct.

3.4-2 Prerogatives

Honorary medical staff members have no medical staff privileges but may serve on committees with or without vote at the discretion of the Medical Executive Committee, and may attend staff and department meetings, including open committee meetings and educational programs.

3.5 CentraCare Credentialed Staff

3.5-1 Qualifications

The CentraCare Credentialed Staff shall consist of practitioners that meet the qualifications for membership on the Medical Staff, APP Staff or AHP Staff as delineated these Bylaws. These practitioners have been recommended for credentialing by the CentraCare Credentialing Committee and have been approved for credentialing by CentraCare – Rice Memorial Hospital.

3.5-2 Prerogatives

A. These practitioners are exempt from the basic responsibilities and rights granted to other members of the Medical Staff, APP Staff or AHP Staff. They are also exempt from all CentraCare Medical Education that is required of physicians and licensed independent practitioners granted privileges at CentraCare – Rice Memorial Hospital.

B. These practitioners may not attend or vote on matters at general or special meetings of the medical staff and of the department and committees.

C. These practitioners may not hold office in the medical staff.

D. These practitioners have not been granted privileges to practice at CentraCare – Rice Memorial Hospital.

E. These practitioners are not required to pay application fees, dues or assessments.

3.5-3 Limitations

A. Practitioners may be appointed to the CentraCare credentialed staff for no longer than 24 months. They may be reappointed if they have successfully completed the reappointment process.

B. Practitioners on the CentraCare credentialed staff that wish to request privileges at CentraCare – Rice Memorial Hospital will be reassigned to the applicable category.

All references to Medical Staff, APP Staff or AHP Staff contained within these Bylaws, the Rules & Regulations and other Medical Staff documents, with the exception of the Credentials Policy, do NOT include the CentraCare Credentialed Staff.

3.6 Limitation of Prerogatives

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other Articles of these bylaws and by the Medical Staff Rules and Regulations.

3.7 General Exceptions to Prerogatives

Exceptions may be approved at the discretion of the Medical Executive Committee.

3.8 Modification of Membership

On its own, upon recommendation of the Privileging Committee, or pursuant to the request by a member under these bylaws, the Medical Executive Committee may recommend a change in the medical staff category of a member consistent with the requirements of the bylaws.

Article IV - Appointment and Reappointment

4.1 General

4.1-1 Except as otherwise specified herein, no person (including persons engaged by the hospital in administratively responsible positions) shall exercise clinical privileges in the hospital unless and until that person applies for and is granted privileges as set forth in these bylaws. Appointment to the medical staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these bylaws.

4.1-2 Details associated with credentialing and privileging are contained within the Credentials Policy.

4.2 Appointment Authority

Appointment, denials, and revocations of appointments to the medical staff shall be made as set forth in these bylaws, but only after there has been a recommendation from the medical staff.

4.3 Duration of Appointment and Reappointment

Unless otherwise provided in these Bylaws, initial appointments and reappointments to the medical staff shall be for a period of two years unless a recommendation for modification is made by the MEC.

4.4 Process for Credentialing and Privileging

Complete applications for appointment and privileges will be transmitted to the applicable department chairperson or the Physician Director-Acute Care, who will review and prepare a written recommendation. This recommendation will be forwarded to the Privileging Committee for review and recommendation. The recommendation of the Privileging Committee will be forwarded, along with the department chairperson's recommendation, to the Medical Executive Committee for review and recommendation. The recommendation of the Medical Executive Committee will be forwarded to the Board for final action.

A. When the disaster plan has been implemented, the President of the Hospital or the Chief of Staff may use a modified credentialing process to grant disaster privileges after verification of the volunteer's identity and licensure.

4.4-1 Application Form

Each application for initial appointment to the medical staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), along with a valid and current hospital picture identification or government-issued picture identification, and signed by the applicant. Application forms shall be approved by the Board upon recommendation from the Medical Executive Committee. The form shall require detailed information as applicable including, but not limited to, information concerning:

A. The applicant's qualifications, including, but not limited to, professional education, training and experience, current licensure, current DEA registration, current Board certification, hospital affiliation history and employment history.

B. Peer references – (as required) who have knowledge of the applicant's professional competence and ethical character from within the past two years (or have been responsible for professional observation of applicant's work) including their current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism;

C. Requests for membership categories, departments, and clinical privileges;

D. Past or pending professional disciplinary action, licensure limitations, or related matters, including challenges to any licensure or registration, voluntary and involuntary termination of medical staff membership, and voluntary and involuntary limitation, reduction, or loss of clinical privileges;

E. Ability to safely and competently perform the clinical privileges requested so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent to perform these privileges and that patients treated by them can reasonably expect to receive quality medical care;

F. Final judgments or settlements made against the applicant in professional liability cases, and any filed cases pending; and

G. Certificate documenting professional liability insurance in an amount required by the Hospital.

When an applicant requests an application form, that person shall have access to a copy of these bylaws, the medical staff rules and regulations, and other documents as applicable.

4.4-2 Effect of Application

By applying for appointment to the medical staff each applicant agrees to abide by these Medical Staff Bylaws, Rules and Regulations, Credentials Policy and other Medical Staff Policies.

A. Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral in conformity with all state and federal legal standards, refraining from improper patient discharges or transfers, providing continuous care of his/her patients, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services and refraining from delegating patient care responsibility to nonqualified or inadequately supervised practitioners;

B. Agrees to submit to a physical or psychological evaluation to determine ability to exercise privileges requested with or without reasonable accommodations, if requested by the Medical Executive Committee.

4.4-3 Department Action

Credentials Reviewer report will be forwarded as follows:

A. Department Chair(s): Active Staff applicants or re-applicants, locum tenens
B. Physician Director-Acute Care: Courtesy Staff, Advanced Practice Providers, Allied Health Professionals, Telemedicine Providers

The department chair or Physician Director-Acute Care shall transmit to the Privileging Committee a written report and recommendation as to appointment and, if appointment is recommended, membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The chair or Physician Director-Acute Care may also request that the Medical Executive Committee defer action on the application.

4.4-4 Privileging Committee Action

The Medical Executive Committee, convened as the Privileging Committee, will complete the Privileging Committee Procedure as detailed in the Credentials Policy Section 3.A.5. Since the Privileging Committee is composed of the same membership as the Medical Executive Committee, its recommendations and actions shall be considered those of the Medical Executive Committee.

4.4-5 Medical Executive Committee Action

The Medical Executive Committee will complete the Medical Executive Committee Recommendation process as detailed in the Credentials Policy Section 3.A.6.

4.4-6 Action on the Application

The Board of Directors will complete the Board Action process detailed in the Credentials Policy Section 3.A.7.

4.4-7 Notice of Final Decision

A. Notice of the final decision shall be given to the applicant, Chief of Staff and the administrator.

B. A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department to which that person is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

C. Applicant will be informed of the Governing Board decision within 60 days.

4.4-8 Reapplication after Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the medical staff for a period of one year. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.5 Procedure for Reappointment, Renewal of Clinical Privileges

Details of the procedure for reappointment and/or the renewal of clinical privileges are contained within the Credentials Policy and Article 4.4 of these Bylaws.

4.6 External Review for Appointment

External review, including monitoring, will take place in the context of investigation, application processing or at any other time only under the following circumstances, if and when deemed appropriate by the relevant department chair, the Medical Executive Committee or, where the potential of conflicting interests within the medical staff is documented, by the Governing Body:

A. Ambiguity when dealing with vague or conflicting recommendations from the Privileging Committee where conclusion from this review could directly and adversely affect an individual's membership or privileges;

B. 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;

C. To promote impartiality in peer review;

D. Upon the reasonable request of a practitioner, when subject to focused review or investigation.

4.7 Expedited Credentialing

An expedited Board of Directors approval process may be used for applications for initial appointment and reappointment and/or for granting privileges when the processes delineated in the Credentials Policy have been completed. The Board may delegate the approval process to a subcommittee consisting of at least two Board members providing there has been a favorable recommendation from the Medical Executive Committee and there is no evidence of any of the following:

A. A current or previously successful challenge to any professional licensure or registration;

B. An involuntary termination of appointment, or involuntary limitation, reduction, denial, suspension, or loss of appointment or privileges at any other hospital or other entity;

C. There has been an excessive number or unusual pattern of professional liability actions resulting in final judgment against the applicant.

Qualifying applications are reviewed by the relevant department chair(s) or Physician Director-Acute Care and, if approved, by the Privileging Committee/Medical Executive Committee. If any of these medical staff authorities makes any adverse recommendation, the application is no longer eligible for expedition, and reverts to the regular application process. An expedited application may be acted upon by a committee of the Board, if permitted by hospital bylaws or policy.

Any decision reached by the subcommittee to appoint will be effective immediately and will be forwarded to the Board for information at its next meeting.

Article V - Clinical Privileges

5.1 Exercise of Privileges

Except as otherwise provided in these bylaws, physicians, oral surgeons and podiatrists providing clinical services at this hospital shall be entitled to exercise only those clinical privileges specifically granted.

5.2 Monitoring and Certification

5.2-1 Monitoring

Except as otherwise determined by the Medical Executive Committee, all providers granted new clinical privileges shall have their practice activities monitored. The monitoring of practice activities shall be carried out in accord with the Focused Professional Practice Evaluation (FPPE) as described in the policy Medical Staff Quality: Professional Practice Evaluation. The monitoring of a staff member shall be sufficient to evaluate the individual's knowledge and proficiency, the Peer Review Committee will determine whether the FPPE process has confirmed competence and monitoring requirements have been met.

5.2-2 Failure to Satisfy Monitoring Measures

If an initial appointee, or practitioner granted new privileges, fails to satisfy the monitoring measures required within the FPPE process, or if a member exercising new clinical privileges fails to satisfy the monitoring measures within the time allowed, those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing, upon request, pursuant to these bylaws. Only when there are extenuating circumstances will the time frame for FPPE extend beyond 24 months from the initial granting of privileges.

Any Medical Staff member or APP/AHP Staff member who has not provided in-person patient services at the Hospital during the prior appointment period, shall not be eligible for reappointment or renewal unless the Medical Executive Committee waives this requirement because the appointee is a member of a medical group that regularly provides services or provides backup services for patient care needs at the Hospital or is a Telemedicine provider or a specialty that does not regularly come on site.

5.3 Temporary Clinical Privileges and Locum Tenens Privileges

5.3-1 Temporary Clinical Privileges

A. In cases of medical necessity, temporary clinical privileges may be granted to a licensed practitioner for the care of specific patients or to fulfill important patient care needs:

   1. Patient: Clinical needs will not be adequately met if the temporary privileges under consideration are not granted.

2. Hospital: The hospital cannot adequately meet the needs of patients who seek care

3. Community: The community is at risk of not receiving appropriate patient care.

B. Temporary clinical privileges may be granted while awaiting completion of the approval process unless applicant is ineligible due to:

1. Current or previously successful challenge to licensure or registration

2. Involuntary termination of medical staff membership at another organization

3. Involuntary limitation, reduction, denial or loss of clinical privileges

5.3-2 Locum Tenens Privileges

Locum Tenens Privileges may be granted to a licensed practitioner to fulfill important patient care needs.

5.3-3 Procedure and Time Period

Temporary clinical privileges or Locum Tenens privileges may be granted, provided that the procedures in Section 4.4 along with the Procedure for Initial Appointment and Privileges as detailed in the Credentials Policy have been followed.

A. Temporary clinical privileges may be granted for a time period not to exceed 120 days.

B. Locum Tenens privileges may be granted for a time period not to exceed twelve (12) months, unless the Department Chair or Medical Executive Committee recommends a longer period for good cause.

5.3-4 Application and Review

A. Upon review of the completed application and supporting documentation from a practitioner authorized to practice in Minnesota, the administrator, or designee, on behalf of the Board of Directors may grant temporary privileges to a member who appears to have qualifications, ability and judgment consistent with these Bylaws, but only after:

1. The applicant's file and supporting documentation are reviewed by the Department Chairperson or Physician Director-Acute Care. The recommendations of the Department Chairperson/Physician Director-Acute Care are forwarded to the Vice-Chief of Staff (Privileging Committee Chair).

2. Reviewing the applicant's file and attached materials, the Medical Executive Committee through the Vice-Chief of Staff or another designee recommends that the Administrator or designee grant or deny temporary privileges.

3. In the event of a disagreement between the Board of Directors and the Medical Executive Committee regarding the granting of temporary clinical privileges, the matter shall be resolved as set forth in these bylaws.

B. If the applicant requests temporary privileges in more than one department, application review and written concurrence shall be obtained from the appropriate department chairs prior to forwarding to the Vice-Chief of Staff.

5.3-5 General Conditions

A. If granted temporary privileges, the practitioner shall be under the supervision of the department chair to which the privileges holder has been assigned, and shall ensure that the chair, or the chair's designee, is kept closely informed as to his or her activities within the hospital.

B. Requirements for monitoring shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges by the Vice Chief of Staff after consultation with the department chair or his/her designee.

C. All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations and other policies of the medical staff.

D. Temporary privileges may at any time be summarily suspended consistent with the terms of these bylaws. In such cases, the appropriate department chair or, in the chair's absence, the chair of the Medical Executive Committee, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.

5.4 Emergency Care

In the case of an emergency, any member of the medical staff with clinical privileges, to the degree permitted by his or her license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the medical staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the hospital.

5.5 Telemedicine Services

Details regarding the process for Telemedicine applications are contained within the Credentials Policy.

5.5-1 Conditions

A. The term "telemedicine" shall mean licensed independent practitioners who prescribe, render a diagnosis, or otherwise provide clinical treatment to a patient at Rice Memorial Hospital through the use of electronic communication or other communication technologies from a distant site.

B. Services shall be provided via telemedicine only after a determination has been made by the Medical Staff that the clinical service involved would be appropriately delivered through this medium according to commonly accepted quality standards.

5.5-2 Quality

A method to evaluate the services provided by the telemedicine practitioner will be established within the department using the telemedicine services. The Medical Staff Executive Committee will evaluate all telemedicine services for quality of services, timeliness and appropriateness. This evaluation will be conducted annually.

5.6 Modification of Clinical Privileges or Department Assignment

On its own or pursuant to a request, the Medical Executive Committee may recommend a change in the clinical privileges or department assignment(s) of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current medical staff member be made subject to monitoring in accordance with procedures similar to those outlined in Article 5.2-1.

5.7 Lapse of Application

If a medical staff member requesting a modification of clinical privileges or department assignments fails to timely furnish the information necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in the Fair Hearing Manual.

5.8 Disaster Privileges

5.8-1 Circumstances

The Chief of Staff, Administrator, Incident Commander or their designees, may grant disaster privileges only when the Hospital emergency management plan has been activated and the hospital is unable to meet immediate patient needs. The medical staff bylaws, rules, regulations and policies apply to the exercise of disaster privileges.

5.8-2 Process

Individuals with disaster privileges are identified and managed as described in the Hospital emergency management documents. The Chief of Staff or the Administrator, or their designees, may, on a case-by-case basis, grant disaster privileges upon presentation of a valid photo identification issued by a state or federal agency and at least one of the following:

A. A current picture hospital identification that clearly identifies professional designation;
B. A current medical license to practice; A current advanced practice nursing license
C. Primary source verification of the license;
D. Identification establishing that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corp (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
E. Identification granted by a federal, state or municipal entity establishing that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances;
F. Confirmation by licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge regarding the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

5.8-3 Post Disaster

Primary source verification of the license of individuals with disaster privileges begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification of licensure cannot be completed within 72 hours, the reason(s) it could not be performed are documented.

5.8-4 Medical Staff Oversight

During the disaster, the medical staff oversees the professional practice of the volunteer. Based on its oversight of each volunteer licensed independent practitioner, the hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue. The individuals listed above may withdraw disaster privileges at any time. Refusal or withdrawal of any disaster privileges does not give the right to the hearing and appeals process, unless the refusal or withdrawal results in a report to any state or national agency.

5.9 History and Physical Privileges

Qualified licensed practitioners granted privileges to do so may perform history and physicals (H&Ps) or updates to H&Ps. Qualified licensed practitioners who are not privileged may perform H&Ps according to state law, however, a credentialed and privileged licensed practitioner must provide an update to the H&P. Privileges to admit include the privilege to perform or update a history and physical.

Privileges to perform an H&P or an update to an H&P are granted only to:

A. Physicians

Privileges to conduct or update the H&P may be granted upon request to qualified physicians who are members of the medical staff or seeking temporary or locum tenens privileges.

B. Oral/Maxillofacial Surgeons and Podiatrists

Privileges to conduct or update H&Ps only for those patients admitted solely for oral/maxillofacial surgery or podiatric surgery, consistent with the time requirements stated in this section may be granted upon request to qualified oral/maxillofacial surgeons or podiatrists, as applicable, who are members of the medical staff or seeking temporary privileges.

C. Advanced Practice Providers or Allied Health Professionals

Who may perform H&Ps within the scope of their practice license.

Every patient receives an H&P within twenty-four hours of admission, but prior to surgery or a procedure requiring anesthesia services. If an H&P was performed within thirty days of admission and is in the patient's medical record, that H&P will be updated by a qualified licensed practitioner within twenty-four hours of admission. Every patient admitted for surgery or a procedure must have an H&P completed by a qualified licensed practitioner within 24 hours but prior to surgery; unless a previous H&P performed within thirty days prior to the surgery is in the medical record, this H&P will then be updated within twenty-four hours of admission. In all cases the H&P must be updated prior to surgery or a procedure requiring anesthesia services.

An exception to the above requirement for a complete history and physical for patients is in the case of patients receiving electro-convulsive therapy (ECT) (details are enumerated in the Rice Memorial Hospital Medical Staff's Rules & Regulations)

Article VI - Advanced Practice Provider Staff and Allied Health Professional Staff

6.1 Qualifications and Basic Responsibilities

Advanced Practice Provider Staff (APPs) includes Advanced Practice Registered Nurses and Physician Assistants. Allied Health Professional Staff (AHP) means the licensed patient care providers other than physicians, oral surgeons, podiatrists and APPs. Appointment to the APP or AHP Staff is a privilege, which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in these Bylaws, in the Credentials Policy and in such policies as are adopted from time to time by the Board.

Only Advanced Practice Providers and Allied Health Professionals who:

A. Have a practice which requires use of the hospital facilities;

B. Document their (1) current Minnesota licensure or certification, as appropriate, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

C. Are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as to not adversely affect patient care, (3) to keep confidential, as required by law, all information or records received in the provider-patient relationship, (4) to be willing to participate in and properly discharge those responsibilities determined by the medical staff;

D. Maintain in force professional liability insurance in amounts not less than $1,000,000/$3,000,000 or as from time to time may be jointly determined by the Board of Directors in consultation with the Medical Executive Committee.

Shall be deemed to possess basic qualifications for membership on the APP or AHP staff.

As a condition of appointment, reappointment, and/or the granting of clinical privileges, every applicant and member of the APP or AHP Staff specifically agrees to the Basic Responsibilities and Requirements delineated in the Credentials Policy and to those basic responsibilities delineated in Article 2.4 of these Bylaws.

6.2 Conditions and Duration of Appointment

6.2-1 Application Process

Details associated with credentialing and privileging are contained within the Credentials Policy.

APP/AHP applicants shall submit an application for privileges in the same manner as an applicant for Medical Staff membership, provided that the application is on a special form as established by the Medical Executive Committee. All such applicants shall provide at least the following information in their application and decisions regarding privilege assignment shall be made based upon such information:

A. Formal education/training in the field in which privileges are desired;

B. Licensure or certification if appropriate;

C. Experience;

D. Privileges if desired;

E. Name of the clinical department or medical staff member and the degree of supervision under which the individual shall work. This is not applicable to an APP who can practice independently;

F. Names of at least two persons who have knowledge of the applicant's professional competence and ethical character from within the past 12 months (or have been responsible for professional observation of applicant's work) including their current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism.

6.2-2 Hospital Board Action

A. Initial appointments and reappointments to the APP staff or AHP staff shall be made by the Hospital Board. The Hospital Board shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the medical staff as provided in these Bylaws, except as hereinafter provided.

B. Except in those circumstances described in Article 6.8-1, or in the case of a breach of the conditions set forth in Article 6.6, or in the case of failure to provide a certificate documenting professional liability insurance in an amount specified by the Board of Directors, the Hospital Board shall not take action on any application, refuse to renew an appointment, cancel an appointment previously made, or modify the privileges requested by the applicant without conference with the Medical Staff as hereinafter provided. Should the Hospital Board wish to take the initiative in refusing to appoint any applicant or make reappointments of any member, it shall so advise the Medical Staff, stating its reasons.

6.2-3 Duration of Appointment

Unless otherwise provided in these bylaws, initial appointments and reappointments shall be for a period of up to two years unless a recommendation for modification is made by the MEC.

6.2-4 Limitations

Appointment to the APP Staff or AHP Staff shall confer on the appointee only such privileges as have been granted by the Hospital Board in accordance with these Bylaws. The procedures relating to application, appointment and delineation of privileges shall be governed by the provisions of these Bylaws applicable to those matters as they relate to the Medical Staff.

6.3 Supervision

Supervision of an APP or AHP, except for those that can practice independently, shall be provided by physician chair of the assigned clinical department or by an individual medical staff member as assigned.

6.4 Scope of Activities

6.4-1 Privileges granted to an APP/AHP shall be based on their education, training, experience, demonstrated competence and judgment, and the scope of their licensure when appropriate.

6.4-2 APP Staff may admit and discharge patients to the extent allowed by the Medical Staff within the scope of their licensure and applicable statutes.

6.4-3 APPs or AHPs may participate directly in the management of patients and may exercise independent judgment within their area of competence, with the ultimate responsibility for patient care being shared by a member of the Medical Staff.

6.4-4 APPs or AHPs may record the history & physical and progress notes in the appropriate area of the medical record.

6.4-5 Privileges to write orders with and without immediate consultation with the supervising Member, if any, shall be delineated.

6.4-6 APPS or AHPs shall follow the requirements outlined in Section B of the Medical Staff Rules and Regulations.

6.5 Activities with the Medical Staff

Attendance by APP Staff at the Medical Staff meetings shall be at the discretion of the Chief of the Medical Staff and the Administrator. APP Staff may vote but may not hold office. They may be asked to serve on committees of the Medical Staff organization.

6.6 Reports of Disciplinary Action

Any practitioner subject to state licensure shall immediately report any warning, reprimand, fine, probation, suspension or revocation action taken against him/her by the involved licensing authority to the Administrator and the Chief of the Medical Staff.

6.7 Conformity to Hospital Standards

All APPs/AHPs shall conduct themselves within the Hospital in accord with these Bylaws, the Medical Staff Rules and Regulations, and all applicable medical staff and hospital policies, and shall accept and carry out committee assignments and other duties as allowed or required under these Bylaws, and shall participate in continuing education activities.

6.8 Reduction or Termination of Privileges

6.8-1 Without Cause

In the event the hospital department to which an APP/AHP Staff member is assigned ceases to function or fails to supervise the APP/AHP Staff member, or the Medical Staff member to whom an APP/AHP Staff member is assigned ceases to practice at the hospital or fails to supervise the APP/AHP Staff member, the APP/AHP Staff member's privileges shall thereby automatically terminate. In this event, the termination of privileges shall be without prejudice to his or her eligibility for privileges and, subject to the ongoing criteria and standards for appointment, the APP/AHP Staff member shall be eligible for appointment in the event a department or member is able to provide the required supervision; however, if another qualified Medical Staff member agrees to become the responsible physician for an APP/AHP Staff member whose original responsible physician is no longer on staff or able to provide adequate supervision, the Privileging Committee may recommend a transfer of responsibility to the willing physician without requiring a new application from the APP/AHP Staff member.

6.8-2 Breach of Standards

In the event that an APP/AHP Staff member to whom privileges have been granted is perceived to be performing below hospital standards, in deviation from the standards of his or her profession, or in violation of the Medical Staff Bylaws and Rules and Regulations, such person shall be subject to one or more of the following remedies: a warning; reprimand; remedial, corrective or rehabilitative action; suspension or revocation of privileges; or denial of an application for reappointment; provided, that this shall not be construed to require "progressive discipline." In this event, the individual shall be entitled and subject to the same review and appeal procedures that would apply to a Member under similar circumstances. Actions related to any provider (physician, APP or AHP Staff) must be reported to the National Practitioner Data Bank in compliance with its rules.

Article VII - Medical Staff/APP/AHP Code of Conduct

7.1 Harassment Prohibited

As a condition of membership and privileges, a medical staff member shall continuously meet these requirements for professional conduct established in these bylaws as well as the applicable CentraCare policies regarding harassment, offensive or disruptive behavior or workplace violence. Privilege holders will be held to the same conduct requirements as members.

7.2 Acceptable Conduct

Acceptable medical staff member conduct is not restricted by these bylaws and includes:

A. Patient advocacy;

B. Recommendations or criticism intended to improve care;

C. Exercising rights granted under the medical staff bylaws, rules and regulations, and policies;

D. Fulfillment of duties of medical staff membership or leadership;

E. Legitimate business activities that may or may not compete with the Hospital.

7.3 Disruptive and Inappropriate Conduct

Disruptive and inappropriate medical staff member conduct is conduct that affects or could affect the quality of care of patients and/or undermines a culture of safety at the Hospital and includes but is not limited to:

A. Harassment by a medical staff member against any individual involved in the Hospital (e.g., against another medical staff member, house staff, Hospital employee or patient) for any reason, including, but not limited to race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated.

B. “Sexual harassment”, defined as unwelcome verbal or physical conduct of a sexual or gender-based nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as display of derogatory cartoons, drawings, or posters). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluations, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual’s employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct that indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

C. Deliberate physical, visual or verbal intimidation or challenge, including disseminating threats or pushing, grabbing or striking another person involved in the Hospital;

D. Carrying a gun or other weapon in violation of the hospital policy Weapons and Contraband.

E. Refusal or failure to comply with these member conduct requirements.

All allegations of harassment shall be immediately investigated by the medical staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of medical staff privileges or membership, if warranted by the facts.

7.4 Medical Staff Conduct Complaints

Complaints or reports of disruptive and inappropriate conduct by medical staff members are subject to review whether or not the witness or complainant requests or desires action to be taken. Complaints or reports must be in writing (i.e. paper, email, documentation in the complaint reporting system), and will be transmitted to the Chief of Staff or to the medical staff officer designated by the Chief of Staff or Medical Executive Committee. The following actions are taken:

7.4-1 Complaints are shared with the subject member, who will be given the opportunity to respond to the officer or, if referred, the Committee handling the complaint.

7.4-2 If there is any indication that the member's health is implicated, the Chief of Staff shall immediately refer the matter to either Human Resources for employed physicians/APPs/AHPs or to the Department Chair or Medical Staff Officer for any non-employed physicians/APPs/AHPs for evaluation.

7.4-3 If there is no indication that the member's health is implicated, the Chief of Staff or designee shall determine whether:

A. the complaint or report is obviously without merit and warrants no further action; or

B. action is warranted. If so, the decision is reported at the next Medical Executive Committee for consideration of investigation and corrective action.

7.5 Complaints Concerning Hospital Staff

Medical staff members' reports or complaints about any hospital administrators, nurses or other employees, contractors, board members or others affiliated with the hospital must be presented in writing and submitted to the Chief of Staff, any medical staff officer, or appropriate hospital staff. The Chief of Staff shall forward the complaint or report to the appropriate hospital authority for action. Reports and complaints regarding hospital staff conduct will be referred to the executive responsible for that person (including the Chairperson of the Hospital Board of Directors for issues involving the Chief Executive Officer) who will report results of such reports and complaints to the Medical Executive Committee.

7.6 Abuse of Process

Retaliation or attempted retaliation against complainants or those who are carrying out medical staff duties regarding conduct will be considered inappropriate and disruptive conduct, and could give rise to evaluation and corrective action pursuant to the medical staff bylaws.

Article VIII - Corrective Action

8.1 Corrective Action

For purposes of this Article, “member” includes those holding temporary privileges awarded pursuant to these Bylaws.

Details associated with the Corrective Action process and the Hearings and Appeals process are contained within the Fair Hearing Manual.

8.1-1 Indications and Process for Professional Review Actions

Following an investigation, the Medical Executive Committee may recommend, subject to final Board action, suspension or revocation of appointment or clinical privileges based on concerns about:

A. clinical competence or clinical practice, including patient care, treatment or management;

B. the known or suspected violation of applicable ethical standards or the bylaws, policies, rules and regulations of the Medical Staff or the Hospital; or

C. conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff or APP/AHP Staff, including the inability of the member to work harmoniously with others.

8.2 Indications and Process for Summary Restriction or Suspension

8.2-1 Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the Chief of Staff, the Chairperson of the Privileging Committee, the chairperson of the relevant clinical department, the Physician Vice President of Acute Care, the Medical Executive Committee, or the Board chairperson is authorized to suspend or restrict all or any portion of an individual’s clinical privileges pending an investigation.

8.2-2 A summary suspension is effective immediately and will remain in effect unless it is modified by the Chief Executive Officer or the Privileging Committee.

8.2-3 The individual will be provided a brief written description of the reason(s) for the summary suspension.

8.2-4 The Medical Executive Committee will review the reasons for the suspension within a reasonable time.

8.2-5 Prior to, or as part of, this review, the individual will be given an opportunity to meet with the Privileging Committee.

8.3 Automatic Suspension or Relinquishment

8.3-1 Appointment and clinical privileges will be automatically suspended or relinquished (as detailed in the Fair Hearing Manual) if any individual:

A. fails to do any of the following:

1. Timely complete medical records;
2. Pay required dues and/or assessments;
3. Satisfy threshold eligibility criteria;
4. provide requested information;
5. attend a requested meeting to discuss issues or concerns; or
6. comply with the requirements outlined in the Professional Practice Evaluation Policy;

B. has action taken by an agency or insurer against their licensure, DEA registration, professional liability insurance coverage, or Medicare and Medicaid participation.

C. is arrested, indicted, convicted, or enters a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) violence; (v) sexual misconduct; or (vi) moral turpitude;

   i. If an individual is arrested for any criminal activity identified in this section, such individual's appointment and clinical privileges may be automatically relinquished, without right to hearing or appeal

D. makes a misstatement or omission on an application form. Prior to automatic suspension of privileges, the Chief of Staff and/or the Physician Director-Acute Care will review the misstatement or omission and consider any written or oral explanation provided by the individual; or

E. in the case of a member of the Advanced Practice Provider Staff, if required, fails to maintain an appropriate supervision/collaboration relationship with a Supervising/Collaborating Physician as defined in the Credentials Policy.

8.3-2 Automatic suspension will take effect immediately and will continue until the matter is resolved, if applicable. Details of the reinstatement process are included in the Fair Hearing Manual.

Article IX – Hearing and Appeal Process

9.1 General Provisions

Details associated with the hearing and appeal process are contained within the Fair Hearing Manual.

9.1-1 Exhaustion of Remedies

If adverse action is taken or recommended, the applicant or member must exhaust the remedies afforded by these bylaws in the Fair Hearing Manual before resorting to legal action.

9.1-2 Application of Article

For purposes of this Article, the term "member" may include "applicant," as it may be applicable under the circumstances, unless otherwise stated.

9.1-3 Timely Completion of Process

The hearing and appeal process shall be completed within a reasonable time. Though this "reasonable time" may depend on external forces, the Medical Executive Committee should strive to complete this process within 90 days.

9.1-4 Final Action

Recommended adverse actions shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived.

9.2 General Process

9.2-1 The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

9.2-2 The Fair Hearing Committee will consist of at least five members and there will be a Hearing Officer.

9.2-3 The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

9.2-4 A stenographic reporter will be present to make a record of the hearing.

9.2-5 Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:

A. to call and examine witnesses, to the extent they are available and willing to testify;

B. to introduce exhibits;

C. to cross-examine any witness;

D. to have representation by counsel who may be present, but not call, examine, and cross-examine witnesses and present the case;

E. to submit a written statement at the close of the hearing; and

F. to submit proposed findings, conclusions and recommendations to the Fair Hearing Committee or Hearing Officer.

9.2-6 The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

9.2-7 The Fair Hearing Committee (or Hearing Officer) may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

9.2-8 The affected individual and the Medical Executive Committee may request an appeal of the recommendations of the Fair Hearing Committee (or Hearing Officer) to the Board.

Article X - Officers

10.1 Officers of the Medical Staff

10.1-1 Identification

The officers of the medical staff shall be the Chief of Staff, Vice Chief of Staff, Secretary-Treasurer and immediate past Chief of Staff.

10.1-2 Qualifications

Officers must be members of the active medical staff at the time of their nominations and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

10.1-3 Nominations

A. The medical staff election year shall be each odd numbered year. A nominating committee shall be named in February of the election year. The nominating committee shall consist of the current Chief of Staff, Vice Chief of Staff, and one other member of the Medical Executive Committee. Should any of the named individuals be unable to serve on the nominating committee, they shall designate their own replacement. The nominating committee shall nominate one or more nominees for each office. The nominations shall be reported to the Medical Executive Committee at least 20 days prior to the scheduled election. The nominations shall also be communicated to the voting members of the medical staff at least 20 days prior to the scheduled election.

B. Further nominations may be made for any office by any voting member of the medical staff, provided that the name of the candidate is submitted in writing to the nominating committee and is accompanied by the candidate's written consent. Such nominations shall be delivered to the nominating committee as soon as reasonably practical, but at least 14 days prior to the scheduled election. Voting members shall be advised of the addition to the posted nominations at least 10 days prior to the scheduled election. Nominations from the floor shall be recognized only if the nominee is present and consents.

10.1-4 Elections

The Chief of Staff, Vice Chief of Staff, and Secretary-Treasurer shall be elected during the fourth quarter of the election year (medical staff year) by all members of the Active medical staff. Voting shall occur via ballot, written or electronic, and ballots shall be considered valid providing no more than one candidate per office is designated by the voter. A nominee shall be elected upon receiving a majority of the valid votes cast, providing the election results are approved by the Board of Directors. If no candidate receives the majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election at its next meeting or at a special meeting called for that purpose.

10.1-5 Term of Elected Office

Each officer shall serve a 2-year term, commencing on the first day of the medical staff year following his/her election. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office. At the end of that officer's term, the Chief of Staff shall automatically assume the office of immediate past Chief of Staff.

10.1-6 Recall of Officers

Any officer whose election is subject to these bylaws may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a medical staff officer may be initiated by the Medical Executive Committee or shall be initiated by a petition signed by at least one-third of the members of the medical staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a majority vote of the medical staff members eligible to vote for medical staff officers who cast votes at the special meeting in person or by mail or electronic ballot.

10.1-7 Vacancies in Elected Offices

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies, other than that of the Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of Chief of Staff, then the Vice Chief of Staff shall assume the duties of the Chief of Staff and shall immediately appoint an ad hoc nominating committee to seek a nominee(s) for the office of Chief of Staff. Such nominee(s) as may be found shall be reported to the Medical Executive Committee and to the medical staff. A special election to fill the position of Chief of Staff shall occur at the next regular staff meeting. If no nominee can be found for the office of Chief of Staff, the Vice Chief of Staff shall continue serving as the Chief of Staff for the remaining term. If there is a vacancy in the office of either Vice Chief of Staff or Secretary-Treasurer, that office need not be filled by election, but the Medical Executive Committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of Chief of Staff.

10.2 Duties of Officers

10.2-1 Chief of Staff

The Chief of Staff shall serve as the chief officer of the medical staff. The duties of the Chief of Staff shall include, but not be limited to:

A. Enforcing the medical staff bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

B. Calling, presiding at, and being responsible for the agenda of all meetings of the medical staff;

C. Serving as chair of the Medical Executive Committee;

D. Serving as an ex officio member of all other staff committees without vote, or with a vote if his/her membership in a particular committee is required by these bylaws;

E. Interacting with the administrator and Board of Directors in all matters of mutual concern within the hospital;

F. Appointing, in consultation with the Medical Executive Committee, committee members for all standing and special medical staff, liaison, or multi-disciplinary committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairs of these committees;

G. Representing the views and policies of the medical staff to the Board of Directors and to the Administrator;

H. Being a spokesperson for the medical staff in external professional and public relations;

I. Performing such other functions as may be assigned to the Chief of Staff by these bylaws, the medical staff, or by the Medical Executive Committee;

J. Serving on liaison committees with the Board of Directors and administration, as well as outside licensing or accreditation agencies.

10.2-2 Vice Chief of Staff

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive Committee, shall serve as the chair of the Privileging Committee, and shall perform such other duties as the Chief of Staff may assign as may be delegated by these bylaws, or by the Medical Executive Committee.

10.2-3 Secretary-Treasurer

The Secretary-Treasurer shall be a member of the Medical Executive Committee. The duties shall include, but not be limited to:

A. Maintaining a roster of members;

B. Keeping accurate and complete minutes of all Medical Executive Committee and general medical staff meetings;

C. Calling meetings on the order of the Chief of Staff or Medical Executive Committee;

D. Attending to all appropriate correspondence and notices on behalf of the medical staff;

E. Overseeing the medical staff funds, including collection of medical staff dues and approval of expenditures;

F. Performing such other duties as ordinarily pertains to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

G. Assuming the duties of the Chief of Staff and/or the Vice Chief of Staff when they are temporarily unavailable or unable to assume their duties.

10.2-4 Immediate Past Chief of Staff

The Immediate Past Chief of Staff may, as able:

A. Serve on the Medical Executive Committee;

B. Serve as an advisor to other Medical Staff leaders;

C. Assume all duties assigned by the Chief of Staff or the Medical Executive Committee; and

D. Attend meetings of the Board, with vote, in accordance with the Hospital corporate bylaws.

10.2-5 Accountability

The medical staff officers are accountable through the Medical Executive Committee to the medical staff as a whole.

10.2-6 Officer Compensation

The compensation for medical staff officers shall be an annual stipend in an amount mutually agreed to by the Medical Executive Committee and the Hospital. The stipend is to be paid twenty percent (20%) by the Medical Staff and eighty percent (80%) by the Hospital.

Article XI - Clinical Departments

11.1 Organization of Clinical Departments

A. The medical staff will be organized into the departments or service lines as listed in the Organization and Functions Manual.

B. Subject to the approval of the Board, the Medical Executive Committee may create new departments, eliminate departments, create sections within departments, or otherwise reorganize the department structure, including but not limited to the creation of service lines.

C. Each department shall be organized as a separate component of the medical staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities as specified in Article 11.4-5.

11.2 Assignment to Departments

A. Upon initial appointment to the Medical Staff, each member shall be assigned membership in at least one department, but may also be granted membership and/or clinical privileges in other departments consistent with practice privileges granted.

B. An individual may request a change in department assignment to reflect a change in the individual's clinical practice.

C. Each Medical Staff Department shall formulate criteria which must be met for a physician, oral surgeon, or podiatrist to be included within their department, including the type of post-graduate education. Such criteria must be approved by the Privileging Committee.

11.3 Functions of Departments

The general functions of each department shall include:

A. Conducting patient care review for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department;

B. Recommending to the Medical Executive Committee the type of data to be collected for ongoing professional practice evaluation and the guidelines for the granting and monitoring of clinical privileges and the performance of specified services within the department which include consideration of ongoing professional practice evaluation information;

C. Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department;

D. Reviewing and evaluating departmental adherence to: (1) medical staff policies and procedures and (2) sound principles of clinical practice;

E. Coordinating patient care provided by the department's members with nursing and ancillary patient care services;

F. Submitting written reports to the Medical Executive Committee concerning: (1) the department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and the hospital;

G. Meeting at least quarterly for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities; as well as reports on other department and staff functions;

H. Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including monitoring protocols;

I. Setting clearly defined triggers for indicating the need for performance monitoring;

J. Taking appropriate and consistent action when important problems in patient care and clinical performance or opportunities to improve care are identified;

11.4 Department Chairs

11.4-1 Qualifications

Each department shall have a department chair (or co-chairs) who is a member of the active medical staff and who is certified by an appropriate specialty board or possesses comparable competence as determined through the credentialing and privileging process. Upon approval of the Medical Executive Committee, a member of the courtesy medical staff who meets all other requirements may be appointed as chair of a department with all due voting rights.

11.4-2 Selection

Department chairs shall be elected every 3 years (unless a department shall choose a lesser term) by those members of the department who are eligible to vote for general officers of the medical staff. Each department shall be free to follow whichever means of nominating and electing its chair as is acceptable to the majority of its members. Election of department chairs (and vice-chairs, if desired by a department) shall be reported to the Medical Executive Committee. Vacancies due to any reason shall be filled by the respective department with such mechanisms as that department may adopt.

11.4-3 Term of Office

Each department chair shall serve a 3 year term (or a lesser term if such has been selected by a department) which coincides with the medical staff year or until their successors are chosen, unless they resign, are removed from office, or lose their medical staff membership or clinical privileges in that department. Department officers shall be eligible to succeed themselves.

11.4-4 Removal

A. After election, removal of department chairs from office may occur for cause by either a majority vote of the Medical Executive Committee subject to Board confirmation; or by the Board; or a majority of valid votes cast by the department members eligible to vote on departmental matters. Grounds for removal shall be:

1. Failure to comply with applicable policies, Bylaws or Rules and Regulations;

2. Failure to perform the duties of the position held;

3. Conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

4. An infirmity that renders the individual incapable of fulfilling the duties of that office.

B. Prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be taken at least ten days prior to the date of the meeting. The individual shall be afforded an opportunity to speak to the department or Medical Executive Committee or the Board, as applicable, prior to a vote on such removal.

11.4-5 Duties

Each department chairperson is responsible for the following functions, either personally or in collaboration with Hospital personnel:

A. All clinically-related activities of the department;

B. All administratively-related activities of the department, unless otherwise provided for by the Hospital;

C. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

D. Recommending criteria for clinical privileges that are relevant to the care provided in the department;

E. Recommending clinical privileges for each member of the department (Courtesy Staff members of the Department are reviewed by the Physician Director of Acute Care for recommendation of clinical privileges);

F. Assessing and recommending off-site sources for needed patient care, treatment and services not provided by the department or the Hospital;

G. Integrating the department into the primary functions of the Hospital;

H. Coordinating and integrating interdepartmental and intradepartmental services;

I. Developing and implementing policies and procedures that guide and support the provision of care, treatment and services;

J. Recommending a sufficient number of qualified and competent persons to provide care, treatment, and services;

K. Making good faith efforts to reach outcomes that are in the best interest of the community served by the Hospital whenever interdepartmental efforts are needed, including working cooperatively with other department chairpersons to develop criteria for clinical privileges that cross specialty lines and resolving any differences related to emergency call;

L. Determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

M. Continuing assessment and quality improvement of the care, treatment, and services provided;

N. Maintaining quality control programs, as appropriate;

O. Orientation and continuing education of all persons in the department;

P. Recommending space and other resources needed by the department;

Q. Assuring an on-call schedule is developed to reflect the services that are available;

R. Appointing special committees as necessary to fulfill the duties of the department;

S. Conducting department meetings;

T. serving as a member of the Medical Executive Committee; and

U. Performing functions authorized in the Credentials Policy.

11.4-6 Accountability

The department chairs are accountable to the members of their department and to the Medical Executive Committee.

Article XII – Committees

12.1 Designation

Medical staff committees include, but are not limited to, the medical staff meeting as a committee of the whole, the Medical Executive Committee, meetings of departments, meetings of other committees identified in the Medical Staff Organization and Functions Manual, and meetings of special committees or task forces created by the Medical Executive Committee or by departments (pursuant to these bylaws). The committees described in this Article and in the Organization and Functions Manual shall be the standing committees of the medical staff. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee. Medical staff committees shall be responsible to the Medical Executive Committee.

12.2 General Provisions

12.2-1 Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of two years, and shall serve until the end of this period or until the member's successor is appointed, unless the member resigns or is removed from the committee. Reappointment may occur without limitation.

12.2-2 Removal

If a member of a committee ceases to be a member in good standing of the medical staff, or loses employment or a contract relationship with the hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the Medical Executive Committee.

12.2-3 Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same way an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

12.3 Medical Executive Committee

12.3-1 Composition

A. The Medical Executive Committee shall consist of the following persons: the officers of the medical staff, the department chairs, the Chief Executive Officer and/or designees (ex-officio) and the Physician Director of Acute Care.

B. The Chief Executive Officer and/or designees and the Physician Director of Acute Care will be ex officio members, without vote, of the Medical Executive Committee.

C. Other administrative personnel may be invited to attend meetings of the Medical Executive Committee to provide input and support for the Committee.

D. The Chief of Staff will serve as Chairperson of the Medical Executive Committee.

E. Members of the active, courtesy, and APP staff may be appointed as members of the Medical Executive Committee.

F. The majority of voting Medical Executive Committee members shall be fully licensed doctors of medicine or osteopathy actively practicing in the Hospital.

12.3-2 Duties

The duties of the Medical Executive Committee include, but are not limited to:

A. Representing and acting on behalf of the medical staff in the intervals between medical staff meetings (the officers are empowered to act in urgent situations between Medical Executive Committee meetings), subject to such limitations as may be imposed by these bylaws;

B. Recommending directly to the Board on at least the following:

1. the Medical Staff's structure;

2. the mechanism used to review credentials and to delineate individual clinical privileges;

3. applicants for appointment and reappointment to the Medical Staff, APP Staff or AHP Staff

4. delineation of clinical privileges for each eligible individual;

5. participation of the Medical Staff in performance improvement activities and the quality of professional services being provided by the Medical Staff;

6. the mechanism by which appointment to the Medical Staff, APP Staff or AHP Staff may be terminated;

7. hearing procedures; and

8. reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

C. Consulting with administration on quality-related aspects of contracts for patient care services;

D. Reviewing quality indicators to ensure uniformity regarding patient care services;

E. Providing leadership in activities related to patient safety;

F. Receiving and acting upon reports and recommendations from medical staff departments, committees, and assigned activity groups;

G. Providing oversight in the process of analyzing and improving patient satisfaction;

H. Reviewing, at least every three years, the Bylaws, Rules and Regulations, policies, and associated documents of the Medical Staff and recommend such changes as may be necessary or desirable; and

I. Performing such other functions as are assigned to it by these Bylaws, the Rules and Regulations, the Credentials Policy, or other applicable policies.

12.3-3 Meetings

The Medical Executive Committee shall meet as often as necessary, but not less than 10 times per year and shall maintain a record of its proceeding and actions.

12.4 Performance Improvement Functions

12.4-1 The Medical Staff is actively involved in the measurement, assessment, and improvement of the following:

A. Medical assessment and treatment of patients;

B. Use of information about adverse privileging decisions for any practitioner privileged through the Medical Staff process;

C. Medication usage;

D. The use of blood and blood components;

E. Operative and other procedures;

F. Appropriateness of clinical practice patterns;

G. Significant departures from established patterns of clinical practice;

H. The use of developed criteria for autopsies;

I. Sentinel event data;

J. Patient safety data;

K. The Hospital's performance on Joint Commission and Centers for Medicare & Medicaid Services' core measures; and

L. The required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Article 5.9 and the Medical Staff Rules & Regulations.

M.

12.4-2 The Medical Staff participates in the following activities:

A. Education of patients and families;

B. Coordination of care, treatment, and services with other practitioners and Hospital personnel;

C. Accurate, timely, and legible completion of patient's medical records;

D. Review of findings of the assessment process that are relevant to an individual's performance. The Medical Staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner's competence; and

E. Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.

12.5 Creation of Standing and Special Committees

12.5-1 The Medical Executive Committee may, by resolution, and without amendment of these Bylaws, establish additional committees to perform one or more staff functions, including peer review activities

12.5-2 The Medical Executive Committee may dissolve or rearrange the structure, duties, or composition of Medical Staff committees with the exception of the Medical Executive Committee and the Privileging Committee.

12.5-3 Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special task force will be performed by the Medical Executive Committee.

12.5-4 Special task forces will be created, and their members and chairpersons will be appointed by the Chief of Staff. Such task forces will confine their activities to the purpose for which they were appointed and will report to the Medical Executive Committee.

Article XIII - Meetings

13.1 General

13.1-1 Medical Staff Year

For the purpose of these Bylaws, the Medical Staff year commences on the first day of July and ends on the thirtieth day of June.

13.1-2 Meetings

A. The Medical Staff may meet annually in May. The date of any Medical Staff meeting can be changed with 14 days' notice.

B. Except as provided in these Bylaws or the Organization and Functions Manual, departments and committees will meet as often as necessary.

C. Meetings may be conducted by telephone conference or by other electronic means.

13.1-3 Regular Meetings

A. At the beginning of each Medical Staff year, the Chief of Staff, the chairperson of each department and the chairperson of each committee, will schedule regular meetings for the year. Notice of these meetings will be provided to members of the Medical Staff, and to members of the respective departments and committees.

13.1-4 Special Meetings

A. Special meetings of the medical staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called upon the written request of ten percent (10%) of the members of the active medical staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within 30 days after receipt of such request. No later than 10 days prior to the meeting, notice shall be mailed or delivered to the members of the staff which includes the stated purpose of the meeting.

B. A special meeting of any department or committee may be called by or at the request of the Chief of Staff, the Medical Executive Committee, the relevant chairperson, or by a petition signed by at least one third of the current members eligible to vote, but not less than two (2) members.

C. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

13.2 Quorum

13.2-1 Staff Meetings

Except as otherwise provided in these Bylaws or the Organization and Function Manual, for any regular or special meetings of the Medical Staff, the presence of twenty (20) members of the active medical staff shall constitute a quorum.

13.2-2 Department and Committee Meetings

A quorum of five voting members shall be required for Medical Executive /Privileging Committee meeting. For department and other committee meetings, a quorum shall consist of those voting members present (minimum of 2 voting members).

13.3 Manner of Action

A. Recommendations and actions of the Medical Staff, departments and committees will be by consensus. Except as otherwise specified, the action of a majority of the members voting at a meeting at which a quorum is present shall be considered the action of the group.

B. Members of the Medical Staff and members of any department or committee may also be presented with a question by mail, facsimile, e-mail, or hand-delivery and their votes returned to the chairperson by the method designated in the notice. Except as otherwise provided in these Bylaws, a quorum for purposes of these votes will be the number of responses returned to the chairperson by the date indicated. The question raised will be determined in the affirmative if a majority of the responses returned has so indicated.

C. Meetings may be conducted by telephone conference.

13.4 Minutes

A. Minutes of Medical Staff, department, and committee meetings will be prepared and approved by the presiding officer. Minutes do not require a signature or electronic signature but will note approval indicated in the subsequent meeting's minutes. Minutes of that next meeting should reflect that the prior meeting's minutes have been approved "as written" or "as amended".

B. Minutes will include a record of the attendance of members and the recommendations made.

C. Minutes of Medical Staff, department, and committee meetings will be forwarded to the Medical Executive Committee.

D. The Chief Executive Officer and the Physician Director-Acute Care will receive a summary report of the minutes of the Medical Staff, departments, and committees. The Board will be kept apprised of the recommendations of the Medical Staff.

E. A permanent file of the minutes of meetings will be maintained by the Hospital.

13.5 Confidentiality

A. Members of the Medical Staff who have access to or are the subject of credentialing and/or peer review information agree to maintain the confidentiality of this information.

B. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy.

C. A breach of confidentiality may result in the imposition of disciplinary action.

13.6 Attendance Requirements

13.6-1 Regular Attendance

A. Each member of the active staff is expected to attend Medical Staff meetings.

1. All general Medical Staff meetings duly convened pursuant to these bylaws; and

2. All meetings of each department and committee of which he or she is a member.

B. Attendance at meetings and participation in medical staff activity is expected of all members of the active staff. Actual attendance at meetings shall be reviewed as part of Ongoing Provider Practice Evaluation.

C. Each member of the courtesy staff shall be encouraged to attend applicable department meetings.

13.6-2 Absence from Meetings

Physicians who anticipate (or subsequently discover) that they shall (or were) unable to attend a meeting should notify Medical Staff Services for documentation of an excused absence.

13.6-3 Special Attendance

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least 7 days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting, with respect to which he or she was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for corrective action.

13.7 Conduct of Meeting

The latest edition of Robert's Rules of Order Revised may be used for reference at meetings and elections, but will not be binding. Specific provisions of these Bylaws and Medical Staff, department, and committee custom will prevail at meetings, and the Chief of Staff, department chairperson, or committee chairperson will have the authority to rule definitively on matters of procedure.

13.8 Executive Session

Executive session is a meeting of the medical staff, or a medical staff committee or department which only voting medical staff committee members may attend, unless others are expressly requested by the membership to attend. Executive session may be called by the presiding officer at the request of any medical staff member, and shall be called by the presiding officer pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

13.9 Permission to Vote

Unless otherwise specified in these bylaws, only members of the Active medical staff may vote in departmental or staff elections, and at committee, department, and medical staff meetings.

Article XIV - Confidentiality, Immunity and Releases

14.1 Authorization and Conditions

By applying for or exercising clinical privileges within this hospital, an applicant:

A. Authorizes representatives of the hospital and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

B. Authorizes persons and organizations to provide information concerning such practitioner to the medical staff;

C. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the medical staff or the hospital who acts in accordance with the provisions of this Article; and

D. Acknowledges that the provisions of this Article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

14.2 Confidentiality of Information

14.2-1 General

Records and proceedings of all medical staff committees having the responsibility of evaluation and improvement of quality of care rendered in this hospital, including, but not limited to, meetings of the medical staff meeting as a committee of the whole, meetings of departments, meetings of committee established under Article XII, and meetings of special or ad hoc committees created by the Medical Executive Committee or by departments and including information regarding any member or applicant to this medical staff shall, to the fullest extent permitted by law, be confidential. Records and proceedings of any medical staff committee may be shared by other/another medical staff committee within Rice Memorial Hospital when the information contained in these records is needed to carry out the purposes of the committee.

14.2-2 Breach of Confidentiality

Inasmuch as effective peer review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff departments or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this medical staff and shall be deemed disruptive to the operations of the hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

14.3 Immunity from Liability

14.3-1 For Action Taken

Each representative of the medical staff and hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised in good faith as a representative of the medical staff or hospital.

14.3-2 For Providing Information

Each representative of the medical staff and hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the medical staff or hospital concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this hospital.

14.4 Activities and Information Covered

14.4-1 Activities

The confidentiality and immunity provided by this Article shall apply to all good faith acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning, but not limited to:

A. Application for appointment, reappointment, or clinical privileges;

B Corrective action;

C. Hearings and appellate reviews;

D. Utilization reviews;

E. Other department, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

F. National Practitioner Data Bank queries and reports, peer review organizations, Minnesota Board of Medical Practice and similar reports.

14.5 Releases

Each applicant or member shall, upon request of the medical staff or hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

14.6 Indemnification

The hospital shall defend (or cover the costs incurred for defense), and cover settlements, judgments and damages amounts on behalf of any member of the medical staff serving on or assisting any hospital or medical staff committee, or assisting in peer review or quality management activities involving care provided at the Hospital, involved in claims arising out of such activities, so long as the member of the medical staff acted in good faith.

Article XV - General Provisions

15.1 Adoption and Amendment of Other Medical Staff Documents

15.1-1 Rules and Regulations

The medical staff shall initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its Rules and Regulations to comply with current medical staff practice.

A. Proposed changes may be originated by the Bylaws Committee, the Medical Executive Committee itself, or by a petition signed by twenty percent (20%) of the active medical staff members. An amendment to the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to the Rules and Regulations will be provided to each member of the active medical staff at least 14 days prior to the vote by the Medical Executive Committee. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

B. In cases of a documented need for an urgent amendment to the rules and regulations necessary to comply with law or regulation, the Medical Executive Committee may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the active medical staff. In such cases, the medical staff will be notified by the Medical Executive Committee of the provisionally adopted amendment as soon as possible. The medical staff then has 14 days to review and comment on the provisional amendment. If there is no conflict between the organized medical staff and the Medical Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the Medical Executive Committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

15.1-2 Credentials Policy

An amendment to the Credentials Policy may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to this document will be provided to each member of the active Medical Staff at least 14 days prior to the vote by the Medical Executive Committee. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

15.1-3 Medical Staff Organization and Functions Manual

An amendment to the Medical Staff Organization and Functions Manual may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments will be provided to each member of the active Medical Staff at least 14 days prior to the vote by the Medical Executive Committee. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

15.1-4 Medical Staff Fair Hearing Manual

An amendment to the Medical Staff Fair Hearing Manual may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments will be provided to each member of the active Medical Staff at least 14 days prior to the vote by the Medical Executive Committee. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

15.1-5 Other Medical Staff Policies

All other Medical Staff policies may be adopted and amended by a majority vote of the Medical Executive Committee. No prior notice is required. Amendments to Medical Staff policies will be distributed to or otherwise made available to Medical Staff/APP/AHP members in a timely manner.

15.1-6 Approval

A. Adoption of and changes to the Credentials Policy, Medical Staff Organization and Functions Manual, Medical Staff Fair Hearing Manual and Medical Staff Rules and Regulations will become effective only when approved by the Board.

B. Applicants and members of the medical staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the bylaws and rules and regulations, the bylaws shall prevail.

C. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff rules and regulations.

15.2 Conflict Management Process

15.2-1 When there is a conflict between the Medical Staff and the Medical Executive Committee with regard to:

A. proposed amendments to the Medical Staff Rules and Regulations;

B. a new policy proposed by the Medical Executive Committee; or

C. proposed amendments to an existing policy that is under the authority of the Medical Executive Committee,

a special meeting of the Medical Staff will be called. The agenda for that meeting will be limited to the amendment(s) or policy at issue. The purpose of the meeting is to resolve the differences that exist with respect to Medical Staff Rules and Regulations or policies.

15.2-2 If the differences cannot be resolved at the meeting, the Medical Executive Committee will forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the Board for final action.

15.2-3 When there is conflict, within a Department or between Departments, related to issues within the scope of but not otherwise addressed by the Medical Staff Bylaws, Policies and Rules and Regulations, the Department Chairperson(s) will make reasonable efforts to manage and resolve the matter collegially and informally following any applicable bylaw, rule, regulation, standards or policy governing the conflict in question. Any conflict that has the potential to affect the safety or quality of care or treatment should be resolved as soon as possible. In the event the Department Chairperson(s) is/are unable to resolve the conflict the Chief of Staff and Physician Director-Acute Care will meet with the Department Chairperson(s) and other interested parties to assist in resolving the conflict. If the conflict remains, the Chief of Staff may refer the matter to the Medical Executive committee for discussion and direction. In that case, the Chief of Staff will present the issue to the MEC for discussion and resolution.

15.2-4 Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the Chief Executive Officer, who will forward the request for communication to the Board chairperson. The Chief Executive Officer will also provide notification to the Medical Executive Committee by informing the Chief of Staff of all such exchanges. The Board chairperson will determine the manner and method of the Board's response to the Medical Staff member(s).

15.2-5 This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

15.3 Construction of Terms and Headings

The captions or headings in these bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these bylaws. These bylaws apply with equal force to both sexes wherever either term is used.

15.4 Authority to Act

Any member or members who act in the name of this medical staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

15.5 Division of Fees

Any division of fees by members of the medical staff (except as required by state and federal law) is forbidden and any such division of fees shall be cause for exclusion or expulsion from the medical staff.

15.6 Notices

Except where specific provisions are otherwise provided in these bylaws, any and all notices or demands are required to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Services, first-class postage prepaid with return receipt requested. An alternative delivery mechanism may be used if it is as reliable and expeditious as the U.S. Mail, and if evidence of its use is obtained. Notice to the medical staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable
Name of department or committee
CentraCare - Rice Memorial Hospital
301 Becker Ave SW
Willmar MN 56201

Mailed notices to a member, applicant, or other party, shall be to the addressee at the address as it last appears in the official records of the medical staff or the hospital.

15.7 Disclosure of Interest

All nominees for election or appointment to medical staff offices, department chairs, or the Medical Executive Committee shall, at least 20 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations, or relationships of which they are reasonably aware which could potentially result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.

15.8 Medical Staff Credentials Files

15.8-1 Insertion of Adverse Information

The following applies to actions relating to requests for insertion of adverse information into the medical staff member's credentials files;

A. As stated in the Fair Hearing Manual, any person may provide information to the medical staff about the conduct, performance or competence of its members.

B. When a request is made for insertion of adverse information into the medical staff member's credentials file, the respective department chair and Chief of Staff shall review such a request.

C. After such a review a decision shall be made by the respective department chair and Chief of Staff to:

1. Not insert the information;

2. Notify the member of the adverse information by a written summary and offer him/her the opportunity to rebut this assertion before it is entered into his/her file; or

3. Insert the information along with a notation that a request has been made to the Medical Executive Committee for an investigation as outlined in the Fair Hearing Manual.

D. This decision shall be reported to the Medical Executive Committee. The Medical Executive Committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

15.8-2 Review of Adverse Information at the Time of Reappointment or Renewal of Privileges

The following applies to the review of adverse information in the medical staff member's credentials file at the time of reappointment or renewal of privileges. The CentraCare Credentials Committee, as part of the reappraisal process for reappointment, reviews any adverse information in the credentials file and proceeds according to the Credentials Policy. The CentraCare –Rice Memorial Hospital Privileging Committee, as part of the reappraisal process for renewal of clinical privileges, reviews any adverse information in the credentials file and proceeds as follows.

A. Prior to recommendation on renewal of privileges, the Privileging Committee, as part of its reappraisal function, shall review any adverse information in the credentials file pertaining to a member to determine whether documentation in the file warrants further action.

B. With respect to such adverse information, the Privileging Committee shall inform the Medical Executive Committee whether:

1. it does not appear that an investigation and/or adverse action on renewal of privileges is warranted, or;

2. an investigation and/or adverse action on renewal of privileges is warranted.

C. In the event that adverse information is not utilized as the basis for a request for corrective action, or disclosed to the member as provided in the Fair Hearing Manual, it shall be removed from the file and discarded, unless the Medical Executive Committee, by a majority vote, determines that such information is required for continuing evaluation of the member's:

1. Character;

2. Competence; or

3. Professional performance.

15.8-3 Confidentiality

The following applies to records of the medical staff and its committees responsible for the evaluation and improvement of patient care:

A. The records of the medical staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital shall be maintained as confidential.

B. Access to such records shall be limited to duly appointed officers and committees of the medical staff for the sole purpose of discharging medical staff responsibilities and subject to the requirement that confidentiality be maintained, except the member may have access to his/her own record as outlined in Article 15.8-3, E immediately below.

C. Information which is disclosed to the governing body of the hospital or its appointed representatives -- in order that the governing body may discharge its lawful obligations and responsibilities -- shall be maintained by the body as confidential.

D. Information contained in the credentials file of any member may be disclosed with the member's consent, and/or as required by law.

E. A medical staff member shall be granted access to his/her own credentials file, subject to the following provisions:

1. Timely notice of such shall be made by the member to the Chief of Staff or his/her designee;

2. The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information -- including peer review committee findings, letters of reference, monitoring reports, complaints, etc. -- shall be provided to the member, in writing, by the designated officer of the medical staff, at the time the member reviews his/her credentials file. Such summary shall disclose the substance, but not the source, of the information summarized;

3. The review by the member shall take place in a mutually agreed upon private conference room during normal work hours, with an officer or designee of the medical staff present.

15.8-4 Member's Opportunity to Request Correction/Deletion of, and to Make Addition to, Information in File

A. When a member has reviewed his/her file as provided under Article 15.8-3(E) he/she may address to the Chief of Staff a written request for correction or deletion of information in his/her credentials file. Such request shall include a statement of the basis for the action requested.

B. The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, whether to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

C. The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.

D. In any case, a member shall have the right to add to his/her own credentials file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

15.9 Contracts for Services

The Hospital may enter into contracts for the performance of clinical and administrative services.

15.9-1 Exclusive Rights

To the extent that a contract confers the exclusive right to perform specified services to one or more practitioners or the Board adopts a resolution that limits the practitioners who may exercise privileges in any clinical specialty to employees of the Hospital or its affiliates, no other practitioner except those authorized by the exclusive contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means only practitioners authorized by the exclusive contract or Board resolution are eligible to apply for the clinical privileges in question at the time of initial appointment, during the term of an appointment, or at reappointment. No other applications will be processed.

15.9-2 Medical Staff Input

Prior to the Hospital signing any exclusive contract and/or passing any Board resolution described above, the Board will request input from the Medical Executive Committee pertaining to quality-of-care issues and service implications.

15.9-3 Process for Existing Privileges

After receiving the Medical Executive Committee's report, the Board will determine whether to proceed with the exclusive contract or Board resolution. If the Board determines to proceed, and if that determination would have the effect of preventing an existing member from exercising clinical privileges that had previously been granted, the following notice and review procedures apply:

A. The affected member(s) will be given at least 30 days advance notice of the exclusive contract or Board resolution and have the right to meet with a committee designated by the Board to discuss the matter prior to the contract being signed by the Hospital or the Board resolution becoming effective.

B. At the meeting, the affected member(s) will be entitled to present any information relevant to the Hospital's decision to enter into the exclusive contract or enact the Board resolution. If, following this meeting, the Board decides to enter into the exclusive contract, or enact the Board resolution, the affected member(s) will be ineligible to continue to exercise the clinical privileges covered by the exclusive contract, or resolution, unless a waiver has been granted. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or resolution is in effect.

C. The affected member(s) will not be entitled to any other procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges.

D. The inability of a physician to exercise clinical privileges because of an exclusive contract or Board resolution is not a matter that requires a report to the Minnesota licensure board or to the National Practitioner Data Bank.

15.10 Medical Staff Policy

The Medical Executive Committee shall review, develop and adopt policies which shall be binding upon the medical staff and its members. Such policies must be consistent with the medical staff bylaws and rules and regulations. Only policies adopted by the Medical Executive Committee are binding upon the medical staff and its members.

Article XVI - Adoption and Amendment of Bylaws

16.1 Procedure

16.1-1 Proposed amendments to these bylaws may be originated by the Medical Executive Committee, by the Bylaws Committee after approval by the Medical Executive Committee, or by a petition signed by twenty percent (20%) of the members of the active medical staff.

16.1-2 All proposed amendments must be reviewed by the Bylaws Committee and the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee will provide notice of all proposed amendments to the active medical staff members. All members of the active medical staff shall receive at least fourteen (14) days advance notice of the proposed changes.

16.1-3 Each member of the active medical staff shall be eligible to vote on the proposed amendment to these bylaws via ballot in a manner determined by the Medical Executive Committee, which may include email or other electronic means. Ballots must be returned to Medical Staff Services by the date indicated by the Medical Executive Committee.

16.2 Action on Bylaws Change

To be adopted, the proposed changes to these bylaws must receive an affirmative vote of the majority of the votes cast.

16.3 Amendments due to Document Format

The Medical Executive Committee will have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

16.4 Approval

Bylaw changes adopted by the medical staff shall become effective following approval by the Board of Directors, which approval shall not be withheld unreasonably. If approval is withheld, the reasons for doing so shall be specified by the Board of Directors in writing, and shall be forwarded to the Chief of Staff and the Medical Executive Committee.

16.5 Prohibition of Unilateral Amendment

These Bylaws may not be unilaterally amended by the Medical Executive Committee, the Medical Staff, or the Board.

16.6 Exclusivity

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff bylaws.

16.7 Successor in interest

These bylaws, and privileges of individual members of the medical staff accorded under these bylaws, shall be binding upon the medical staff, and the Board of Directors of any successor in interest in this hospital, except where hospital medical staffs are being combined.

ADOPTED by the medical staff on December 6, 2022

APPROVED by the Willmar Area Advisory Board on January 11, 2023