MEDICAL STAFF BYLAWS
OF
THE SAINT CLOUD HOSPITAL

MEDICAL STAFF BYLAWS

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

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

1.B. 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.C. DELEGATION OF FUNCTIONS

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

1.D. MEDICAL STAFF DUES

(1) Annual dues may be as recommended by the Medical Executive Committee and may vary by category.

(2) Dues will be payable annually upon request. Failure to pay dues will result in ineligibility to apply for reappointment.

(3) The Chief of Staff and Secretary-Treasurer are signatories to the Hospital's Medical Staff account.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

2.A. OVERVIEW

(1) Qualifications and conditions for appointment to the Medical Staff, Advanced Practice Provider Staff, and Allied Health Professional ("Medical Staff/APP/AHP") are outlined in the Credentials Policy. The qualifications for appointment to the specific categories are outlined below.

(2) Appointments will be made by the Board, upon recommendation of the Medical Executive Committee, to one of the following categories: Active, Consulting, Courtesy, Affiliate, Limited Active Staff, Administrative, Honorary, Centracare Credentialed Staff, Advanced Practice Provider, or Allied Health Professional.

2.B. ACTIVE STAFF

2.B.1. Qualifications:

The Active Staff consists of physicians, dentists, and podiatrists who:

(a) are involved in at least 50 patient contacts at the Hospital per appointment term; or

(b) fail to meet the activity requirements of this category but are clinically active at the Hospital and have demonstrated a commitment to the Medical Staff through service on Medical Staff or Hospital committees or active participation in performance/quality improvement functions of at least 24 documented hours per appointment term; and

2.B.2. Prerogatives:

Active Staff members who have served on the Active Staff for at least two years:

(a) may vote in all general and special meetings of the Medical Staff, and applicable department and committee meetings;

(b) may hold office; and

(c) may serve as department chairperson or committee chairperson.

2.B.3. Responsibilities:

(a) Active Staff members:

(1) perform the functions and responsibilities of membership on the Active Staff, including care for unassigned patients, emergency call, committee service, evaluation of members during the provisional period, and teaching assignments;

(2) participate in the peer review and performance improvement process;

(3) accept consultations;

(4) attend applicable meetings; and

(5) must pay application fees, dues and assessments.

(b) Active Staff members who do not want to participate in Medical Staff responsibilities (e.g., committee service, evaluation of members; participate in peer review functions) may opt out by paying an annual fee as determined by the Medical Executive Committee, which will be used to support those members who perform those responsibilities. However, members may **not** opt out of those responsibilities related to care for unassigned patients and emergency call and the Medical Executive Committee reserves the right to assign responsibilities at any time it finds there are insufficient members to perform needed responsibilities.

2.C. CONSULTING STAFF

2. C.1. Qualifications:

The Consulting Staff consists of physicians, dentists, and podiatrists who:

(a) are of recognized professional ability and expertise and provide a service that is not otherwise available on the Active Staff; or

(b) are appointed to the Active or Associate Staff at another hospital where they are currently practicing, unless their clinical specialty does not support an active inpatient practice and the Board makes an exception to this requirement.

2. C.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may treat (but not admit) patients in conjunction with another physician on the Medical Staff;

(b) may attend meetings of the Medical Staff (with vote);

(c) may attend applicable department meetings (with vote) and committee meetings (with vote);

(d) may hold office or serve as department chairperson or committee chairperson;

(e) will participate in the peer review and performance improvement process; and

(f) must pay application fees, dues and assessments.

2.D. COURTESY STAFF

2. D.1. Qualifications:

The Courtesy Staff consists of physicians, dentists, and podiatrists who:

(a) have fewer than 50 patient contacts, per appointment term, at the Hospital (involvement in a greater number of patient contacts will result in the automatic transfer to the Active Staff); and

(b) are members of the Active or Associate Staff at another hospital, unless their clinical specialty does not support an active inpatient practice and the Board makes an exception to this requirement.

2. D.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may attend Medical Staff meetings (without vote);

(b) are encouraged to attend department meetings (without vote);

(c) may not hold office or serve as department chairperson or committee chairperson;

(d) may be invited to serve on committees (with vote);

(e) must perform all functions and responsibilities assigned, including, where appropriate, care for unassigned patients, emergency service care, consultations, and teaching assignments;

(f) will participate in the peer review and performance improvement process; and

(g) must pay application fees, dues and assessments.

2.E. AFFILIATE STAFF

2. E.1. Qualifications:

The Affiliate Staff will consist of physicians, dentists, and podiatrists who desire to be associated with the Hospital but who do not wish to exercise clinical privileges.

(a) The primary purpose of the Affiliate Staff is to permit these members access to Hospital services for their patients by referral to members of the Active Staff, while at the same time providing follow-up care, on an outpatient basis, for unassigned patients presenting to the Emergency Trauma Center and providing additional physician alternatives for patients with outpatient needs;

(b) Individuals requesting appointment to the Affiliate Staff must submit an application as prescribed in the Credentials Policy; and

(c) At the time of initial appointment and at each reappointment time thereafter, 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).

2. E.2. Prerogatives and Responsibilities:

(a) Affiliate Staff members:

(1) may attend meetings of the Medical Staff and applicable departments (all without vote; the department may grant voting rights within the department to an affiliate member at its discretion);

(2) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote) if appointed by the Chief of Staff;

(3) may attend educational activities sponsored by the Medical Staff and the Hospital;

(4) may refer patients to members of the Active Staff for admission and/or care;

(5) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(6) are encouraged to communicate with hospitalists and/or Active Staff members about the care of any patients referred and are encouraged to visit any patients who are hospitalized;

(7) may not: admit patients, attend patients, exercise any clinical privileges, write orders or progress notes, perform consultations, assist in surgery, make notations in the medical record, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(8) shall participate with the peer review and performance improvement process;

(9) may refer patients to the Hospital's diagnostic facilities;

(10) are not required to pay application fees, dues, and assessments.

(b) The granting of appointment to the Affiliate Staff is a courtesy only, which may be terminated by the Board upon recommendation of the Medical Executive Committee, with no right to a hearing or appeal.

2.F. LIMITED ACTIVE STAFF

2. F.1. Qualifications:

The Limited Active Staff consists of physicians, dentists, and podiatrists who:

(a) Provide ambulatory services in a provider-based (Hospital) setting such that hospital credentials are required. This would include but is not limited to the Pediatric Short-Stay Unit, Sleep Center and Wound Center;

(b) Provide services deemed by the Hospital as necessary;

(c) Do not attend, consult or otherwise provide care to inpatients;

(d) Individuals requesting appointment to the Limited Active Staff must submit an application as prescribed in the Credentials Policy; and

(e) At the time of initial appointment and each reappointment thereafter, 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 provider-based practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms, completed by referring/referred to physicians).

2. F.2. Prerogatives:

Limited Active Staff members may:

(a) Provide specific (limited scope) provider-based ambulatory care commensurate with the individuals training and current competence;

(b) Attend meetings of the Medical Staff (with vote);

(c) Attend applicable department meetings (with vote) and committee meetings (with vote); and

(d) Serve as an officer of the Medical Staff but may not serve as department chair.

2. F.3. Responsibilities:

(a) Participate in the peer review and performance improvement process; and

(b) must pay application fees, dues and assessments.

2.G. ADMINISTRATIVE STAFF

2. G.1. Qualifications:

(a) The Administrative Staff will consist of any physician, dentist, or podiatrist who is not otherwise eligible for another staff category and who is retained by the Hospital or Medical Staff to perform administrative activities.

(b) Administrative Staff membership will automatically terminate on the date on which the member's affiliation with the Hospital is terminated.

2. G.2. Prerogatives and Responsibilities:

Administrative Staff members:

(a) Administrative Staff appointees will devote their full time to performing administrative duties at the Hospital and shall not engage in any clinical practice or have the responsibility for patient care, except as these activities may directly relate to an administrative duty. They may, but are not required to, attend Medical Staff meetings, except where designated in their job descriptions.

(b) Persons appointed to the Administrative Staff will not be eligible to hold Medical Staff office, to vote, or to serve on standing Medical Staff committees, except where designated in their job descriptions.

(c) must pay application fees, dues and assessments.

2.H. HONORARY STAFF

2. H.1. Qualifications:

(a) The Honorary Staff will consist of physicians, dentists, and podiatrists who:

(1) have a record of previous long-standing service to the Hospital and have retired from the active practice of medicine; or
(2) are recognized for outstanding or noteworthy contributions to the medical sciences.

(b) None of the specific qualifications for appointment are applicable to members of the Honorary Staff.

2. H.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not admit, attend, or consult on patients;

(b) may attend Medical Staff and department meetings (without vote);

(c) may be appointed to committees (with vote); and

(d) are not required to pay application fees, dues or assessments.

2.I. CENTRACARE CREDENTIALED STAFF

2. I.1. Qualifications:

(a) The CentraCare Credentialed Staff will consist of providers who meet the qualifications for membership on the Medical Staff, APP Staff and AHP Staff as delineated in these Bylaws.

(b) These providers have been recommended for credentialing by the CentraCare Credentialing Committee and have been approved for credentialing by the CentraCare St. Cloud Hospital.

2. I.2. Prerogatives:

These providers:

(a) are exempt from the basic responsibilities and rights granted to other members of the Medical Staff, APP Staff and AHP Staff. They are also exempt from all St. Cloud Hospital medical education that is required of physicians and licensed independent practitioners granted privileges at St. Cloud Hospital;

(b) may not attend or vote on matters at Medical Staff and department meetings;

(c) may not hold office or be appointed to committees;

(d) have not been granted privileges to practice at CentraCare St. Cloud Hospital; and

(e) are not required to pay application fees, dues or assessments.

2. I.3. Limitations

(a) These providers may be appointed to CentraCare Credentialed Staff for no longer than 24 months. They may be reappointed if they have successfully completed the reappointment process.

(b) Providers on the CentraCare Credentialed Staff that wish to request privileges at CentraCare-St. Cloud Hospital will be reassigned to the applicable medical staff category.

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

2.J. ADVANCED PRACTICE PROVIDER STAFF

2.J.1. Qualifications:

The Advanced Practice Provider Staff consists of advanced practice providers who satisfy the qualifications and conditions for appointment to the Advanced Practice Provider Staff contained in the Credentials Policy. The Advanced Practice Provider Staff is not a category of the Medical Staff but is included in this Article of the Bylaws for convenient reference.

2. J.2. Prerogatives and Responsibilities:

Advanced Practice Provider Staff members:

(a) may attend applicable department meetings, voting rights per discretion of department;

(b) may not hold office or serve as department chairperson or committee chairperson;

(c) may serve on a committee, if requested (with vote);

(d) must cooperate in the peer review and performance improvement process; and

(e) are not required to pay applicable fees, dues, and assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The Medical Staff will have the following officers:

(1) Chief of Staff;

(2) Chief of Staff-Elect;

(3) Secretary-Treasurer; and

(4) Immediate Past Chief of Staff.

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously will be eligible to serve as an officer of the Medical Staff. They must:

(1) be appointed in good standing to the Active Staff, have served on the Active Staff for at least two years, and meet the patient contact requirements outlined in Section 2.B.1(a) of these Bylaws;

(2) be willing to faithfully discharge the duties and responsibilities of the position;

(3) have experience in a leadership position, or other involvement in performance improvement functions;

(4) have demonstrated an interest in maintaining quality medical care at the Hospital;

(5) have demonstrated an ability to work well with others;

(6) attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;

(7) have no pending adverse recommendations concerning staff appointment or clinical privileges;

(8) not presently be serving as a Medical Staff officer, Board member, or department chairperson at any other hospital and will not so serve during their terms of office; and

(9) not have any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with an entity that competes with the Hospital or any

affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

3.C. DUTIES

3.C.1. Chief of Staff:

The Chief of Staff will:

(a) act in coordination and cooperation with the Vice President for Medical Affairs, the President of the Hospital, and others in management positions in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies and needs, and report on the activities of the Medical Staff to the President of the Hospital, Vice President for Medical Affairs, and the Board;

(c) provide day-to-day liaison on Medical Staff matters with the President of the Hospital, the Vice President for Medical Affairs, and the Board;

(d) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the Medical Executive Committee;

(e) appoint all committee members and chairpersons, in consultation with the Vice President for Medical Affairs, subject to approval by the Medical Executive Committee, except as expressly stated in these Bylaws or the Organization and Functions Manual;

(f) serve as chairperson of the Medical Executive Committee (with vote, as necessary);

(g) be a member of all other Medical Staff committees, *ex officio*, without vote;

(h) cause to be kept accurate and complete minutes of Medical Staff and Medical Executive Committee meetings;

(i) promote adherence to these Bylaws, Medical Staff policies, the Rules and Regulations and to the policies and procedures of the Hospital;

(j) recommend Medical Staff representatives to Hospital committees;

(k) be the spokesperson for the Medical Staff in external professional and public relations;

(l) perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy; and

(m) attend meetings of the Board, with vote, in accordance with the Hospital corporate bylaws.

3.C.2. Chief of Staff-Elect:

The Chief of Staff-Elect will:

(a) assume all duties of the Chief of Staff and act with full authority as Chief of Staff in his or her absence;

(b) serve on the Medical Executive Committee;

(c) serve on the Credentials Committee;

(d) automatically succeed the Chief of Staff at the expiration of the Chief of Staff's term;

(e) assume all such additional duties as are assigned by the Chief of Staff or the Medical Executive Committee; and

(f) attend meetings of the Board, without vote, in accordance with the Hospital corporate bylaws.

3.C.3. Secretary-Treasurer:

The Secretary-Treasurer will:

(a) assume all duties of the Chief of Staff, if the Chief of Staff and the Chief of Staff-Elect are temporarily unable or unavailable to perform these duties;

(b) serve on the Medical Executive Committee;

(c) be responsible for the collection of, accounting for, and disbursements of any funds collected, donated, or otherwise assessed and present in the Medical Staff Fund and report to the Medical Staff; and

(d) attend to such other duties as ordinarily pertain to this office.

3.C.4. Immediate Past Chief of Staff:

The Immediate Past Chief of Staff will:

(a) serve on the Medical Executive Committee;

(b) serve on the Credentials Committee;

(c) serve as an advisor to other Medical Staff leaders;

(d) assume all duties assigned by the Chief of Staff or the Medical Executive Committee; and

(e) attend meetings of the Board, with vote, in accordance with the Hospital corporate bylaws.

3.D. NOMINATION AND ELECTION PROCESS

3.D.1. Nominating Process:

(a) The Credentials Committee will nominate candidates for the following positions:

(1) Chief of Staff-Elect of the Medical Staff; and

(2) Secretary-Treasurer of the Medical Staff.

(b) The Credentials Committee will convene three months prior to the annual meeting and prepare a slate of qualified nominees for each office. Notice of the nominees will be provided to the voting members of the Medical Staff two months prior to the annual meeting.

(c) Additional nominations may be submitted to the Credentials Committee, in writing, by a petition signed by at least ten voting members of the Medical Staff. Any such petition must be received at least 30 days prior to the election.

(d) In order for a nominee to be placed on the ballot, the candidate must be willing to serve and must, in the judgment of the Credentials Committee, satisfy the qualifications in Section 3.B of these Bylaws.

(e) Nominations from the floor will not be accepted.

3.D.2. Election:

(a) If there are two or more candidates for any office or position, the vote will be by written ballot.

(b) If any voting member of the Medical Staff is unable to attend the meeting, the member may vote by absentee ballot.

(c) The absentee ballots must be returned to the Medical Staff Office by noon on the date of the annual meeting. The absentee ballots will be counted prior to the meeting and will be included in the vote at the meeting.

(d) The candidates receiving a majority of written votes cast will be elected.

(e) If no candidate receives a simple majority vote on the first ballot, a run-off election will be held promptly between the two candidates receiving the highest number of votes.

3.E. TERM OF OFFICE, VACANCIES AND REMOVAL

3.E.1. Term of Office:

(a) The Chief of Staff will serve a term of one year with an optional second year at his or her discretion. If the Chief of Staff chooses to serve the optional second year, he or she must declare his or her intentions in writing to the Medical Executive Committee 90 days prior to the first day of the Medical Staff year. No less than 60 days prior to the first day of the Medical Staff year, a closed ballot will be sent to the voting members of the Medical Staff to approve or disapprove the Chief of Staff for a second year by majority vote. If the vote does not yield a majority approval, the Chief of Staff's term will end on June 30 and the Chief of Staff-Elect will assume the Chief of Staff position on July 1.

(b) The Chief of Staff-Elect will advance to the Chief of Staff position if the Chief of Staff decides not to serve the optional second year term. However, if the Chief of Staff decides to serve the optional second year term, and that decision is confirmed by the voting members of the Medical Staff, the Chief of Staff-Elect has the option to continue a second term in that position or end his or her service as an officer. In either case, the Chief of Staff-Elect must declare his or her intentions in writing to the Medical Executive Committee 30 days prior to the first day of the Medical Staff year.

(c) The Secretary-Treasurer will serve for a term of one year and may be reelected for additional terms.

(d) All officers will assume office on the first day of the Medical Staff year.

3.E.2. Vacancies:

(a) Except as otherwise described in Section 3.E.1, a vacancy in the office of Chief of Staff will be filled by the Chief of Staff-Elect, who will serve until the end of the unexpired term of the Chief of Staff.

(b) A vacancy in the office of Chief of Staff-Elect will be filled by a special election at the next staff meeting using the general nomination and election process described in these Bylaws.

(c) A vacancy in the office of Secretary-Treasurer will be filled by the Medical Executive Committee, until a special election can be held.

3.E.3. Removal:

(a) The Medical Executive Committee, by a two-thirds vote, may remove any officer or member of the Medical Executive Committee for:

(1) failure to comply with applicable policies, Bylaws, or the Rules and Regulations;

(2) failure to perform the duties of the position held;

(3) conduct detrimental to the interests of the Medical Staff or the Hospital; or

(4) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(b) Prior to scheduling a meeting to consider removal, a representative from the Medical Executive Committee will meet with the individual in question and inform the individual of the reasons for the proposed removal proceedings.

(c) The individual subject to removal will be given at least ten days' special notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to speak to the Medical Executive Committee prior to a vote on removal.

(d) Removal proceedings will be effective when approved by the Board.

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

4.A.1. Organization of 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.

4.A.2. Assignment to Departments:

(a) Upon initial appointment to the Medical Staff, each member will be assigned to a clinical department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.

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

4.A.3. Functions of Departments:

(a) Departments will be organized for the purpose of implementing processes to monitor and evaluate the quality and appropriateness of the care of patients served by the department, and to monitor the practice of all those with clinical privileges in a given department.

(b) Each department will oversee emergency call coverage for all patients who present to the Emergency Department and elsewhere in the Hospital, as may be needed.

4.B. DEPARTMENT CHAIRPERSONS AND VICE CHAIRPERSONS

4.B.1. Qualifications:

Each department chairperson and vice chairperson must:

(a) be an Active Staff member or a Consulting Staff Member;

(b) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and

(c) satisfy the eligibility criteria in Section 3.B. as amended for applicability to their membership category.

4.B.2. Selection of Department Chairpersons and Vice Chairpersons:

(a) The vice chairperson may automatically succeed the department chairperson at the expiration of his or her term or whenever there is a vacancy in a department chairperson position, unless otherwise determined by an individual department.

(b) The Medical Staff Office will call for nominations eight weeks prior to scheduled election. The names of nominated individuals are due back to the Medical Staff Office within four weeks of nominee call. The Medical Staff Office will seek the permission of the nominated individuals to move forward as nominated candidates. The names of nominated candidates will then be provided to the current respective department chairs to vet vice chair candidate(s) with a focus on the requirements of Section 3.B, professional expertise, leadership skills, administrative capabilities, and commitment to the support and development of the Medical Staff and the department. Chairs should notify department leadership consisting of current respective department vice-chair, Chief of Staff, Chief of Staff Elect, Vice President of Medical Affairs and Chair of the Credentials Committee if there are any professional or leadership related issues. Concerns regarding any candidate(s) that falls out will be addressed at a leadership meeting as appropriate. The names of nominated candidates to be on the ballot will be forwarded to the department members two weeks in advance of the election.

(c) The nominated candidates will be elected by eligible Medical Staff appointees in the department making a motion at department meetings. Motion follows with one of the Active Staff members to second the motion. Once motion is seconded, the presiding officer will call for a vote on the motion. The vote is called taking the “yeas” and “nays” of members in attendance at the meeting. Active Staff department members vote on the motion. An absentee ballot is permissible for members unable to attend the meeting to vote or if the department does not have a department meeting during the election process. The nominated candidate is elected by majority vote of those members voting.

(d) Removal of a chair or vice chair may be initiated by a two-thirds vote of all Active Staff appointees in the department, or by the Board on its own motion.

4.B.3. Term of Appointment and Performance Evaluation for Department Chairpersons and Vice Chairpersons:

(a) Initial appointment and reappointment of a department chairperson will be for a period of two years. If nominated and elected, a chairperson may serve consecutive terms.

(b) A performance evaluation of the department chairperson may be initiated by the Vice President for Medical Affairs, who may appoint a committee to assist in this function.

(c) The following factors may be addressed as part of the evaluation:

(1) quality and support of the department as it interfaces with other Hospital departments;

(2) communication, coordination, quality and service of care within the department;

(3) effectiveness of the performance improvement program; and

(4) where appropriate, contribution to patient care, education and research.

(d) The Vice President for Medical Affairs will prepare a written report of the evaluation and provide a copy to the department chairperson concerned. The Medical Executive Committee will also receive a copy of the report and have an opportunity to comment on it.

(e) The Vice President for Medical Affairs will monitor the department chairperson's improvement activities and report progress to the Medical Executive Committee and the Board.

4.B.4. Duties of Department Chairpersons:

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) evaluating requests for clinical privileges for each member of the department;

(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 interdepartment and intradepartment 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 improvement of the quality of care, treatment, and services provided;

(n) maintaining quality monitoring 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) developing an on-call schedule 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 ensuring that the vice-chairperson or other representative of the department will attend meetings of the Committee in his or her absence;

(u) performing functions authorized in the Credentials Policy; and

(v) vetting new vice chair candidate(s) during election cycle or whenever there is a vacancy in the department.

4.B.5. Removal of Department Chairpersons and Vice Chairpersons:

(a) Any department chairperson or vice chairperson may be removed by a two-thirds vote of the department members; or by a two-thirds vote of the Medical Executive Committee subject to Board confirmation; or by the Board, after reasonable notice and opportunity to be heard. 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.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. GENERAL

5.A.1. Appointment:

(a) Except as otherwise provided by these Bylaws or the Organization and Functions Manual, the Chief of Staff, in consultation with the Vice President for Medical Affairs, will appoint the members and the chairperson of each committee. Non-Medical Staff members, including APP and MAS staff, may also be appointed to committees. These appointments are subject to approval by the Medical Executive Committee.

(b) Committee chairpersons and vice chairpersons will be selected based on the criteria set forth in Section 4.B of these Bylaws.

(c) Chairpersons, vice chairpersons, and members of standing committees will be appointed for an initial term of two years, but may be reappointed for additional terms.

(d) Chairpersons, vice chairpersons, and members of standing committees may be removed and vacancies filled at the discretion of the Chief of Staff, subject to approval by the Medical Executive Committee.

(e) The Chief of Staff will be an *ex officio* member, without vote, on all Medical Staff committees.

(f) The President of the Hospital and the Vice President of Medical Affairs will be *ex officio* members, without vote, on all Medical Staff committees.

5.A.2. Medical Staff Functions:

Provision will be made for the effective performance of Medical Staff functions through committees as may be established by the Medical Executive Committee. The composition, duties and meeting requirements of additional committees are set forth in the Organization and Functions Manual.

5.B. MEDICAL EXECUTIVE COMMITTEE

5.B.1. Composition:

(a) The Medical Executive Committee will consist of the following: the Chief of Staff, Chief of Staff-Elect, Secretary-Treasurer, Immediate Past Chief of Staff, Chairperson of the Medical Care Review Committee, Residency Program Director, the chairperson of each clinical department, one Advanced Practice Registered Nurse and one Physician

Assistant. The following will serve as ex officio members with no vote: Chief Nursing Officer, APP Practice Director, and Vice President for Medical Affairs.

(b) The President of the Hospital, the Vice President of Medical Affairs, and the Graduate Medical Education Director 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) There may be a non-physician member of the Board who serves as a non-voting Board representative.

(e) The Chief of Staff will serve as Chairperson of the Medical Executive Committee.

(f) The Advanced Practice Registered Nurse and Physician Assistant members of the Medical Executive Committee will be appointed to two (2) year terms by the Chief of Staff. They will have practiced for at least four (4) years at St. Cloud Hospital or another CentraCare Health facility. They will be recognized for their professionalism and leadership skills. They may be reappointed at the discretion of the Chief of Staff.

5.B.2. Duties:

The Medical Executive Committee is delegated the primary authority over activities related to functions of the Medical Staff and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed by amending these Bylaws and related policies. The Medical Executive Committee is responsible to:

(a) act 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);

(b) recommend 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/MAS;

(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/MAS may be terminated;

(7) hearing procedures; and

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

(c) consult with administration on quality-related aspects of contracts for patient care services;

(d) review quality indicators to ensure uniformity regarding patient care services;

(e) provide leadership in activities related to patient safety;

(f) provide oversight in the process of analyzing and improving patient satisfaction;

(g) review, at least every two 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

(h) perform such other functions as are assigned to it by these Bylaws, the Rules and Regulations, the Credentials Policy, or other applicable policies.

5.B.3. Meetings:

The Medical Executive Committee will meet as often as necessary to fulfill its responsibilities and maintain a permanent record of its proceedings and actions.

5.C. PERFORMANCE IMPROVEMENT FUNCTIONS

(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 and individual practitioners' 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 9.

(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.

5.D. CREATION OF STANDING AND SPECIAL COMMITTEES

(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.

(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 Credentials Committee.

(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.

(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 6

MEETINGS

6.A. GENERAL

6.A.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.

6.A.2. Meetings:

(a) The Medical Staff will meet annually. 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.

6.A.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.

(b) The annual meeting of the Medical Staff will be held in May.

6.A.4. Special Meetings:

(a) A special meeting of the Medical Staff may be called by the Chief of Staff, a majority of the Medical Executive Committee, the President of the Hospital, the Vice President for Medical Affairs, the Chairperson of the Board, or by a petition signed by at least 25% of the voting members of the Medical Staff.

(b) A special meeting of any department or committee may be called by or at the request of the Chief of Staff, the Vice President for Medical Affairs, the relevant chairperson, or by a petition signed by at least 25% of the voting members of the department or committee.

(c) No business will be transacted at any special meeting except that stated in the meeting notice.

6.B. PROVISIONS COMMON TO ALL MEETINGS

6.B.1. Notice:

(a) The notice of regular and special meetings will state the date, time, and place of the meeting.

(b) Notice of any regular or special meeting of the Medical Staff, or of a department or committee, will be posted on the Medical Staff bulletin board and sent to each voting member of the Medical Staff, department, or committee, via electronic mail, at least five business days in advance of the meeting.

(c) The absence of any individual at any meeting will constitute a waiver of that individual's notice of the meeting.

6.B.2. Quorum:

(a) Except as otherwise provided in these Bylaws or the Organization and Functions Manual, for any regular or special meeting of the Medical Staff the presence of at least 20 voting members will constitute a quorum.

(b) For department or committee meetings, those voting members present will constitute a quorum.

(c) For meetings of the Medical Executive Committee and the Credentials Committee, the presence of at least 50% of the committee members will constitute a quorum.

(d) Once a quorum is established, the business of the meeting may continue and actions taken will be binding.

6.B.3. Voting:

(a) Any individual, regardless of position or staff category, will be entitled to only one vote.

(b) Recommendations and actions of the Medical Staff, departments, and committees will be by consensus. Except as otherwise provided in these Bylaws, in the event it is necessary to vote on an issue, the issue will be determined by a majority of the voting members.

(c) Members of the Medical Staff and members of any department or committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, 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.

(d) Meetings may be conducted by telephone conference.

6.B.4. Agenda:

(a) The Chief of Staff will set the agenda for regular and special meetings of the Medical Staff. An effort will be made to provide notice of the proposed agenda to members of the Medical Staff five days in advance of the meeting. The agenda may be revised, including at the meeting, as needed.

(b) The chairperson of each department and committee will set the agenda for general and special meetings of the respective department and committee.

6.B.5. Rules of Order:

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.

6.B.6. 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 President of the Hospital and the Vice President for Medical Affairs will receive a copy of minutes and reports 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.

6.B.7. 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.

6.C. ATTENDANCE

6.C.1. Regular and Special Meetings:

(a) Members of the Active Staff are expected to attend all regular Medical Staff meetings and applicable department meetings.

(b) Members of the Consulting, Courtesy and Affiliate Staff are expected to attend and participate in applicable department meetings.

(c) Members of the Medical Executive Committee and the Credentials Committee are expected to attend all meetings and are required to attend at least one-half of the meetings held.

6.C.2. Required Meetings:

(a) Whenever there is an apparent or suspected deviation from standard clinical practice, or professional conduct, involving any individual, the department chairperson or the Chief of Staff may require the individual to attend a meeting with Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff.

(b) The procedures for, and consequences of failing to abide by, these special attendance requirements are addressed in the Credentials Policy.

ARTICLE 7

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy.

7.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff/APP/MAS, or for the grant 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.

7.B. PROCESS FOR CREDENTIALING AND PRIVILEGING

(1) Complete applications for appointment and privileges will be transmitted to the applicable department chairperson, who will prepare a written report. This report will be forwarded to the Credentials Committee for review and recommendation. The recommendation of the Credentials Committee will be forwarded, along with the department chairperson's report, 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.

(2) 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.

7.C. INDICATIONS AND PROCESS FOR RELINQUISHMENT

(1) Appointment and clinical privileges will be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information;

(iv) attend a requested meeting to discuss issues or concerns; or

(v) fulfill duties during the provisional period;

(vi) comply with the requirements outlined in the Professional Practice Evaluation Policy;

(b) 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;

(c) makes a misstatement or omission on an application form; or

(d) 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.

(2) Automatic relinquishment will take effect immediately and will continue until the matter is resolved, if applicable.

7.D. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President of the Hospital, the Chief of Staff, the Chairperson of the Credentials Committee, the chairperson of the relevant clinical department, the Vice President for Medical Affairs, 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.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the President of the Hospital or the Credentials Committee.

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

(4) The Credentials Committee will review the reasons for the suspension within a reasonable time.

(5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the Credentials Committee.

7.E. 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:

(1) clinical competence or clinical practice, including patient care, treatment or management;

(2) the known or suspected violation of applicable ethical standards or the bylaws, policies, rules and regulations of the Medical Staff or the Hospital; or

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

7.F. HEARING AND APPEAL PROCESS

(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.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

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

(4) A stenographic reporter will be present to make a record of the hearing.

(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 Hearing Panel or Hearing Officer.

(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.

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

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

ARTICLE 8

AMENDMENTS

8.A. MEDICAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by a petition signed by 25% of the voting members of the Medical Staff, by the Bylaws Committee, or by the Medical Executive Committee.

(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, including amendments proposed as set forth above, to the voting members of the Medical Staff. The Medical Executive Committee may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose.

(3) The proposed amendments may be voted upon at any meeting provided the amendments have been posted on the Medical Staff bulletin board at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(4) The Medical Executive Committee may also present any proposed amendments to the voting staff by written or electronic ballot, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee, provided the amendments have been posted on the Medical Staff bulletin board at least 14 days prior to the return date requested for the vote. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast.

(5) 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.

(6) All amendments will be effective only after approval by the Board.

(7) If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference will be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the President of the Hospital within two weeks after receipt of a request.

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

8.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there are the Rules and Regulations and Medical Staff policies and procedures that are applicable to Medical Staff/APP/MAS members and to other individuals who have been granted a scope of practice.

(2) An amendment to the Credentials Policy may be made by a majority vote of the members of the Medical Executive Committee provided that the written recommendations of the Credentials Committee concerning the proposed amendments have first been received and reviewed by the Medical Executive Committee. Notice of all proposed amendments to this document, via posting on the Medical Staff bulletin board or electronic mail, will be provided to each voting member of the 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.

(3) An amendment to the Medical Staff Organization Manual or 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 these two documents, via posting on the Medical Staff bulletin board or electronic mail, will be provided to each voting member of the 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.

(4) The Medical Executive Committee and the Board will have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments will be provided to each member of the Medical Staff as soon as possible. The Medical Staff will have 14 days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendments will stand. If there is conflict over the provisional amendments, then the process for resolving conflicts set forth below will be implemented.

(5) 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/MAS members in a timely manner.

(6) Amendments to the Credentials Policy, or any other Medical Staff policy, the Organization and Functions Manual, or the Rules and Regulations, may also be proposed by a petition signed by at least 25% of the voting members of the Medical Staff. Notice of any such proposed amendment to these documents will be provided to the Medical Executive Committee at least 30 days prior to being voted on by the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendment before it is forwarded to the Medical Staff for vote.

(7) Adoption of and changes to the Credentials Policy, Medical Staff Organization Manual, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

8.C. CONFLICT MANAGEMENT PROCESS

(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.

(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.

(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, Chief of Staff Elect and Vice President of Medical Affairs 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.

(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 President of the Hospital, who will forward the request for communication to the Board chairperson. The President of the Hospital 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).

(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.

ARTICLE 9

HISTORY AND PHYSICAL

9.A. GENERAL DOCUMENTATION REQUIREMENTS

(1) A medical history and physical examination must be completed and documented by a licensed practitioner who is credentialed and privileged by the Medical Staff to perform a history and physical examination for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services except as provided in 9.A.(5). An H&P is required prior to surgery and prior to procedures requiring anesthesia services, regardless of whether care is being provided on an inpatient or outpatient basis.

When a history and physical examination is conducted within thirty (30) days before admission or registration, an update must be completed and documented by a licensed practitioner who is credentialed and privileged by the hospital's medical staff to perform a history and physical examination. The update must include any changes in the patient's condition that might impact on the planned procedure, and must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

If, upon examination, the licensed practitioner finds no change in the patient's condition since the history and physical examination was completed, he/she may indicate in the patient's medical record that the history and physical examination was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the history and physical examination was completed.

(2) The scope of the medical history and physical examination will include, as pertinent:

- patient identification;
- chief complaint;
- history of present illness;
- review of systems;
- personal medical history, including medications and allergies;
- family medical history;
- social history, including any abuse or neglect;
- physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
- data reviewed;
- assessments, including problem list;
- plan of treatment; and
- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion, which will be documented in the plan of treatment.

(3) In the case of a pediatric patient, the history and physical examination report must also include: (i) length or height; and (ii) weight.

(4) Concerning patients receiving electro-convulsive therapy (ECT), a medical history and physical examination must be completed:

a. A full operative history and physical must be completed and documented within 30 days prior to initiation of ECT as per the Medical Staff Bylaws, Policies, and Rules and Regulations of St. Cloud Hospital for a medical history and physical examination.

b. On-going full operative history and physical examinations are required at 6-month intervals unless otherwise indicated during pre-ECT treatment assessment, or the patient condition changes as identified by the psychiatrist or anesthesiologist.

c. An interval history and physical examination for ECT must be completed and documented prior to the start of each treatment. The minimum elements of the interval history and physical are:

1. Chief Complaint/HPl
2. Procedure planned
3. Past Medical and Surgical history
4. Current medication review
5. Allergies
6. Physical examination to include heart and lung assessment & mental status
7. Overall assessment
8. Plan this for ECT treatment

(5) A comprehensive H&P, or any update to it, is not required for the patients identified below. For these patients, a comprehensive assessment of the patient must be completed and documented prior to or during the admission process. Required components of this assessment are identified in Policy. This assessment must be completed within 3 calendar days after admission. The assessment must be completed and documented by a qualified licensed individual in accordance with State law and hospital policy.

a. Adolescent and Adult Addiction Services

9.B. HISTORY AND PHYSICALS PERFORMED PRIOR TO ADMISSION

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and a new H&P needs to be completed.

9.C. CANCELLATIONS, DELAYS, AND EMERGENCY SITUATIONS

(1) When the history and physical examination is not recorded in the medical record before an elective, non-emergent surgical case or other invasive procedure (including, but not limited to, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until a complete history and physical examination is recorded in the medical record.

(2) When there is not time to document a consult or history and physical prior to an emergency operation this documentation needs to be done within 6 hours of the finish of the operation.

9.D. PRENATAL RECORDS

The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

ARTICLE 10

ADOPTION

(a) These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter thereof.

(b) The present Rules and Regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended. To the extent they are inconsistent, the Rules and Regulations are of no force or effect.

Adopted by the Medical Staff on:

Date: January 10, 2023

Approved by the Board:

Date: February 15, 2023