BYLAWS
OF THE
PROFESSIONAL STAFF

Recommended by Professional Executive Council on August 24, 2016

Approved by Vote of the Organized Professional Staff on August 23, 2016

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DEFINITIONS

The following definitions shall apply to terms used in these Bylaws, Rules and Regulations of the Professional Staff (herein after Rules and Regulations), and Policies of the Professional Staff. Bylaws refer to Bylaws of the Professional Staff unless otherwise stated.

1. **"Board"** means the Board of Directors of Children's Hospitals and Clinics of Minnesota, which has the overall responsibility for the conduct of the Hospital, and its designees.

2. **"Hospital"** means Children's Health Care, Inc., doing business as Children's Hospitals and Clinics of Minnesota, a Minnesota nonprofit corporation, and all its subsidiaries and sites.

3. **"Hospital Sites"** means all locations and campuses of the Hospital where the Professional Staff Bylaws govern the organization and governance of professionals engaged in child health care.

4. **"Chief Executive Officer"** or **"CEO"** means the Chief Executive Officer of the Hospital or his/her designee.

5. **"Chief of Staff"** means the individual elected by the Professional Staff to act as the chief administrative officer of the Professional Staff, and who serves as the chair of the Professional Executive Council.

6. **"Chief Medical Officer"** means the Physician chosen by the Chief Executive Officer to act as the chief medical administrative officer of Hospital (or the Chief Medical Officer's designee).

7. **"Chief Operating Officer" or "COO**" means the Chief Operating Officer of the Hospital or his/her designee.

8. **"Vice Chief of Staff"** means the Physician elected by the Professional Staff to act as Vice Chief Administrative Officer of the Professional Staff.

9. **"Vice Chief Medical Officer"** means the physician chosen by the Chief Executive Officer to act as the vice chief medical administrative officer of the Hospital.

10. **"Executive Committee"** means the Executive Committee of the Board of Directors.

11. **"Professional Executive Council"** or **"PEC"** means that Professional Executive Council of the Professional Staff.

12. **"Professional Staff"** or **"Staff"** means the single, organized, self-governing body consisting of all professionals who have been appointed by the Board as Members of the Professional Staff with or without granted privileges to evaluate, treat, and/or care for patients or to engage in other professional activities at the Hospital. The Professional Staff shall consist of individuals certified or recognized as specialists in a child health care field with advanced degrees at the Masters level or above from accredited educational institutions, in accordance with the definition of "Professional Staff" in the Policy on Appointment, Reappointment, and Clinical Privileges.

13. **"Organized Professional Staff"** means the Members of the Active Staff as defined below whose primary function is to approve and amend these Bylaws and to provide oversight for the quality of care, treatment and services provided by Practitioners with privileges.

14. **"Professional Staff Documents"** means the Bylaws of the Professional Staff, the Rules & Regulations of the Professional Staff, and Policies of the Professional Staff duly approved as such by the Board.

15. **"Active Staff"** means Staff Members who meet all qualifications for Active Staff as defined in these Bylaws, and have been granted Active Staff status by the Board.

16. **"Affiliate Staff"** means Staff Members who meet all qualifications for Affiliate Staff as defined in these Bylaws, and have been granted Affiliate Staff status by the Board.

17. **"Member"** means a professional appointed to, and maintaining membership in, any category of the Professional Staff in accordance with these Bylaws.

18. **"Physician"** shall be interpreted to include doctors of medicine ("M.D."), doctors of osteopathy ("D.O."), Bachelor of Medicine and Bachelor of Surgery or Medicinæ Baccalaureus et Baccalaureus Chirurgiæ ("MB Bchir", "MB BCh", "MB ChB", "BM BS", "MB BS").

19. **"Practitioner"** shall be interpreted to include all health care professionals, such as but not limited to Physicians, dentists, psychologists, nurse practitioners, social workers, etc., who are either Members of the Professional Staff or are Individuals with Privileges who currently hold clinical privileges.

20. **"Provider"** means an individual authorized to provide health care services within the scope of the individual's licensure, authorization or privileges, law, regulation, and policies that pertain to the setting and role in which the services are provided.

21. **"Board Admissible"** shall be defined as the status which commences immediately upon completion of all education, training, certification, and other qualifications required for application to the appropriate national board, whether or not the Professional Staff Member actually applies at that time to their respective board.

22. **"Board Certified"** shall be defined as the status which commences immediately following notification of successful completion of all qualifying and certifying examinations required for certification in the specialty appropriate for the Professional Staff Member, by the appropriate national board.

23. **"Patient Contact"** shall be defined as direct involvement in the care of a patient at or for the Hospital, such as inpatient admissions, emergency department visits, consultations, clinic visits, outpatient or inpatient surgeries including history and physical examinations, or other direct patient care, treatment or services resulting in the Practitioner's signature appearing in the medical record documenting direct involvement in the care of a patient.

24. **"Credentials Committee"** shall refer to the committee which reviews and evaluates qualifications of each applicant for appointment, reappointment or modification of appointment and for granting clinical privileges pursuant to the Policy on Appointment, Reappointment and Clinical Privileges, these Bylaws, and performs other duties consistent with the Professional Staff Bylaws and the Policy on Professional Staff Committees.

25. **"Complete Application"** shall be refer to an application for appointment and/or clinical privileges which has been received by the Credentials Office on which all required questions have been answered, supporting documentation has been received, and primary source verification has been accomplished sufficient to meet regulatory requirements, accreditation standards, and requirements of the Hospital, and the application has been reviewed by the division chief (or designee) and is found to contain sufficient clinical performance documentation to make a recommendation to grant, limit, or deny the appointment and/or privileges.

26. **"Qualified Applicant"** shall be defined as an individual with a Complete Application for Professional Staff membership and/or clinical privileges and who meets the qualifications for membership and/or clinical privileges.

27. **"Physician Assistant"** is a health professional licensed as a physician assistant by the Minnesota Board of Medical Practice.

28. **"Volunteer Practitioner"** is an individual without privileges who qualifies to apply for privileges and offers to provide patient care when the Emergency Operations Plan has been activated and the Hospital is unable to meet immediate patient needs.

29. **"Individual with Privileges"** is a professional who is not eligible to be a Member of the Professional Staff, but who is eligible for and has been granted clinical privileges according to the same processes as a Member of the Professional Staff.

30. **"Board Committee"** is the Board's Professional Staff Committee appointed by the Board to perform the functions of expedited board approvals when an individual's application meets the established criteria and the request for membership and/or clinical privileges has been approved by the Credentials Committee and the Professional Executive Council.

31. **"Shared Service Sites"** include sites not under the control of the Hospital to which patients of the Hospital are taken to receive a portion of their care.

32. **"Impairment"** is the inability to engage in clinical practice skillfully and safely due to physical or mental illness, including the loss of cognitive or motor skill; or through the excessive use or abuse of drugs, including alcohol.

33. **"Disruptive Conduct"** is behavior that is unprofessional, intimidating, threatening, reckless, antisocial or creates an environment that discourages appropriate communication, placing patients and/or other persons at physical or emotional risk.

Words used in these Bylaws shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

ARTICLE I: GENERAL PROVISIONS

PART A. PURPOSE OF BYLAWS

The purpose of the Professional Staff organization is to bring the professionals who practice at or for the Hospital together into a single, organized, self-governing body which is approved by and accountable to the Board for the quality of patient care, treatment, and services provided by Members or Individuals with Privileges (Practitioners). To this end, among other activities, it will assist in screening applicants for initial appointment or reappointment for Professional Staff membership and/or granting of clinical privileges, evaluate and assist in improving the work done by the Staff, provide education, and offer advice to the Chief Executive Officer.

ARTICLE I
PART B. INTERPRETATION

By submitting an application for appointment, reappointment, or privileges every applicant, Member, and Individual with Privileges agrees that these Bylaws, the Policy on Appointment, Reappointment and Clinical Privileges, and all other bylaws, policies, procedures, rules, regulations, guidelines, and requirements of the Hospital and/or its Staff are subject to the interpretation of the Professional Executive Council and/or the Hospital, through the Hospital administration and/or the Board, in their sole discretion.

In addition, these Bylaws are intended to comply with all relevant laws, regulations and accreditation standards. If changes in laws, regulations or accreditation standards establish higher standards than stated in these Bylaws, the relevant laws, regulations or accreditation standards shall apply.

ARTICLE I
PART C. MECHANISMS FOR ESTABLISHING CRITERIA & STANDARDS

The mechanism for establishing criteria and standards for Professional Staff membership, establishing criteria for delegating oversight responsibilities to Practitioners with Privileges, and establishing and maintaining patient care standards and credentialing and delineation of clinical privileges shall be by amendment to these Bylaws (see Bylaws Article XIV), or through the mechanisms for adoption of the Rules & Regulations and Policies & Procedures of the Professional Staff as described in Articles XI and XII, respectively.

ARTICLE I
PART D. MECHANISMS FOR ENFORCEMENT

The mechanism for enforcing criteria and standards for Professional Staff membership and enforcing criteria for delegating oversight responsibilities to Practitioners with Privileges shall be by the Organized Professional Staff with support by the Officers of the Professional Staff, the Hospital and its Chief Medical Officer. Compliance is monitored by ad hoc reporting, quality monitoring, medical record and other audits. Compliance is evaluated and plans of action are formulated and implemented through retrospective, concurrent and prospective review processes, performance improvement processes, investigations, and fair hearing processes as outlined in these Bylaws, the Policy on Professional Staff Committees, the Rules and Regulations of the Professional Staff, the Policy on Appointment, Reappointment, and Clinical Privileges, and other bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Hospital and its Professional Staff duly approved from time to time.

ARTICLE II: PROFESSIONAL STAFF MEMBERSHIP

PART A. PROFESSIONAL STAFF APPOINTMENT

Appointment to the Professional Staff of the Hospital is a privilege that shall be extended only to competent professionals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws, the Policy on Appointment, Reappointment and Clinical Privileges, and all other bylaws, policies, procedures, rules, regulations, guidelines, and requirements of the Hospital and/or the Professional Staff.

1. All appointment, reappointment, credentialing, and privileging processes are outlined in the Policy on Appointment, Reappointment and Clinical Privileges and these Bylaws.

2. Criteria, qualifications, and standards for Professional Staff appointment shall be established or amended from time to time according to the process set forth in Articles XII and XIV of these Bylaws.

ARTICLE II
PART B. QUALIFICATIONS FOR MEMBERSHIP[1]

Applicants must be able to document their individual background, experience, training, judgment, character, demonstrated competence, physical and mental capabilities, adherence to the ethics of their profession, and ability to work with others with sufficient adequacy to assure the Professional Staff and Board of Directors that any patient treated by them at or for the Hospital will be given a high quality of patient care. No professional is entitled to membership on the Professional Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of licensure to practice in this or any other state, board certification, membership in any professional organization, or privileges at another hospital.

Only those health care professionals in the professional disciplines listed in the definition of "Professional Staff" in the Policy on Appointment, Reappointment and Clinical Privileges and who meet the qualifications set forth below shall be eligible for appointment or reappointment to the Staff:

1. Licensure: Current licensure or registration by the State of Minnesota, if such licensure or registration is available for the specific discipline. This requirement is exempted for Honorary Staff and Retired Staff.

2. Board Certification: Members of the Professional Staff with clinical privileges are required to achieve and maintain current Board Certification in all specialties and/or subspecialties in which they hold themselves out to practice for which an approved certifying board[2] is available.

   While certification by a United States certifying board is preferred, competent applicants certified by boards in other countries may be considered to have met Children's Professional Staff requirement for Board Certification if the qualifications for certification by the foreign board are deemed to be comparable. Even if a foreign board is deemed acceptable, certification by a United States board is encouraged. Board Certification will be accepted from the following foreign boards: Royal College of Physicians & Surgeons of Canada, Royal College of Surgeons of Great Britain, and the National Board of Health & Welfare of Sweden.

   Members are required to be recertified according to the requirements to maintain continuing Board Certification (if any) of the respective Boards for all specialties or subspecialties that the

[1] Conditions of Participation 482.22(c)(4)
[2] With regard to Advanced Practice Registered Nurses, current certification is required in the advanced practice nursing discipline in which the APRN holds himself or herself out to practice, however other certifications generally available to registered nurses are not required to meet this current Board certification requirement.

(Continuation of Article II, Part B)

Member holds himself or herself out to practice.

The Hospital Board may temporarily or permanently waive the requirement of Board Certification for those applicants who meet the following criteria:

(a) Waivers for Initial Privileging: All applicants for clinical privileges who are not yet Board Certified in one or more specialties and/or subspecialties in which they hold themselves out to practice and for which the requested privileges are relevant, must be Board Admissible in the relevant specialty and/or subspecialty at the time the privileges are granted. The Board Certification requirement is automatically temporarily waived for such

Board Admissible applicants for a period of three (3) years from the date privileges are initially granted. In addition, this three (3) year waiver shall be automatically extended by the unfulfilled portion of any post-training clinical experience requirement stipulated by the relevant certifying board[3]. If a Practitioner pursues additional training that establishes board eligibility in a new specialty or reestablishes board eligibility in a specialty, a new 3-year waiver shall apply for that specialty.

(b) Waivers for Lack of Clinical Privileges: Board Certification requirements are automatically waived for Members without clinical privileges, including but not limited to Member Only, Retired, or Honorary Staff. Board Certification requirements for Members on leave of absence are automatically waived during the period of the leave of absence, but any waiver period for initial privileging is not automatically extended.

(c) Waivers for Availability and Prevalence by Discipline: The availability of credible certifying Boards and the national prevalence of Board Certification vary by discipline (MD, DO, DDS, DMD, APRN, etc. Discipline is not equivalent to specialty). All disciplines in which Board Certification is either not available from a credible Board or disciplines for which Board Certification is low national prevalence (<50%) are waived from this requirement. The disciplines that qualify for this waiver are Dentists (but not including Oral & Maxillofacial Surgeons for whom Board Certification is required), Clinical Social Workers, and Clinical Psychologists. Members of such waived disciplines are nonetheless encouraged to seek Board Certification.

(d) Waivers by Date on Staff (grandfathering): Board certification requirements are automatically waived in the following situations:

(1) Members of the St. Paul Children's Hospital Medical Staff prior to the May 1997 merger with the Minneapolis Professional Staff to form the Children's Professional Staff.

(2) Members of the Minneapolis Children's Hospital Professional Staff prior to the January 1988 Bylaws revision.

(3) Recertification is not required of Members who meet criteria for a waiver by date on Staff, although recertification is encouraged.

(4) If a non-Board Certified Member with privileges acting under a waiver for date on staff resigns from the Professional Staff, then, after a period of time, applies again for appointment and privileging in the same specialty or subspecialty, the original waiver for date on staff shall continue to apply. However, the waiver shall not apply for privileges in another specialty or subspecialty.

[3] Clinical experience requirement as stated in the current ABMS annual report.

(Continuation of Article II, Part B)

(5) Board Certification requirements are waived for Members with patient care activity on Children's patients at Shared Service Sites prior to the date that such individuals were required to obtain Children's Professional Staff privileges, if the relevant patient care activity occurred prior to a waiver for date on staff that would have been applicable had they been privileged on the Professional Staff.

(e) Waivers for Newly Established Certifying Boards: If a certifying Board is established that did not exist prior to a Member's date of initial appointment to the Professional Staff with privileges in the specialty or subspecialty in question, and the Member qualifies to apply for such Board Certification, the Member's requirement for Board Certification is automatically waived for that specialty or subspecialty for a period of three (3) years from the initial date applications are accepted. In addition, this three (3) year waiver shall be automatically extended by the unfulfilled portion of any post-training clinical experience requirement stipulated by the relevant certifying board[4].

(f) Waivers for Advanced Practice Registered Nurses by Date of Certification: For Advanced Practice Registered Nurses in the State of Minnesota, the Minnesota Nurse Practice Act – Minnesota Statutes 148.284(c) allows Advanced Practice Registered Nurses certified by a national nurse certification organization prior to January 1, 1999 to continue to practice in the field of nursing in which the nurse was practicing as of July 1, 1999, regardless of the type of certification held, if the advanced practice registered nurse is not eligible for the proper certification. Such APRNs that meet these criteria are grandfathered as to the requirement for board certification.

(g) Special Requests for Waivers: Special requests for waivers of Board Certification may arise from time to time. Such waivers not otherwise addressed here shall be reviewed on a case-by-case basis by the Credentials Committee for recommendation to the Professional Executive Council and the Board of Directors.

3. Applicants not subject to Board Certification must provide evidence, acceptable to the Board, of credentialing or licensure by a national board or authority in their area of expertise. If there is no credentialing, licensure, national board or authority relevant to the area of expertise this requirement will be reviewed on a case by case basis.

4. All applicants shall provide evidence of an advanced degree at the Masters level or above, unless the applicant meets the written criteria for waiver of this requirement as follows:

(a) Applicants for appointment to the Professional Staff who meet all qualifications for membership on the Professional Staff except master's degree attainment, completed their training at a time when master's degree attainment was not required for board certification, are currently licensed / registered by the State of Minnesota within a discipline that meets qualifications for Professional Staff membership, are currently certified by an accepted certifying board, and demonstrate current clinical competence may be recommended for waiver of master's degree requirements by the division chief, with the approval of the Credentials Committee, Professional Executive Council, and the Board. Board approvals of such individuals recommended for waiver may occur through the expedited board approval process as long as the applicant is otherwise qualified for such approval.

[4] Clinical experience requirement as stated in the current ABMS annual report.

(Continuation of Article II, Part B)

(b) Other requests for waivers of master's degree attainment may arise from time to time. Such waivers not otherwise addressed in (a) shall be reviewed on a case-by-case basis by the division chief and the Credentials Committee for recommendation to the Professional Executive Council and the Board of Directors. Applicants for such other waivers must be approved by the Board, but may not be approved through the expedited board approval process.

5. All applicants for clinical privileges must have current, valid professional liability insurance coverage in such form and in amounts required by the Hospital's Policy on Professional Liability Insurance Requirements.

6. All applicants for privileges must be able to demonstrate clinical activity that meets system-wide quality and performance improvement indicators and regulatory, accreditation, hospital and professional and other standards.

7. All applicants must be able to document their:

   (a) Background, experience, training and demonstrated competence;

   (b) Adherence to the ethics of their profession;

   (c) Good reputation and character, including the applicant's physical and mental health status;

   (d) Ability to work harmoniously with others sufficiently to convince Hospital that all patients treated by them at the Hospital Sites or at any Shared Service Site will receive quality care and that the applicant will not impede the orderly operation of the Hospital and its Professional Staff in accordance with the Hospital's Service Standards, and Principles of Integrity and Compliance .

8. Applications received for which evidence is documented of any of the following disqualifications will not be processed, without right to a hearing or appeal:

   (a) Prior revocation of licensure in any state, county or territory for substantiated breaches of clinical competence;
   (b) Prior conviction of Medicare, Medicaid, or other federal or state governmental fraud or program abuse;
   (c) Current exclusion or preclusion from participation in Medicare, Medicaid, or other federal or state government health care programs;
   (d) Felony conviction, over the age of majority, involving violent behavior, moral turpitude, or resulting in the death or permanent disability of another person.

9. All applicants for privileges must be able to declare a designated alternate, currently on the Professional Staff with privileges that are sufficiently comparable so as to be acceptable to the Professional Staff, who agrees to provide care at such times when the applicant would not be available to provide such care, unless an exemption has been granted for this applicant or membership category.

10. Meet such other qualifications as the Hospital or its Professional Staff may require.

ARTICLE II
PART C. NONDISCRIMINATION

The Hospital will not discriminate in granting Staff appointment and/or clinical privileges on the basis of age, gender, race, creed, religion, color, sexual orientation, marital status, or national origin.

ARTICLE II
PART D. APPOINTMENT & REAPPOINTMENT PROCESS, CONDITIONS, AND DURATION

The appointment process consists of collection, verification, and assessment of information regarding education, training, experience, licensure, certification, current clinical competence, physical ability to discharge patient care responsibilities, interpersonal and communication skills, professionalism and any other specified qualifications or requirements as a foundation for objective, evidence-based decisions regarding appointment to membership on the Professional Staff. The reappointment process consists of collection, verification, and assessment of information regarding additional education, additional training, additional experience, current licensure, current certification, current clinical competence, current physical ability to discharge patient care responsibilities, interpersonal and communication skills, professionalism, focused and ongoing professional practice evaluation, and any other specified qualifications or requirements as a foundation for objective, evidence-based decisions regarding reappointment to membership on the Professional Staff.

The detailed requirements of the appointment and reappointment process are contained in the Policy on Appointment, Reappointment and Clinical Privileges. A brief description of the appointment and reappointment process follows:

The appointment and reappointment processes begin upon the receipt of an application by the Professional Staff Credentials Office. The Credentials Office staff verifies the credentials stated in the application according to methods and within standards established by the Hospital and all applicable regulatory bodies, before presenting the application and all verification documentation to the division chief, or designee, for review. The division chief makes recommendations to approve or deny appointment or reappointment to the Credentials Committee of the Professional Staff as delegated by the Professional Executive Council. The Credentials Committee, as delegated by the Professional Executive Council, reviews each applicant and makes recommendation to approve or deny appointment or reappointment to the Professional Executive Council. The Professional Executive Council reviews each applicant and makes recommendations to approve or deny appointment or reappointment to the Board. The Professional Executive Council may act upon the recommendations of the division chief without prior review and recommendation of the Credentials Committee with communication to the Credentials Committee of such. The Board reviews each applicant and approves or denies appointment or reappointment. The Credentials Office, on behalf of the Board, communicates the decision of the Board to the applicant, relevant personnel, and as required by law, external entities, of the appointment or reappointment.

The Hospital may require payment of a reasonable processing fee for applications for appointment and reappointment. The Board shall require payment of application fees prior to the effective date of any appointment or reappointment.

Applicants shall be informed of the status of their application for appointment or reappointment, upon request.

Appointments and reappointments to the staff will be no more than twenty-four (24) months and reappointments will be based upon the results of an objective review of performance. At reappointment, the effective date of the new period of appointment need not match the date upon which the Board made the decision to approve. Typically, at reappointment, the effective date of the new period of appointment will be the day following the date of expiration of the immediately preceding period of appointment. The date the Board makes the decision to approve a new period of appointment may precede the effective date of the period of appointment by up to sixty (60) days.

Professional Staff appointment or reappointment as such shall not confer any clinical privileges or right to practice at Hospital Sites.

ARTICLE II
PART E. STAFF DUES

All persons appointed to the Professional Staff shall pay annual staff dues to the Professional Staff account as may be required by the Professional Executive Council. Signatories to this account shall be the Chief of Staff and the Secretary-Treasurer of the Professional Staff.

Dues shall be payable upon request. Failure to pay dues, without good cause, within 30 days after the second of two written notices sent at least 30 days apart may be construed as a voluntary resignation from the Staff.

1. Retired and Honorary Staff are exempt from paying annual Staff dues.

2. Members on leave of absence for more than six months of a calendar year are exempt from paying annual Staff dues.

3. Members who provide volunteer direct patient care services as their sole involvement in patient care at the Hospital Sites without billing or receiving payment for these services are exempt from paying annual Staff dues.

4. Member only without privileges shall pay annual Staff dues.

ARTICLE II
PART F. RESPONSIBILITIES OF MEMBERSHIP

1. Each Professional Staff Member shall have the following responsibilities, in addition to and consistent with, the responsibilities of his/her category of the Professional Staff. The Professional Staff does not designate members as licensed independent practitioners (LIP). However, all Members of the Professional Staff are responsible to perform the functions attributed to LIPs, including, but not limited to, the responsibilities listed in 2 through 13 within the scope of their license, law, and as defined in these Bylaws.

2. Direct the care of his/her patients and supervise the work of any caregivers under his/her direction, and provide for continuous care of his/her patients.

3. Prepare and complete in timely fashion medical records for all the patients to whom the Member provides care in the Hospital.

4. Assist the Hospital in fulfilling its responsibilities for providing charitable care.

5. Provide emergency consultation and treatment and participate in emergency department call as requested, and as referenced in the Rules and Regulations of the Professional Staff, Article VI Part B.

6. When on call for any Children's Hospital Site, verbally respond as soon as possible, but at least within 20 minutes, for a request for care, and use best efforts to arrive at the Hospital for an emergency within 30 minutes and for other urgent care within 90 minutes after the verbal response.

7. Assist other Professional Staff Members in the care patients when asked, if reasonably possible.

8. Act in an ethical and professional manner.

9. Immediately notify the chair of Credentials Committee, or designee, in writing if:

(a) Fail to maintain continuous qualifications[5] for membership on the Professional Staff; or

(b) The licensing board of any state issues any adverse action related to the Member's license, including, but not limited to any stipulation and order, professional review action, reprimand, restriction, limitation, revocation, consulting requirement, or other adverse action imposed by the board:

(c) Charged with, indicted, or convicted of a felony;

(d) Charged with, indicted, or convicted of a gross misdemeanor;

(e) There is knowledge of any other Member who fails to maintain continuous qualifications[6], if charged with, indicted, or convicted of a felony;

(f) Information provided in the initial application for appointment or the renewal application has changed during the course of the appointment; or

(g) Address changes for official notification.

10. Avoid exclusion from Medicare, Medicaid, or any other federal health care program.

11. Refuse to engage in improper inducements for patient referral or participating in any form of fee splitting.

12. Treat employees, patients, visitors, and other Members in a dignified and courteous manner.

13. Participate, upon request, in focused professional practice evaluation activities of the Professional Staff, including, but not limited to, chart review, proctoring, and mentoring.

14. Comply with these Bylaws, the Rules & Regulations, Professional Staff Policies, Children's Service Standards, Principles of Integrity and Compliance and all other bylaws, policies, procedures, rules, regulations, guidelines, and requirements, including the Articles of Incorporation of the Hospital and its Professional Staff

ARTICLE III: CATEGORIES OF THE PROFESSIONAL STAFF

All appointments to the Professional Staff shall be made by the Board upon recommendation of the Professional Executive Council and shall be to one of the following categories of the Staff. All Members shall be assigned to a specific division, but shall be eligible for clinical privileges in other divisions as applied for and processed pursuant to these Bylaws and the Policy on Appointment, Reappointment and Clinical Privileges and granted by the Board.

PART A. ACTIVE STAFF
Section 1. Qualifications

The Active Staff shall consist of Members who (a) have ten (10) or more Patient Contacts per year at or for the Hospital, (b) have maintained continuous qualifications[7] for membership as outlined in the Policy on Appointment, Reappointment, and Clinical Privileges, and (c) have achieved and continue

[5] The requirement to maintain continuous qualifications is defined in the Policy on Appointment, Reappointment and Clinical Privileges, Article III Part A Section 2.
[6] The requirement to maintain continuous qualifications is defined in the Policy on Appointment, Reappointment and Clinical Privileges, Article III Part A Section 2.
[7] The requirement to maintain continuous qualifications is defined in the Policy on Appointment, Reappointment and Clinical Privileges, Article III Part A Section 2.

to maintain current Board Certification in at least one specialty[8].

All Active Professional Staff Members must be able to demonstrate current competency and clinical activity that meets system-wide quality and performance improvement indicators, regulatory, accreditation, hospital and professional standards within the scope of their granted privileges.

ARTICLE III - PART A
Section 2. Rights

Members of the Active Staff:

(a) Who are Physicians may serve as the Professional Staff Officers and Division Chiefs;

(b) May serve as chairpersons and members of Staff committees, as set forth in these Bylaws and the Policy on Professional Staff Committees;

(c) Shall elect Professional Staff Officers and at-large members of the Professional Executive Council;

(d) Shall be entitled to vote on all matters brought to the attention of the Professional Staff as a whole, including matters presented for a vote at a general or special meeting of the Staff, and shall be entitled to vote at meetings of the division or committees of which they are designated as voting members; and

(e) Constitute the Organized Professional Staff and, as such, shall be entitled to approve and amend these Bylaws by the process defined in Article XIV.

ARTICLE III – PART A
Section 3. Responsibilities

Members of the Active Staff, by accepting appointment, shall agree to assume all the functions and responsibilities of appointment to the Active Staff including, but not limited to:

(a) Responsibility for the continuous care and supervision of all patients at or for the Hospital for whom they are providing services, or arrange a suitable alternative for such care and supervision;

(b) Actively participate in the quality/performance improvement activities required of the Professional Staff;

(c) Responsibility, as members of the Organized Professional Staff, for oversight of care, treatment, and services provided by practitioners with privileges;

(d) Accept and fulfill assignments in the education program; and

(e) Discharge such other Professional Staff functions as may be required from time to time.

ARTICLE III
PART B. AFFILIATE STAFF
Section 1. Qualifications

The Affiliate Staff shall consist of Members who (a) are not currently Board Certified in at least one

[8] Board Certification is not required for Active Staff status if no relevant certifying Board is available, or, a waiver of Board Certification has been granted by the Board of Directors for Date on Staff (grandfathering) or for low prevalence of Board Certification in the discipline.

specialty, or (b) have less than ten (10) Patient Contacts per year at or for the Hospital and (c) have maintained continuous qualifications for membership as outlined in the Policy on Appointment, Reappointment, and Clinical Privileges[9]. In the case of Members with time limited Board certification, Affiliate Staff also includes those whose certification has expired until that time that the Member becomes recertified.

All Affiliate Professional Staff Members must be able to demonstrate current competency and clinical activity that meets system-wide quality and performance improvement indicators and regulatory, accreditation, hospital and professional standards within the scope of their granted privileges.

ARTICLE III – PART B
Section 2. Rights

Members of the Affiliate Staff:

(a) May serve on Professional Staff committees as set forth in these Bylaws and the Policy on Professional Staff Committees;

(b) May vote as members of committees as set forth in these Bylaws and the Policy on Professional Staff Committees;

(c) Shall not be eligible to vote on matters brought before the Professional Staff as a whole; *e.g.*, the election or removal of Staff officers, or adoption of amendments to these Bylaws.

ARTICLE III – PART B
Section 3. Responsibilities

Members of the Affiliate Staff, by accepting appointment, shall agree to assume all the functions and responsibilities of appointment to the Affiliate Staff including, but not limited to:

(a) Responsibility for the continuous care and supervision of all patients at or for Hospital for whom they are providing services, or arrange a suitable alternative for such care and supervision;

(b) Actively participate in the quality/performance improvement activities required of the Professional Staff;

(c) Accept and fulfill assignments in the education program;

(d) Discharging such other Professional Staff functions as may be required from time to time.

ARTICLE III
PART C. RETIRED STAFF
Section 1. Qualifications

(a) The Retired Staff shall consist of Members who have retired from active clinical practice.

(b) Current licensure/registration is not required.

(c) Current Board Certification is not required.

(d) Current professional liability insurance is not required.

[9] The requirement to maintain continuous qualifications is defined in the Policy on Appointment, Reappointment and Clinical Privileges, Article III Part A Section 2.

ARTICLE III – PART C
Section 2. Rights

Members of the Retired Staff:

(a) Shall not be eligible to admit or attend patients;

(b) Shall not be eligible to vote on matters brought before the Professional Staff as a whole; *e.g.*, the election or removal of Staff officers, or adoption of amendments to these Bylaws;

(c) May be appointed to serve as a member (with or without a vote) on committees for which they are qualified as set forth in these Bylaws and the Policy on Professional Staff Committees; and,

(d) May attend Professional Staff meetings.

ARTICLE III
PART D. HONORARY STAFF
Section 1. Qualifications

(a) The Honorary Staff shall consist of retired Professional Staff Members who are of outstanding reputation in the field of child health, not necessarily residing in the community, and are recommended by the Credentials Committee and Professional Executive Council.

(b) Current licensure/registration is not required.

(c) Current Board Certification is not required.

(d) Current professional liability insurance is not required.

ARTICLE III – PART D
Section 2. Rights

Members of the Honorary Staff:

(a) Shall not be eligible to admit or attend patients;

(b) Shall not be eligible to vote on matters brought before the Professional Staff as a whole; *e.g.*, the election or removal of Staff officers, or adoption of amendments to these Bylaws;

(c) May be appointed to serve as a Member (with or without a vote) on committees for which they are qualified as set forth in these Bylaws and the Policy on Professional Staff Committees;

(d) May attend Professional Staff meetings.

ARTICLE III
PART E: MEMBER ONLY STAFF (WITHOUT PRIVILEGES)
Section 1. Qualifications

(a) The Member Only Staff shall consist of Members without clinical privileges.

(b) Current licensure/registration in the State of Minnesota is required.

(c) Current Board Certification is not required.

(d) Current professional liability insurance is not required.

ARTICLE III – PART E
Section 2. Rights

Members of the Member Only Staff:

(a) Shall not be eligible to admit or attend patients**,** and therefore are exempt from providing a name of a designated alternate;

(b) Shall not be eligible to vote on matters brought before the Professional Staff as a whole; *e.g.*, the election or removal of Staff officers, or adoption of amendments to these Bylaws;

(c) May be appointed to serve as a Member (with or without a vote) on committees for which they are qualified as set forth in these Bylaws and the Policy on Professional Staff Committees;

(d) May attend Professional Staff meetings.

ARTICLE III – PART E
Section 3. Responsibilities

Members of the Member Only Staff, by accepting appointment, shall agree to assume all the functions and responsibilities of appointment to the Member Only Staff including, but not limited to:

(a) Participate in the quality/performance improvement activities required of the Professional Staff, as requested;

(b) Accept and fulfill assignments in the education program; and

(c) Discharge such other Professional Staff functions as may be required from time to time.

ARTICLE IV: CREDENTIALING AND PRIVILEGING

PART A. CREDENTIALING PROCESS[10]

The credentialing process consists of collection, verification, and assessment of information regarding education, training, experience, licensure, certification, current clinical competence, physical ability to discharge patient care responsibilities, interpersonal and communication skills, professionalism and any other specified qualifications or requirements as a foundation for objective, evidence-based decisions regarding appointment to membership on the Professional Staff and/or recommendations to grant or deny initial, revised or renewed clinical privileges.

A description of the credentialing process relevant to appointment and reappointment are contained in these bylaws (see Article II, Part D). A description of the credentialing process relevant to the granting of initial privileges, revision of privileges, or renewal of privileges is contained in these bylaws (see Article IV, Part B). The detailed requirements of the credentialing process are contained in the Policy on Appointment, Reappointment and Clinical Privileges.

ARTICLE IV

[10] CMS Conditions of Participation 482.12(a)(6) ; The Joint Commission MS.01.01.01 EP 26 and MS.06.01.03 EP 4

PART B. PRIVILEGING PROCESS[11]

The privileging process consists of development and approval of setting-specific clinical privilege descriptions with associated qualifications and criteria for granting the same available to applicants; processing applications for privileges (including credentialing of relevant training, education, experience, current clinical competence, and physical ability to perform the privileges); evaluation by qualified reviewers and review bodies who consider the qualifications of the applicant (including, but not limited to individual character, individual competence, individual training, individual experience, individual judgment,[12] quality of care, treatment and services[13]), then submit a report with an appraisal of qualifications for the privileges requested to the Board to grant or deny initial, revised, or renewed clinical privileges; the decision of the Board; notification of the applicant, relevant personnel, and, as required by law, external entities of the privileging decision; and monitoring the use of privileges and issues of quality of care.

The detailed requirements of the privileging process are contained in the Policy on Appointment, Reappointment and Clinical Privileges. A brief description of the privileging process follows:

The privileging process begins upon the receipt of an application by the Professional Staff Credentials Office. The Credentials Office staff verifies the credentials stated in the application according to methods and within standards established by the Hospital and all applicable regulatory bodies, before presenting the application and all verification documentation to the division chief, or designee, for review. The division chief makes recommendations to approve or deny clinical privileges to the Credentials Committee of the Professional Staff, as delegated by the Professional Executive Council. The Credentials Committee, as delegated by the Professional Executive Council, reviews each applicant and makes recommendation to approve or deny clinical privileges to the Professional Executive Council. The Professional Executive Council reviews each applicant and makes recommendations to approve or deny clinical privileges to the Board. The Professional Executive Council may act upon the recommendations of the division chief without prior review and recommendation of the Credentials Committee with communication to the Credentials Committee of such. The Board reviews each applicant and approves or denies clinical privileges. The Credentials Office, acting for the Board, communicates the decision of the Board to the applicant, relevant personnel, and as required by law, external entities of the privileging decision.

Prior to granting a privilege, the resources necessary to support the requested privilege are determined to be currently available, or available within a specified time frame[14].

Prior to granting privileges to or renewing privileges for a period that will extend beyond the seventieth (70^{th}) birthday, a physical examination by an approved practitioner, which includes a cognitive screening test acceptable to the Board, must have been accomplished within one hundred eighty (180) days prior to the initial review by the Credentials Committee with findings reported on a reporting form approved by the Board for determination whether a physical or cognitive Impairment exists that would affect the applicant's ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a Practitioner in the requested area of practice without posing a health or safety risk to patients.

The granting of initial clinical privileges shall be become effective on the date of Board approval or any future date specified by the Board (up to sixty (60) days later) for a period of no more than twenty-four (24) months. The granting of additional privileges shall become effective on the date of Board approval or any future date specified by the Board (up to sixty (60) days later) and shall remain effective until the current period of appointment and/or clinical privileges expires. At renewal of privileges, the effective

[11] The Joint Commission – Hospital Accreditation Standards MS.01.01.01 EP 14.
[12] CMS Conditions of Participation 482.12(a)(6)
[13] The Joint Commission – Hospital Accreditation Standards MS.06.01.07 EP 6
[14] The Joint Commission – Hospital Accreditation Standards MS.06.01.01 EP1

date of the new period of granted privileges need not match the date upon which the Board made the decision to approve. Typically, at renewal of privileges, the effective date of the new period of granted privileges will be the day following the date of expiration of the immediately preceding period of granted privileges. The date the Board makes the decision to approve a new period of granted privileges may precede the effective date of the period of granted privileges by up to sixty (60) days.

Re-privileging will be based on the results of an objective review of performance.

A Board decision (including Board approval through the expedited process) shall be accomplished within one hundred twenty (120) days after a Complete Application has been determined by the division chief (or designee). If a Board decision cannot be accomplished within one hundred twenty (120) days, for any reason, the applicant will be given a written explanation of the delay including an estimate of the date on which a Board decision is anticipated.

A period of focused professional practice evaluation (FPPE) is implemented for all initially requested privileges beginning on the date the privileges become effective, and extending to the date that all requirements are met to the satisfaction of the relevant Division Chief and the Credentials Committee. Failure to complete FPPE within the required timeframe may result in administrative suspension.

A period of focused professional practice evaluation may also be initiated at any time during the period privileges are granted based upon criteria defined in the Policy on Appointment, Reappointment & Clinical Privileges and/or the Policy on Peer Review. Information for the focused professional practice evaluation may include, but is not limited to, medical record review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient (e.g. consulting Physicians, assistants at surgery, nursing or administrative personnel). Relevant information thus obtained is integrated into performance improvement activities. Detailed requirements are described in the Policy on Appointment, Reappointment and Clinical Privileges.

Ongoing professional practice evaluation is implemented during the period privileges are granted to identify professional practice trends that impact on quality of care and patient safety. Information used in ongoing professional practice evaluation may be obtained from, among other sources, periodic medical record review, direct observation, monitoring of diagnostic and treatment techniques, and discussion with other individuals involved in the care of each patient including consulting Physicians, assistants at surgery, nursing and administrative personnel. Relevant information thus obtained is integrated into performance improvement activities, and may trigger focused professional practice evaluation based upon criteria established in the Policy on Appointment, Reappointment & Clinical Privileges and/or the Policy on Peer Review. Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege(s) prior to or at the time of renewal. Detailed requirements are described in the Policy on Appointment, Reappointment and Clinical Privileges.

A new applicant may be granted temporary clinical privileges by the Chief Executive Officer (or authorized designee) after the application has been determined by the division chief (or designee) to be a Complete Application that raises no concerns while awaiting review and approval by the Credentials Committee, Professional Executive Council and the Board. The Chief of Staff, or authorized designee, must submit a written recommendation to the Chief Executive Officer, (or authorized designee) for recommendation for approval. The Chief Executive Officer, (or authorized designee) grants the temporary clinical privileges to the applicant. Temporary clinical privileges granted under this Section shall remain in effect for no more than one hundred twenty (120) days. Detailed requirements are described in the Policy on Appointment, Reappointment and Clinical Privileges.

In order to meet an important patient care need, temporary clinical privileges may be granted for up to 30 days (except under special circumstances) to a qualified professional by the Chief Executive Officer (or Board-approved designee) upon the recommendation of the Chief of Staff (or designee). Privileges may be restricted to the care of an individual patient. Detailed requirements are described in the Policy on Appointment, Reappointment and Clinical Privileges.

Disaster privileges may be granted when the Emergency Operations Plan has been activated and the Hospital is unable to handle the immediate patient needs. (See Organizational Policy 948.00 Emergency Operations Plan.) The granting of disaster privileges and oversight of the care provided by Volunteer Practitioners shall be under the direction of individuals assigned to relevant roles under the Hospital Incident Command System (HICS). In circumstances of disaster, in which the Hospital Emergency Operations Plan has been activated, the Incident Commander shall have immediate authority to grant disaster privileges and oversee the care of Volunteer Practitioners, or, by delegation, provide for such under the Hospital Incident Command System. Under HICS, the Incident Commander may designate a Medical/Technical Specialist for Medical (Professional) Staff, who, in turn, shall direct and assist the Logistic Chief and its Labor Pool & Credentialing Unit Leader with credentialing and privileging of Volunteer Practitioners. For as long as the role of Medical/Technical Specialist for Medical (Professional) Staff shall be filled, the individual filling this role shall have final authority to grant, modify, limit, or terminate disaster privileges, however such authority may be delegated to other appropriate individuals as needed to respond to patient care need. Detailed requirements for granting and removing disaster privileges are described in the Policy on Appointment, Reappointment and Clinical Privileges. When the Emergency Operations Plan is deactivated, the oversight of privileging and patient care returns to the regular functions of Hospital operations and the Organized Professional Staff.

The Hospital may require payment of a reasonable processing fee for applications for initial privileges, renewal of privileges, and additional privileges. The Board shall require payment of application fees prior to the effective date of any appointment, reappointment, initial privileges, renewed privileges, and/or additional privileges.

Applicants shall be informed of the status of their application for privileges, upon request.

ARTICLE IV
PART C. OTHER REQUIREMENTS
Section 1. History and Physical Examination Requirements[15]

A medical history and physical examination must be completed and documented 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. The medical history and physical examination must be completed and documented by a Physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy. See Rules & Regulations of the Professional Staff Article IV Part G History and Physical Examinations for additional requirements.

ARTICLE IV – PART C
Section 2. Requirements for Update to History and Physical Examination[16]

An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a Physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy. See Rules & Regulations of the Professional Staff Article IV Part G History and Physical Examinations for additional requirements.

ARTICLE V: STRUCTURE OF THE PROFESSIONAL STAFF

[15] The Joint Commission – Hospital Accreditation Standards MS.01.01.01 EP 16, PC.01.02.03 EPs 4 & 5
[16] CMS Conditions of Participation 482.22(c)(5)(i) & (ii)

PART A. PROFESSIONAL STAFF YEAR

For the purposes of these Bylaws, the Professional Staff Year begins on January 1 and ends on December 31 of each year.

ARTICLE V
PART B. OFFICERS OF THE PROFESSIONAL STAFF

The officers of the Professional Staff shall be:

1. Chief of Staff;

2. Vice Chief of Staff;

3. Secretary-Treasurer; and

4. Immediate Past Chief of Staff.

ARTICLE V
PART C. QUALIFICATIONS OF PROFESSIONAL STAFF OFFICERS

Only those Members who satisfy the following criteria shall be eligible to serve as Professional Staff Officers:

1. Be a Physician with clinical privileges;

2. Have served on the Active Professional Staff for at least twenty-four (24) months;

3. Be appointed in good standing to the Active Professional Staff and continue so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved;

4. Have no pending adverse recommendations concerning Professional Staff appointment or clinical privileges;

5. Be willing to faithfully discharge the duties and responsibilities of the position;

6. Have experience in a leadership position or previous involvement in performance improvement functions;

7. Commit to participate in continuing education relating to Professional Staff leadership or credentialing functions prior to or during the term of the office;

8. Have demonstrated an ability to work well with others;

9. Disclose 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 disclosure requirement does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner; and

10. Have no conflict of interest that may arise from simultaneously holding leadership positions on another hospital professional staff or any other circumstance that would lead to a conflict of interest.

ARTICLE V

PART D. DUTIES AND RESPONSIBILITIES OF OFFICERS

The Hospital shall have a Chief of Staff and Vice Chief of Staff. The responsibility of all officers of the Professional Staff is to provide oversight, either directly or by delegation, of patient care, treatment and services provided by Members with privileges.

ARTICLE V – PART D
Section 1. Chief of Staff

The Chief of Staff shall:

(a) Call, preside at, and be responsible for the agenda of all general and special meetings of the Professional Staff;

(b) Make appointments of committee chairpersons (with the concurrence of the Professional Executive Council) and approve members of the committees except the Professional Executive Council, in accordance with the provisions of these Bylaws;

(c) Work with division chiefs on Professional Staff issues;

(d) Make appointments of associate division chiefs and associate division chiefs elect, section chiefs (if any), and voting members of divisions with the concurrence of the Professional Executive Council, in accordance with the provisions of these Bylaws;

(e) Serve as chairperson of the Professional Executive Council;

(f) Serve as chairperson of the Nominating Committee;

(g) Serve as *ex-officio* member with a vote on all Professional Staff Committees, unless otherwise specified in these Professional Staff Bylaws or in other Professional Staff documents such as the Policy on Professional Staff Committees;

(h) Serve as a voting member of the Board;

(i) Receive and interpret the policies of the Board to the Professional Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Professional Staff to provide medical care; and

(j) Act as day-to-day liaison on medical matters and Professional Staff matters with the Hospital administration and the Board.

ARTICLE V – PART D
Section 2. Vice Chief of Staff

The Vice Chief of Staff shall:

(a) Assume all functions and have the authority of the Chief of Staff in the event of the Chief's temporary inability to perform for any reason;

(b) Automatically succeed the Chief of Staff:

(1) Should the office of the Chief of Staff become vacated for any reason during the Chief of Staff's term of office;

(2) Upon completion of the Chief of Staff's term of office.

(c) Serve on the Professional Executive Council and the Nominating Committee;

(d) Recommend appointments of committee chairpersons to the Chief of Staff;

(e) Recommend appointments of associate division chiefs, associate division chiefs elect and section chiefs (if any), to the Chief of Staff;

(f) Act as day to day liaison on medical matters and Professional Staff matters with the Hospital administration and the Board; and,

(g) Attend meetings of the Board (without vote).

ARTICLE V – PART D
Section 3. Secretary-Treasurer

The Secretary-Treasurer shall:

(a) Serve on the Professional Executive Council;

(b) Assure that accurate and complete minutes of all Professional Executive Council and Professional Staff meetings are maintained;

(c) See that all notices of meetings are given in accordance with the provisions of these Bylaws;

(d) Call meetings on order of the Chief of Staff;

(e) Have charge and custody of and be responsible for all funds entrusted to him/her; and whenever requested to do so, render true and correct statements with respect to all such funds and provide for a true and accurate accounting thereof; and

(f) Perform other duties to the office of Secretary-Treasurer, such as but not limited to, attending to all correspondence of the Professional Staff, and acting as custodian of the records of the Professional Staff.

ARTICLE V – PART D
Section 4. Immediate Past Chief of Staff

The Immediate Past Chief of Staff shall:

(a) Serve on the Professional Executive Council, Bylaws Committee, and the Nominating Committee and the Health and Conduct Committee

(b) Serve as Chairperson of the Bylaws Committee; and the Health and Conduct Committee; and

(c) Perform such additional or special duties as shall be assigned by the Chief of Staff, the Vice Chief of Staff, the Professional Executive Council, or the Board.

ARTICLE V
PART E. ELECTION OF OFFICERS

1. The Vice Chief of Staff and Secretary-Treasurer shall be elected by the Active Professional Staff through a preferential ballot to be completed by the Annual Meeting of the Professional Staff in even years.

2. The Nominating Committee shall prepare election ballots from a slate of one or more nominees for each office. In order to be included on the ballot as a candidate, each nominee must possess

all the qualifications set forth in Article V Part C and must consent to the nomination prior to being included on the election ballot. Election ballots shall include space for write-in candidates.

3. Election ballots shall be transmitted by mail, fax, email, or other reasonable method to each member of the Active Professional Staff at least fourteen (14) days prior to the annual meeting, and shall be returned to the Secretary-Treasurer by the date stated on the ballot (or any extensions thereof) before the Annual Meeting.

4. A plurality of the votes cast shall be sufficient to elect any officer, provided that at least twenty percent (20%) of the Active Staff has voted and that the candidate meets all qualifications as set forth in Article V Part C. The ballots shall be opened and counted by individuals appointed by the Chief of Staff.

5. In any election, in which at least twenty percent (20%) of the Active Professional Staff vote, if no candidate receives a plurality, there shall then be successive balloting until a plurality is obtained by one candidate. In such successive balloting, if there are more than two candidates, the name of the candidate receiving the fewest votes shall be omitted from each successive slate until a plurality is obtained by one candidate.

ARTICLE V
PART F. TERM OF OFFICE

1. The new officers shall take office on January 1st of odd years, and shall end their two-year terms on December 31st of even years, except as otherwise provided in these Bylaws.

2. The new officers shall hold office for one two-year term or until a successor is duly elected and installed.

3. The Active Staff Member who is elected as Vice Chief of Staff shall hold office for six (6) years; two (2) as Vice Chief of Staff, two (2) as Chief of Staff, and two (2) as Immediate Past Chief of Staff.

4. The Secretary-Treasurer may serve more than one two-year term, consecutive or otherwise.

ARTICLE V
PART G. REMOVAL OF OFFICERS

1. The following may request removal of a Professional Staff Officer:

   (a) Chief of Staff;
   (b) Vice Chief of Staff;
   (c) Chief Executive Officer;
   (d) Board Chair; or
   (e) Petition of 25% of the Active Staff (Organized Professional Staff)

2. Grounds for removal shall include, but are not limited to:

   (a) An adverse action regarding the officer's Professional Staff appointment or clinical privileges;

   (b) Mental, cognitive or physical Impairment;

   (c) The inability or unwillingness to perform the duties and responsibilities of the office;

   (d) The inability or unwillingness to conform to Professional Staff Bylaws, Rules & Regulations, or Policies; Hospital policies; Children's Service Standards or Principles of

Integrity and Compliance;

(e) Any action, statements, demeanor or conduct inside or outside the Hospital that are or could reasonably be disruptive to the operations of the Hospital or its Professional Staff, or impairs the community's confidence in the Hospital, or

(f) Failure to meet one or more of the qualifications set forth in Article V Part C above.

3. The Professional Executive Council can take action directed towards removing an officer by a resolution recommending removal adopted by at least two-thirds (2/3) of the members of the Active Professional Staff present and voting at a special meeting of the Professional Staff.

4. An officer may also be removed from office by petition of twenty-five percent (25%) of the Active Staff members and a subsequent two-thirds (2/3) vote by ballot of the Active Professional Staff present and voting at a special meeting for such purpose.

5. The special meeting must be called pursuant to the rules in Article V Part J Section 1-3 for the removal of any officer, and notice of the special meeting shall be provided to such officer at least ten (10) days prior to the date of the meeting.

6. Such officer shall be afforded the opportunity to speak prior to the vote on such removal at the special meeting.

7. The removal shall be effective when approved by the Board.

8. The Professional Executive Council may, in its discretion, suspend an officer during such time as conduct which could constitute grounds for removal are being reviewed, but before action directed towards removal of an officer is initiated by the Professional Executive Council.

ARTICLE V
PART H. RESIGNATIONS

An officer may resign at any time by giving written notice to the Board. The resignation is effective upon acceptance of the notice by the Board, unless a later effective date is specified in the notice.

ARTICLE V
PART I. VACANCIES IN OFFICE

1. If there is a vacancy for whatever reason in the office of the Chief of Staff or Immediate Past Chief of Staff during the term of office, the Chief next in line for the vacant position shall perform the duties of the vacant office (as well as the duties of his/her own office) for the unexpired portion of the term of office.

2. A vacancy in the office of Vice Chief of Staff shall be filled by a special election by the Active Staff. Such special election shall be conducted as soon as reasonably possible after the vacancy occurs, and the Vice Chief of Staff so elected shall take office immediately and serve for the remainder of the term of office, and shall succeed to the position of Chief of Staff in the succeeding term. The special election shall be conducted according to the procedures set forth in Article V Part E. If, at the time the vacancy occurs, a Vice Chief of Staff has already been elected to take office in the upcoming term of office, that individual shall instead take office as Vice Chief of Staff and continue to serve as Vice Chief of Staff through the upcoming term of office.

3. Any vacancy in the office of Secretary-Treasurer during the Professional Staff Year shall be filled by appointment by the Professional Executive Council on the recommendation of the Chief of Staff. Such appointment will be effective when approved by the Professional Executive

Council and continue through the end of the current term of office.

4. Any vacancy in the office of Immediate Past Chief of Staff may be filled, at the discretion of the Chief of Staff, by appointment by the Chief of Staff of a previous Chief of Staff who continues to meet the qualifications of a Professional Staff Officer as set forth in Article V Part C of these Bylaws. Such appointment will be effective when approved by the Professional Executive Council and continue through the end of the current term of office.

ARTICLE V
PART J. PROFESSIONAL STAFF MEETINGS
Section 1. Meetings

(a) Annual Meeting.

The Annual Meeting of the Staff shall be held each year at such time and place as the Chief of Staff shall designate.

(b) Regular Meetings.

(1) Regular meetings of the Staff shall be held as directed by the Professional Executive Council.

(2) The primary objective to be obtained through the regular meetings shall be the transaction of the business of the Professional Staff.

(a) Special Meetings.

(1) The Chief of Staff, the Professional Executive Council, or the Board may call a special meeting of the Professional Staff at any time. The Chief of Staff shall call a special meeting within thirty (30) days after receipt by him/her of a written request for same signed by at least twenty-five percent (25%) of the Active Professional Staff and stating the purpose for such meeting. The Professional Executive Council shall designate the time and place of any special meeting.

(2) Written or printed notice stating the time, place, and purpose of any special meeting of the Staff shall be delivered to all Members not less than five (5) or more than thirty (30) days before the date of such meeting. No business shall be transacted at any special meeting except that stated in the notice of the meeting.

ARTICLE V – PART J
Section 2. Quorum

At any duly called meeting of the Professional Staff, a quorum shall be defined as the Active Staff Members present.

ARTICLE V – PART J
Section 3. Attendance at Meetings

Requirements, if any, for any duly-called meeting of the Professional Staff shall be set forth in the Policy on Professional Staff Committees.

ARTICLE VI: CLINICAL DIVISIONS

PART A. CLINICAL DIVISIONS
Section 1. Division Organization

The Staff hereby organizes itself into a non-departmentalized staff in accordance with this Article VI as follows:

(a) The Division of Medicine, including the following specialties:

(1) Pediatrics
(2) Adolescent Medicine
(3) Allergy & Immunology
(4) Clinical Immunology
(5) Developmental/Behavioral Pediatrics
(6) Dermatology
(7) Endocrinology
(8) Family Medicine
(9) Gastroenterology
(10) Genetic Counseling
(11) Gynecology
(12) Hematology & Oncology
(13) Infectious Disease
(14) Medical Genetics & Genomics
(15) Nephrology
(16) Neurodevelopmental Disabilities
(17) Neurology
(18) Pain, Hospice & Palliative Medicine
(19) Physiatry / Physical Medicine & Rehabilitation
(20) Psychiatry
(21) Psychology
(22) Pulmonary Medicine
(23) Radiation Oncology
(24) Rheumatology
(25) Sleep Medicine
(26) Social Work
(27) Non-Surgical Subspecialties not otherwise listed

(b) The Division of Surgery, including the following specialties:

(1) Anesthesiology
(2) Audiology
(3) Cardiothoracic Surgery
(4) General/Pediatric Surgery
(5) Dentistry
(6) Gynecology
(7) Neurological Surgery
(8) Ophthalmology
(9) Oral & Maxillofacial Surgery
(10) Orthopedic Surgery
(11) Otolaryngology
(12) Pathology
(13) Plastic & Reconstructive Surgery
(14) Podiatry
(15) Urology
(16) Vascular Surgery
(17) Surgical Specialties not otherwise listed

(c) The Division of Critical Care, including the following specialties:

(1) Cardiology
(2) Critical Care Medicine
(3) Emergency Medicine
(4) Neonatology
(5) Radiology
(6) Endovascular Surgical Neuroradiology

ARTICLE VI
PART B. FUNCTIONS OF DIVISIONS

1. Each division through its division chief shall recommend to the Credentials Committee written criteria for the assignment of clinical privileges within the division. Such criteria shall be consistent with and subject to the Staff Bylaws, policies, rules and regulations of the Staff. These criteria shall be effective when approved by the Board. Clinical privileges shall be based upon demonstrated competence, training and experience within the specialties covered by the division.

2. Each division shall monitor and evaluate medical care provided by Practitioners acting within the specialties of the division on a retrospective, concurrent and prospective basis in all major clinical activities of the division. This monitoring and evaluation must at least include:

   (a) The identification and collection of information about important aspects of patient care provided in the division;

   (b) The identification of the indicators used to monitor the quality and appropriateness of the important aspects of patient care; and

   (c) The periodic assessment of patient care information to evaluate the quality and appropriateness of patient care; to identify opportunities to improve care and to identify important problems in patient care.

3. Each division shall recommend objective criteria for the monitoring and evaluation of patient care. Such criteria shall reflect current knowledge and clinical experience. These criteria shall be used by each division and by the Hospital's performance improvement program in the monitoring and evaluation of patient care. When important problems in patient care and clinical performance or opportunities to improve care are identified, each division shall act to ensure a uniform standard of quality patient care, treatment and services, shall document the actions taken, and shall evaluate the effectiveness of such actions.

4. In discharging these functions, each division shall report a performance improvement annual plan to the Professional Executive Council or to a body designated by the Professional Executive Council detailing its analysis of patient care, and to the Credentials Committee whenever further investigation and action are indicated involving any individual Practitioner acting within the specialties of the division.

ARTICLE VI
PART C. SECTIONS

Each clinical division may be divided into sections by its division chief (with the approval of the Professional Executive Council) as necessary for the proper functioning of the division. The division chief shall recommend individuals for appointment as section chiefs, subject to appointment by the Chief of Staff with the concurrence of the Professional Executive Council as set forth in Article V Part D, Section 1.

ARTICLE VI

PART D. DIVISION CHIEFS, ASSOCIATE DIVISION CHIEFS, AND ASSOCIATE DIVISION CHIEFS ELECT

Section 1. Division Chief

1. At the time of initial appointment, the chief of each division shall be a Physician Member of the Active Staff who possesses the qualifications set forth in Articles II Part B, Article III Part A, Section 1 and Article V Part C of these Bylaws, and shall be certified by an appropriate specialty board or be affirmatively established to have comparable competence through the credentialing process. While continuing retention of Active Staff status is not required, continuing Professional Staff membership is required for the duration of the tenure as division chief.

2. Selection of Division Chief

   (a) Members of the selection committee shall be selected by the Chief of Staff, Chief Medical Officer, and Chief Operating Officer;

   (b) Majority of members of the selection committee shall be Professional Staff Members;

   (c) Recommendation of candidate(s) shall be made to Chief Executive Officer;

   (d) Chief Executive Officer shall appoint one candidate to be the chief of each division for Hospital operations;

   (e) The Chief of Staff shall recommend to the Professional Executive Council the candidate(s) to handle the Professional Staff activities of each division. A two-thirds (2/3) vote of the Professional Executive Council is required for approval;

   (f) If Professional Executive Council fails to approve a candidate, the Chief Executive Officer shall be notified with the reasons for failure to approve.

3. The division chief shall report to the Chief of Staff for Professional Staff issues.

4. Initial term of office shall be for five (5) years, subject to annual performance reviews. Subsequent terms may be approved through the same selection process.

5. If the division chief is unable to continue the duties or resigns from the position, the associate division chief will assume Professional Staff responsibilities until a new division chief is approved.

ARTICLE VI – PART D
Section 2. Associate Division Chief

1. The associate division chief for each division shall be appointed every two years by the Chief of Staff with the concurrence of the Professional Executive Council as set forth in Article V Part D, Section 1.

2. The associate division chief shall be a Physician Member of the Active Staff who possesses the qualifications set forth in Articles II Part B, Article III Part A, Section 1 and Article V Part C of these Bylaws, and shall be certified by an appropriate specialty board or be affirmatively established to have comparable competence through the credentialing process.

3. The associate division chief of each division may act for the chief in the chief's absence, or if the chief has delegated the function to the associate division chief.

4. The associate division chief shall be a voting member of the Professional Executive Council.

5. If the associate division chief is, for any reason, unable to fulfill his or her term, or resigns, the Chief of Staff shall appoint another qualified Physician Member to complete the term with the concurrence of the Professional Executive Council.

ARTICLE VI – PART D
Section 3. Associate Division Chief Elect

1. The associate division chief elect for each division shall be appointed for a two years term by the Chief of Staff with the concurrence of the Professional Executive Council as set forth in Article V Part D, Section 1.

2. The associate division chief elect shall be a Physician Member of the Active Staff who possesses the qualifications set forth in Articles II Part B, Article III Part A, Section 1 and Article V Part C of these Bylaws, and shall be certified by an appropriate specialty board or be affirmatively established to have comparable competence through the credentialing process.

3. The associate division chief elect of each division may act for the chief or associate division chief in the division chief's or associate division chief's absence, or if the division chief or associate division chief has delegated the function to the associate division chief elect.

4. The associate division chief elect shall assume the office of associate division chief following the two-year term of office, or in the event the associate division chief position is vacated.

5. The associate division chief elect shall be a voting member of the Professional Executive Council.

6. If the associate division chief elect is, for any reason, unable to fulfill his or her term, or resigns, the Chief of Staff shall appoint another qualified Physician Member to complete the term with the concurrence of the Professional Executive Council.

ARTICLE VI
PART E. FUNCTIONS OF DIVISION CHIEFS

Each division chief shall perform the functions set forth in these Bylaws and the Policy on Professional Staff Committees. The division chief may delegate his/her functions to the associate division chief or associate division chief elect, or others as appropriate.

Each division chief shall:

1. Conduct (unless otherwise provided for by the Hospital) and oversee professional, and clinical activities within the division;

2. Utilize a mechanism to communicate with all Practitioners acting within the specialties of the division, such as a regular meeting or newsletter;

3. Be a member of the Professional Executive Council;

4. Serve as a member of the Credentials Committee or appoint a designee;

5. Maintain continuing surveillance of the professional performance of all Practitioners who have delineated clinical privileges in the division, and take such actions as appropriate to ensure quality care, and document those actions in the Practitioners' files;

6. Recommend to the Credentials Committee objective criteria for granting clinical privileges in the division;

7. Enforce the Staff Bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Hospital and its Staff within the division;

8. Implement actions taken by the Board and the Professional Executive Council with the division;

9. Make a recommendation to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for all applicants seeking privileges in the division. This function may only be delegated to the associate division chief or associate division chief elect;

10. Establish, implement and monitor the effectiveness of any teaching, education or research programs in the division by working with the Hospital's Director of Medical Education;

11. Assess and make recommendations to Hospital management regarding matters affecting patient care in the division; including offsite sources for needed patient care services not provided within the division or the Hospital, personnel, supplies, special regulations, standing orders and techniques;

12. Assist Hospital management in the preparation of annual reports and such budget planning pertaining to the division as may be required by the Chief Executive Officer or the Board;

13. Establish and implement risk management activities within the division designed to assist the Hospital in risk management activities related to the clinical aspects of patient care and safety and make reports to the Professional Executive Council regarding such activities;

14. Establish division sections (with approval of the Professional Executive Council) and division committees, and recommend individuals to the Chief of Staff for appointment as chairpersons thereof, subject to appointment by the Chief of Staff;

15. Attend all meetings of the division, Professional Executive Council, Credentials Committee, and Professional Staff, or delegate attendance to the associate division chief or associate division chief elect or otherwise provide for appropriate division leadership attendance;

16. Recommend voting members of the division to the Chief of Staff for appointment (to be approved by the Professional Executive Council); and

17. Collaborate with the Hospital leadership in accomplishing the following activities relevant to the division:

    (a) The integration of the division into the primary functions of the organization;

    (b) The coordination and integration of interdivisional, intradivisional, interdepartmental and intradepartmental services;

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

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

    (e) The recommendations to the Hospital regarding qualifications and competence of individuals who are not Members of the Professional Staff and who provide patient care, treatment, or services critical to the functioning of the division;

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

provided;

(g) The maintenance of quality control programs, as appropriate;

(h) The orientation and continuing education of all Practitioners acting within the specialties of the division; and,

(i) Recommendations for space and other resources needed by the division;

(j) Provide oversight in the process of analyzing and improving patient satisfaction.

ARTICLE VI
PART F. VOTING MEMBERSHIP OF DIVISIONS

1. Qualifications: Be a member in good standing of the Active Professional Staff.

2. The composition of the voting membership of a division shall be a fair and reasonable representation of the diversity of the division membership.

3. The voting members of the division shall be appointed by the Chief of Staff upon recommendation by the division chief with approval of the Professional Executive Council and may be changed from time to time by the same process.

ARTICLE VI
PART G. REMOVAL OF DIVISION CHIEFS

1. Grounds for removal shall include, but are not limited to:

    1. An adverse action regarding the individual's Professional Staff appointment or clinical privileges;

    (b) Mental, cognitive or physical Impairment;

    (c) Failure to continue to meet the qualifications of the position, as set forth in these Bylaws;

    (d) Failure to conform to the Children's Service Standards, Principles of Integrity and Compliance; or,

    (e) Inability or unwillingness to perform the duties and responsibilities of the position.

2. The Chief of Staff may recommend removal of a division chief, associate division chief, associate division chief elect, section chief (if any), which shall become effective when approved by two-thirds (2/3) of the voting members of the Professional Executive Council.

3. Such individual shall be afforded the opportunity to speak before the Professional Executive Council prior to the taking of any vote on such removal.

4. The Chief of Staff may, in his/her discretion, suspend an individual from such position (a) during such time as conduct which could constitute grounds for removal are being reviewed, or (b) until the Professional Executive Council meets and votes on the proposed removal.

ARTICLE VI
PART H. RESIGNATIONS

A division chief, associate division chief, associate division chief elect, section chief (if any), or voting member of a division, may resign at any time by giving written notice to the Chief of Staff or the

Professional Executive Council. The resignation is effective upon acceptance of the notice by Chief of Staff or the Professional Executive Council, as applicable, unless a later effective date is specified in the notice.

ARTICLE VI
PART I. DIVISION MEETINGS
Section 1. Division Meetings

Each division shall meet as necessary to accomplish its functions but at least quarterly. Such meetings shall be conducted in accordance with the procedures set forth herein. Members of each division shall meet at a time set by the division chief to review and evaluate the clinical work of the division, to consider the findings of ongoing quality/performance improvement monitoring and evaluation activities, and to discuss any other matters concerning the division. The agenda for the meeting and its general conduct shall be set by the division chief. Each division shall maintain a record of its findings, proceedings, and actions, and after each meeting shall make a report thereof to the Professional Executive Council, other committees as applicable, and the Chief Executive Officer.

ARTICLE VI – PART I
Section 2. Special Division Meetings

(a) A special meeting of any division may be called by or at the request of the division chief, the Chief of Staff, or by a petition signed by at least twenty-five percent (25%) of the Active Staff members of the division or at least fifty percent (50%) of the voting members of the division. Except in an emergency or otherwise unusual situation, notice of this meeting must be sent to all voting members of the division at least five (5) working days in advance of the meeting~~,~~ preferably in writing, but notice also may be given in person, by email, by telephone or by other method reasonably calculated to notify the voting member, using the contact information currently on record with the division.

(b) In the event that it is necessary for a division to act on a question without being able to meet, the voting members of the division may be presented with the question, in person or by mail, or by other method reasonably calculated to reach the voting member, and their vote returned to the chief of the division. Such a vote shall be binding so long as the question is voted on by a majority of the division members eligible to vote.

ARTICLE VI – PART I
Section 3. Quorum

At any duly called meeting of the division, a quorum shall be defined as the voting members present. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

ARTICLE VI – PART I
Section 4. Minutes

Minutes of each meeting of each division shall be prepared and shall include a record of the attendance of the division members, of the recommendations made, and of the votes taken on each matter. The minutes shall be signed by the division chief or his/her designee and copies thereof shall be forwarded promptly to the Professional Executive Council and, at the same time, to the Chief Executive Officer and certain committees as specified elsewhere in the Bylaws. The minutes of each division meeting shall be maintained by the Hospital.

ARTICLE VI
PART J. DIVISION COMMITTEES

Each division chief may establish division committees as necessary for the proper functioning of the

division. At any duly called division committee meeting, a quorum shall be defined as the voting members present. All other rules and procedures regarding staff committees contained in Article II of the Policy on Professional Staff Committees shall be followed by division committees to the extent applicable.

ARTICLE VII: COMMITTEES OF THE PROFESSIONAL STAFF

PART A. APPOINTMENT
Section 1. Chairpersons

(a) All committee chairpersons shall be members of the Active Staff.

(b) All committee chairpersons shall be appointed by the Chief of Staff as set forth in Article V Part D, Section 1(b) with the concurrence of the Professional Executive Council.

(c) Such appointments shall be made for a term of one (1) year unless otherwise stated in these Bylaws or the Policy on Professional Staff Committees, or until successors are appointed.

ARTICLE VII - PART A
Section 2. Members

(a) Except as otherwise provided for in these Bylaws or the Policy on Professional Staff Committees, members of each committee shall be appointed yearly by the committee chairpersons with the consent of the Chief of Staff as set forth in Article V Part D, Section 1 (b) and there shall be no limitation in the number of terms they may serve. Any appointed committee member may be removed at any time by the Chief of Staff, and such vacancies filled at any time by him/her.

(b) The Professional Executive Council voting membership shall be comprised only of Members of the Active or Affiliate Staff. The Chief Executive Officer or designee, Chief Medical Officer, and Vice Chief Medical Officer shall be *ex-officio* nonvoting members of all committees except where otherwise provided.

ARTICLE VII
PART B. REMOVAL OF CHAIRPERSONS

1. Grounds for removal shall include, but are not limited to:

   (a) An adverse action regarding the officer's Professional Staff appointment or clinical privileges;

   (b) Mental cognitive or physical Impairment;

   (c) Failure to continue to meet the qualifications of the position, as set forth in these Bylaws;

   (d) Failure to conform to the Children's Service Standards, Principles of Integrity and Compliance; or,

   (e) Inability or unwillingness to perform the duties and responsibilities of the office.

2. The Chief of Staff may remove a committee chairperson from such position with the concurrence of the Professional Executive Council.

3. Such Member shall be afforded the opportunity to speak before the Professional Executive Council prior to the taking of any vote on such removal.

4. The removal shall be effective when approved by the Professional Executive Council.

5. The Chief of Staff may, in his/her discretion, suspend a committee chairperson from such position (a) during such time as conduct which could constitute grounds for removal are being reviewed, or (b) until the Professional Executive Council meets and votes on the proposed removal.

ARTICLE VII
PART C. RESIGNATIONS

A committee chairperson may resign at any time by giving written notice to the Chief of Staff or the Professional Executive Council. The resignation is effective upon acceptance of the notice by Chief of Staff or the Professional Executive Council, as applicable, unless a later effective date is specified in the notice.

ARTICLE VII
PART D. STAFF COMMITTEE MEETINGS
Section 1. Staff Committee Meetings

All committees shall meet as needed, at a time set by the chairperson of the committee and communicated to the committee members. The agenda for the meeting and its general conduct shall be set by the chairperson. Each committee shall maintain a record of its findings, proceedings, and actions, and after each meeting shall make a report thereof to the Professional Executive Council and the Chief Executive Officer.

ARTICLE VII – PART D:
Section 2. Special Staff Committee Meetings

(a) A special meeting of any Staff committee may be called by or at the request of the chairperson, the Chief of Staff, or by a petition signed by not less than one-third (1/3) of the voting members of the committee. Except in an emergency or otherwise unusual situation, notice of this meeting must be sent to all committee members at least five (5) working days in advance of the meeting preferably in writing, but notice also may be given in person, by email, by telephone or by other method reasonably calculated to notify the committee member, using the contact information currently on record with the committee.

(b) In the event that it is necessary for a Staff committee to act on a question without being able to meet, the committee members eligible to vote may be presented with the question, in person or by mail, and their vote returned to the chairperson of the committee. Such a vote shall be binding so long as the question is voted on by a majority of the committee members eligible to vote.

ARTICLE VII - PART D:
Section 3. Quorum

Quorum requirements for any Staff committee meeting shall be set forth in the Policy on Professional Staff Committees. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

ARTICLE VII - PART D:
Section 4. Voting

Decisions shall be determined in all Staff committees by majority vote of the voting members present at the time of the vote unless otherwise specified.

ARTICLE VII – PART D
Section 5. Minutes

Minutes of each meeting of each committee shall be prepared and shall include a record of the

attendance of the committee members, of the recommendations made, and of the votes taken on each matter. The minutes shall be signed by the chair of the committee or his/her designee and copies thereof shall be forwarded promptly to the Professional Executive Council and, at the same time, to the Chief Executive Officer and certain committees as specified elsewhere in the Bylaws. The minutes of each committee meeting shall be maintained by the Hospital as set forth in the Policy on Professional Staff Committees Article II Part A Section6, except as otherwise set forth by Committee in that Policy.

ARTICLE VII – PART D
Section 6. Standing Committees

The standing committees of the Professional Staff are:

(a) Professional Executive Council;
(b) Credentials Committee;
(c) Nominating Committee;
(d) Patient Care Practices Committee;
(e) Education and Research Committee;
(f) Health and Conduct Committee;
(g) Bylaws Committee;
(h) Performance Improvement Committee; and
(i) Peer Review Committee(s)

The Professional Executive Council is described here below. Descriptions of all other standing committees are described in Article II of the Policy on Professional Staff Committees.

ARTICLE VII
PART E. PROFESSIONAL EXECUTIVE COUNCIL
Section 1. Purpose

The Professional Executive Council shall be the governing body of the Staff.

ARTICLE VII – PART E
Section 2. Membership

Composition and size of the Professional Executive Council and selection of its members.

(a) The voting members of the Professional Executive Council shall consist of the following:

(1) Chief of Staff;
(2) Vice Chief of Staff;
(3) Immediate Past Chief of Staff;
(4) Secretary-Treasurer;
(5) Chairperson of the Education and Research Committee;
(6) Chairperson and Vice Chairperson of the Credentials Committee; and
(7) Chief, associate division chief, and associate division chief elect of the Division of Surgery.
(8) Chief, associate division chief, and associate division chief elect of the Division of Medicine,
(9) Chief, associate chief, and associate division chief elect of the Division of Critical Care,
(10) Five (5) at-large members.

(b) The Chief of Staff shall be the Chairperson of the Professional Executive Council.

(c) The members at-large shall be members of the Professional Staff, shall not be chiefs of divisions, and shall not be all from the same division. At least one at-large member shall

represent the mental health specialties, and at least one shall represent advanced practice nurses. The five at-large members shall be elected by the Active Staff according to the same procedures as for the election of officers of the staff as stated in these Bylaws, Article V, Part E. Each at-large member shall be eligible for election to two consecutive three-year terms; thereafter, the members at large shall not be eligible for reelection for one year following completion of the two terms.

(d) The majority of voting members of the Professional Executive Council must be fully licensed Physicians actively practicing at or for the Hospital.[17]

(e) Each voting member of the Professional Executive Council shall have one vote, even if such member serves in multiple capacities on the Professional Executive Council. If a voting member of the Professional Executive Council is not a member of the Active Staff, he or she shall have one vote on the Professional Executive Council until the completion of his or her tenure on the council, including the right to vote on amendments to the Bylaws and other Professional Staff Documents and on the removal of officers, even though he or she does not hold the regular voting rights of members of the Active Staff.

(f) If an at-large vacancy occurs for any reason between elections, it shall be filled by a Member of the Professional Staff appointed by the Chief of Staff. An at-large member appointed to fill a vacancy shall continue as a member at large until the date the term of the member being replaced would have expired. Thereafter, the member who was appointed to fill the vacancy shall be eligible for election for two consecutive three-year terms, on the same basis as an individual who has not been a member in the preceding one-year period.

(g) The Chief Executive Officer, the Chief Operating Officer, the Chief Medical Officer, the Vice Chief Medical Officer and the Chief Nurse Executive shall serve as *ex-officio* members of the Professional Executive Council, without vote. In addition, the Professional Executive Council may designate other *ex-officio* members, without vote. Other persons may attend as requested by the Chief of Staff.

(h) The Board Chair may designate a director to attend meetings of the Professional Executive Council and participate in its discussions, but without vote.

ARTICLE VII – PART E
Section 3. Removal of Members of Professional Executive Council

(a) The following may request removal of a member of the Professional Executive Council:

(1) Chief of Staff;
(2) Vice Chief of Staff;
(3) Chief Executive Officer;
(4) Board Chair; or
(5) Petition of 25% of the Active Staff (Organized Professional Staff)

(b) Grounds for removal shall include, but are not limited to:

(1) An adverse action regarding the Member's Professional Staff appointment or clinical privileges;

(2) Mental, cognitive or physical Impairment;

(3) The inability or unwillingness to perform the duties and responsibilities of the office;

[17] The Joint Commission – Hospital Accreditation Standards, MS.02.01.01 EP 4

(4) The inability or unwillingness to conform to the Professional Staff Bylaws, Rules & Regulations, or Policies; Hospital policies; Children's Service Standards, or Principles of Integrity and Compliance;

(5) Any action, statements, demeanor or conduct inside or outside the Hospital that are or could reasonably be disruptive to the operations of the Hospital or its Professional Staff, or impairs the community's confidence in the Hospital; or

(6) Failure to meet one or more of the qualifications set forth in these Bylaws.

(c) The Professional Executive Council may take action directed toward removing a member of the Professional Executive Council by a resolution recommending removal adopted by at least two-thirst (2/3) of the members of the Active Professional Staff present and voting at a special meeting of the Professional Staff.

(d) A member of the Professional Executive Council may also be removed by petition of twenty-five percent (25%) of the Active Staff members and a subsequent two-thirds (2/3) majority vote by ballot of the Active Professional Staff present and voting at a special meeting for such purpose.

(e) The special meeting must be called pursuant to the rules in the Bylaws, Article V, Part J, Section 1-2 for the removal of any member of the Professional Executive Council, and notice of the special meeting shall be provided to such member at least ten (10) days prior to the date of the meeting.

(f) Such member shall be afforded the opportunity to speak prior to the vote on such removal at the special meeting.

(g) The removal shall be effective when approved by the Board.

(h) The Professional Executive Council may, in its discretion, suspend an individual from membership on the Professional Executive Council during such time as conduct which could constitute grounds for removal is being reviewed, and until final determination on the proposed removal is made.

ARTICLE VII – PART E
Section 4. Functions

The Organized Professional Staff delegates authority to the Professional Executive Council to execute the following functions on its behalf; subject only to any limitations imposed by these bylaws and duly approved amendments thereto:

(a) To act as the governing body of the Professional Staff with the power to represent and to act between its regular meetings, on behalf of the Professional Staff in all matters, without requirement of subsequent approval by the Staff, subject only to any limitations imposed by these Bylaws; it shall recommend, administer, and supervise the policies and activities of the Professional Staff;

(b) To approve appointment of division chiefs, associate division chiefs, associate division chiefs elect, section chiefs (if any), voting members of divisions, and committee chairpersons recommended by the Chief of Staff;

(c) To coordinate the activities and general policies of the divisions;

(d) To receive and to act upon those division and committee reports as specified in these Bylaws and the Policy on Professional Staff Committees, and to make recommendations

concerning them to the Hospital administration, Board, or other groups as appropriate;

(e) To implement policies of the Hospital that affect the Staff;

(f) To provide liaison among the Staff, the Chief Executive Officer, and the Board;

(g) To keep the Staff informed of applicable accreditation and regulatory requirements affecting the Hospital;

(h) To enforce these Bylaws, policies, procedures, rules, regulations, guidelines, and requirements in the best interest of patient care, treatment and services, and of the Hospital, with regard to all persons who hold appointment to the Staff and individuals with privileges;

(i) To review recommendations of the Credentials Committee regarding situations involving questions of the clinical competence, patient care and treatment, case management, citizenship or inappropriate behavior of any Professional Staff Member, and to take such action as might be appropriate, consistent with Article VIII in these Bylaws and consistent with the Policy on Appointment, Reappointment, and Clinical Privileges;

(j) To request evaluations of Practitioners privileged through the Professional Staff process in instances where there is doubt about an applicant's ability to perform the privileges requested;

(k) To review Professional Staff peer review and performance improvement activities;

(l) To review quality improvement activities[18], and implement the Hospital's quality/performance improvement plan;

(m) To review these Bylaws, policies, rules, regulations, and associated documents of the Professional Staff at least once each calendar year and recommend such changes as may be necessary or desirable;

(n) To establish, at its option, minimum continuing education requirements for Members[19] in addition to any such requirements established by law;

(o) To periodically review and approve the qualifications of radiology staff who use equipment and administer procedures[20];

(p) To make recommendations to the Board on at least the following:

(1) The organized Professional Staff's structure;

(2) The process used to review credentials and delineated privileges;

(3) The delineation of privileges for each Practitioner privileged through the Professional Staff process;

(4) Professional Staff membership; and,

(5) Professional Staff termination.

[18] The Joint Commission – Hospital Accreditation Standards, MS.05.01.01 – EP 1
[19] The Joint Commission – Hospital Accreditation Standards, MS.12.01.01 – EP 4
[20] The Joint Commission – Hospital Accreditation Standards, MS.03.01.01 – EP 16. See also Rules & Regulations of the Professional Staff, Article V, Part H. Radiology & Nuclear Medicine Services.

(p) The Professional Executive Council shall conduct a periodic self-evaluation.

ARTICLE VII – PART E
Section 5. Meetings, Reports, and Recommendations

The Professional Executive Council shall meet as necessary to transact pending business, but no less frequently than quarterly. Copies of all minutes and reports of the Professional Executive Council shall be transmitted to the Chief Executive Officer routinely as prepared. Recommendations of the Professional Executive Council shall be transmitted to the Board through the Chief of Staff or Chief Executive Officer in accordance with these Bylaws and other bylaws, policies, procedures, rules, regulations, guidelines, and requirements of the Hospital and its Professional Staff. The Chairperson of the Professional Executive Council shall be available to meet with the Board or its applicable committee on all recommendations that the Professional Executive Council may make.

ARTICLE VII
PART F. CREDENTIALS COMMITTEE

The Credentials Committee, acting as delegated by the Professional Executive Council, shall submit reports and recommendations to the Professional Executive Council on the qualifications of each applicant for Staff appointment or reappointment and for granting, renewing, or revising clinical privileges. The membership, functions, and meetings are as set forth in the Policy on Professional Staff Committees Article II Part E.

ARTICLE VII
PART G. QUALITY/PERFORMANCE IMPROVEMENT AND OTHER FUNCTIONS PERFORMED BY PROFESSIONAL STAFF COMMITTEES

A description of other Staff committees that carry out quality/performance improvement and other functions delegated to the Professional Staff, including their composition and functions, is contained in the Policy on Professional Staff Committees. The results of this quality monitoring, assessment, and improvement activity are reported through the quality/performance improvement structure of the organization.

ARTICLE VII
PART H. CREATION OF STANDING COMMITTEES

The Professional Executive Council may, without amendment of these Bylaws, establish additional committees to perform one or more Staff functions. In the same manner, the Professional Executive Council may, dissolve or rearrange committee structure, functions, or composition as needed to better accomplish Professional Staff functions. Any function required to be performed by these Bylaws which is not assigned to a standing or ad hoc committee shall be performed by the Professional Executive Council.

ARTICLE VII
PART I. AD HOC COMMITTEES

Ad hoc committees of the Professional Staff shall be created and their members and chairpersons shall be appointed by the Chief of Staff with the approval of the Professional Executive Council as required and as appropriate. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Professional Executive Council.

ARTICLE VII
PART J. NOMINATING COMMITTEE

The Nominating Committee shall prepare a list of nominees for each election. Nominations shall be made for Vice Chief of Staff Secretary-Treasurer, and all members-at-large of the Professional Executive Council. The membership, functions, and meetings are as set forth in the Policy on Professional Staff

Committees Article II Part C.

ARTICLE VIII: PROFESSIONAL REVIEW ACTIONS

All professional review actions must be taken: (1) in the reasonable belief that the action is in furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the Practitioner involved or after such other procedures as are fair to the Practitioner under the circumstances; and (4) in the reasonable belief that the action is warranted by the facts known after such reasonable efforts to obtain facts and after due process[21].

ARTICLE VIII
PART A. COLLEGIAL INTERVENTION

In some circumstances, formal or informal methods may be used, such as routine monitoring, education, mentoring and concurrent review as alternatives to formal professional review action.

These Bylaws encourage the use of progressive steps by Professional Staff leaders and the Hospital, beginning with collegial and educational efforts (where appropriate), to address questions relating to an individual's clinical practice or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement and peer review.

Collegial intervention efforts may include reviewing and following up on questions raised about the clinical practice or conduct of Practitioners and pursuing counseling, education, and related steps.

Examples may include:

1. Advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

2. Proctoring, monitoring, consultation, and letters of guidance; and

3. Sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

The relevant Professional Staff leader(s) shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file(s).

Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Professional Staff leaders and the Hospital.

The relevant Professional Staff leader(s), in conjunction with the VPMA or CEO, shall determine whether to direct that a matter be handled in accordance with another policy. Professional Staff leaders may also direct these matters to the Professional Executive Council for further action.

ARTICLE VIII
PART B: ACTION WITHOUT AN INVESTIGATION

The Credentials Committee may make a recommendation for professional review action to the Professional Executive Council without initiating an investigation as described in Part C, Section 1, below:

1. After review and discussion of reliable, duly-documented information, received in the ordinary course of its functions or otherwise provided, that is determined, after sufficient inquiry, to be

[21]Health Care Quality Improvement Act, 42 U.S.C. § 11101 *et. seq*.

credible; and

2. After determining that the information received is sufficient to warrant such recommendation without further inquiry and investigation.

If the recommendation for professional review action is anticipated to meet the grounds for a hearing, the Member or Individual with Privileges shall be notified in writing with delivery confirmation that a recommendation for professional review action has been made.

ARTICLE VIII
PART C: INVESTIGATION
Section 1. Criteria for the Initiation of an Investigation

A request for an investigation may be made by one or more of the following: Chief of Staff, division chief, associate division chief, associate division chief elect, chair or a majority of any Professional Staff committee, Chief Medical Officer, Chair of Health and Conduct Committee, Chair of the Board, or Chief Executive Officer, if, on the basis of information and belief, there is cause to question:

a) The clinical competence of any Practitioner;

b) The care or treatment of a patient or patients or management of a case by any Practitioner;

c) Performing patient care, treatment or services at or for the Hospital outside the scope of currently granted privileges or during a period in which privileges are suspended or inactive, except in situations in which emergency temporary privileges[22] apply;

d) The known or suspected violation by any Practitioner of applicable ethical standards, bylaws, policies, rules, regulations, guidelines, expectations, or standards of the Professional Staff, the Hospital, or its Board, or of any regulatory standard, including, but not limited to Children's Service Standards, Principles of Integrity and Compliance, or Hospital quality assessment, risk management, and utilization review requirements; or

e) Behavior or conduct on the part of any Practitioner that is disruptive to the orderly operation of the Hospital and its Professional Staff, including the inability of the Practitioner to work harmoniously with others (Disruptive Conduct).

ARTICLE VIII - PART C
Section 2. Process for Requesting an Investigation

All requests for investigation must be submitted in writing to the Chair of the Credentials Committee (or designee), or to the Chief of Staff (or designee). The Credentials Committee or Professional Executive Council may request an investigation verbally, provided the request is duly documented in the minutes of the meeting in which the request is made. All requests for investigation must make specific reference to the information, activity, or conduct that gave rise to the request. The chair of the Credentials Committee, or designee, shall promptly notify the Chief of Staff and Professional Executive Council in writing of the request and keep the Chief Executive Officer, Chief of Staff and Professional Executive Council fully informed of all action taken in connection therewith.

If the Credentials Committee responds to the request by initiating an investigation such response shall be documented in the minutes of the meeting.

ARTICLE VIII - PART C
Section 3. Review of Request for Investigation and Initiation of Investigation

[22] Policy on Appointment, Reappointment and Clinical Privileges, Article III, Part B, Section 6.

(a) The Credentials Committee shall meet as soon as practicable after receiving the request for an investigation and if, in the opinion of the Credentials Committee:

(1) The request for investigation does not contain information sufficient to warrant a

(Continuation of Article VIII, Part C, Section 3)

recommendation for professional review action, no further action is necessary.

(2) The request for investigation contains information sufficient to warrant a recommendation for professional review action, the Credentials Committee, at its discretion, shall make such a recommendation to the Professional Executive Council. If the recommendation for professional review action is anticipated to meet the grounds for a hearing, the Member or Individual with Privileges shall be notified in writing with delivery confirmation that a recommendation for professional review action has been made, and shall be offered an opportunity to meet with an appropriate Professional Staff leader or committee.

(3) The request for investigation does not contain information sufficient to determine whether a recommendation for professional review action is warranted, the Credentials Committee shall promptly proceed with one of the following options:

a. Investigate the matter itself;

b. Appoint a subcommittee of one or more Credentials Committee Member(s) to conduct an investigation;

c. Appoint an investigation committee, if deemed necessary for more serious matters;

d. Refer the matter to the appropriate division peer review committee; or;

e. Proceed with another option it determines appropriate.

Any of the above mentioned in a through d is considered an investigating body for purposes of this article.

An investigation will be deemed to have been initiated upon the taking any action set forth in (2) or in (3) a – c, above.

(b) An investigation committee shall consist of up to five (5) persons, who may or may not hold appointments to the Professional Staff and the majority of whom are Physicians licensed to practice medicine in Minnesota. This committee shall not include partners, associates or relatives of the Practitioner, nor shall it include any person who investigated or made the initial request for professional review action.

(c) An investigating body shall have available to them the full resources of the Professional Staff and Hospital to aid in their work, as well as the authority to use outside consultants as required. The investigating body may, but is not obliged to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article IX, nor shall the procedural rules with respect to hearing or appeals apply.

(d) Except in cases in which the Credentials Committee, without further investigation, determines that no action is warranted, the Practitioner shall be notified by the chair of the Credentials Committee, or designee, that an investigation has been initiated including the reason for the investigation, and be given an opportunity to provide information in a manner

and upon such terms as the investigating body deems appropriate. If the Practitioner is invited to meet with the investigating body, legal counsel for the Practitioner may attend only by invitation of the chair of the investigating body, and only after notification of the Hospital general counsel.

(e) Upon request of the investigating body, the Chair of the Credentials Committee, or designee, may require a physical and/or mental examination of the Practitioner by a physician or other professional and shall require that the results of such examination be made available to the investigating body for consideration. Failure of the Practitioner to procure such an examination within a designated reasonable time period, after being requested to do so in writing, shall be grounds for administrative suspension in accordance with Article VIII Part D, Section 4 until such time as the chair of the Credentials Committee, or designee, has received the examination results. The requirement of such an examination or evaluation shall not invoke any hearing or appeal rights under Article IX of the Bylaws or under any other provision of the Professional Staff Bylaws.

(f) If at any time during an investigation, the investigating body determines the Practitioner's conduct may be grounds for precautionary suspension of Professional Staff membership and/or precautionary restriction/suspension of all or any part of the clinical privileges, it shall notify any person authorized under Article VIII Part B, Section 1(a).

(g) If at any time during an investigation the Practitioner resigns from his/her appointment and/or all privileges (whichever is applicable), the investigation documentation shall be preserved and summarized in writing and the investigation suspended indefinitely as of the effective date of the resignation. The investigation documentation, including the summary, shall be retained in a confidential file, indefinitely. The Hospital shall continue to fulfill any reporting required by law, regulation, and Professional Staff bylaws, rules & regulations and policies. If the Practitioner reapplies for membership or clinical privileges, the investigation shall be reopened as a part of the application review process.

(h) Upon completion of the investigation, the investigating body shall submit to the Credentials Committee a written report of its findings with recommendation(s), including a summary of information considered by the committee including, but not limited to, literature, education and training, interviews with persons involved, and the meeting with the Practitioner.

ARTICLE VIII
PART D: INDICATIONS FOR RECOMMENDING TERMINATION, SUSPENSION, REDUCTION, CONDITION OR OTHER LIMITATION

Except as otherwise stated in these Bylaws or other Professional Staff Documents, the indications for recommending termination, suspension, reduction, condition or other limitation of clinical privileges or termination or suspension of appointment may include, but are not limited to, acts, failure to act, demeanor, conduct, or professional performance of a Member or Individual with Privileges on or off Hospital premises that are determined, based upon reliable information, to:

(a) Be detrimental to or present undue risk of detriment to patient safety or to the delivery of patient care within the Hospital;

(b) Be contrary to the requirements of these Bylaws, the Rules & Regulations, Professional Staff Policies, Children's Service Standards, Principles of Integrity and Compliance; applicable legal, regulatory or accreditation standards; and all other bylaws, policies, procedures, rules, regulations, guidelines, and requirements, including the Articles of Incorporation, of the Hospital (including its departments) and its Professional Staff and any amendments or modifications thereto;

(c) Be below applicable professional standards;

(d) Be unethical, unprofessional, illegal, reckless, inappropriate, or harassing;

(e) Be disruptive to the orderly operations of the Hospital, including the ability of the Member or Individual with Privileges to work harmoniously with others, including, but not limited to patients, staff, and visitors (Disruptive Conduct);

(Continuation of Article VIII Part D)

(f) Be detrimental to or contrary to peer review or performance improvement activities of the Professional Staff or the Hospital; or

(g) Result in the Member or Individual with Privileges being charged with, indicted for, or convicted (including a plea of guilty or no contest) of a crime involving violence, sexual misconduct, drugs, fraud, misrepresentation, or other crime involving dishonesty or deception.

Examples of these indications, include, but are not limited to:

(a) Failure to exercise privileges with sufficient competence to deliver safe, evidence-based care to patients;

(b) Failure to obtain and continuously maintain a qualification or credential required by the Professional Staff for appointment or one or more clinical privileges;

(c) Action by another institution (including, but not limited to, a licensing/registration board, certifying board, hospital, healthcare entity, health plan, professional liability insurer, etc.) to terminate, revoke, not renew, suspend, limit, stipulate, condition, or monitor the appointment, clinical privileges, and/or engagement in care, treatment or services a patient, such that a reasonable person would consider that such action is relevant to appointment and/or privileges at the Hospital;

(d) Evidence of an unusual pattern or an excessive number of professional liability actions resulting in a settlement or final judgment against the applicant;

(e) Exclusion from Medicare, Medicaid, or any other federal health care program;

(f) Disqualification or exclusion by the Minnesota Department of Human Services from direct contact with, or access to, people receiving services from the Hospital;

(g) Significant change in health status that would be reasonably expected to affect the Practitioner's ability to provide patient care, treatment, and services, even with accommodation;

(h) Substantive misrepresentation, verbal or written;

(i) Indicted, convicted of, pled "guilty" or "no contest" or its equivalent to a any felony, or to a misdemeanor involving a charge of violent behavior against another or moral turpitude in any jurisdiction;

(j) Egregious or repeated failure to comply with bylaws, rules, regulations, or policies of the Hospital and/or its Professional Staff;

(k) Unprofessional, unethical, illegal, or reckless behavior not remediated by Health & Conduct process;

(l) Engaging in or threatening to engage in behavior that threatens the life, health, safety, or

well-being of any patient, prospective patient, or other person;

(m) Engaging in a pattern of poor judgment, clinical or non-clinical;

(n) Engaging in patient care or taking call in an impaired state;

(Continuation of Article VIII Part D)

(o) Engaging in a pattern of care that lies outside the boundaries of generally accepted care or outside a pattern of care established by policies of the Hospital or the Professional Staff;

(p) Engaging in patient care, treatment or services outside the scope of licensure;

(q) Inappropriately accessing, using or disclosing protected health information or otherwise failing to comply with the privacy and/or security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and does so recklessly, repeatedly, out of curiosity, with malicious intent, or for other unauthorized reasons;

(r) Failure to perform enough clinical work during a period for which privileges have been granted to enable qualifications and competence to be evaluated at the time of renewal of privileges;

(s) Failure to maintain professional liability insurance meeting the requirements of the Hospital;

(t) Failure to complete medical records meeting the requirements of the Hospital;

(u) Failure to pay application fees for appointment or clinical privileges;

(v) Failure to pay Professional Staff dues;

(w) Failure to satisfy a special appearance requirement;

(x) Failure to participate in an evaluation;

(y) Failure to become board certified or failure to maintain board certification;

(z) Failure to execute general or specific release and/or provide documents when requested to evaluate competency and/or credentialing/privileging qualifications;

(aa) Failure to meet the confidentiality requirements of the Hospital, its Professional Staff, or any peer review body;

(bb) Failure to complete mandated continuing education requirements;

(cc) Failure to respond when on-call;

(dd) Failure to meet the reporting requirements of the Hospital, its Professional Staff, or any accreditation, legal or regulatory body;

(ee) Failure to maintain a designated alternate;

(ff) Failure to comply with the requirements of Focused Professional Practice Evaluation.

(gg) Engaging in patient care at or for the Hospital outside the scope of granted clinical privileges, except as allowed by Emergency Temporary Privileges for Practitioners (see PARCP, Article III, Part B, Section 6); or

(hh) Exercising clinical privileges under suspension.

Notwithstanding the foregoing indications and examples, each situation will be judged on its own facts. In all cases, aggravating and mitigating facts may be considered. The foregoing indications and examples are not intended to limit the forming of a recommendation that is warranted by the facts and circumstances of the situation.

ARTICLE VIII
PART E: REVIEW AND APPROVAL PROCESS
Section 1. Credentials Committee Action

The Credentials Committee may act with or without an investigation. The Credentials Committee may accept, modify or reject the recommendation(s) it receives from the investigating body. As soon as practicable after the conclusion of the investigation (if any), the Credentials Committee shall transmit its written recommendation to the Professional Executive Council as follows without limitation:

(a) Recommend that no action be taken;

(b) Defer action for a reasonable time where circumstances warrant;

(c) Issue a letter of admonition, reprimand, or warning;

(d) Recommend to impose special limitation(s) upon continued Professional Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, proctoring, or monitoring;

(e) Recommend reduction, modification, suspension or revocation of clinical privileges;

(f) Recommend suspension, or revocation of Professional Staff appointment; or;

(g) Make such other recommendations it deems necessary or appropriate.

The chair of the Credentials Committee, or designee, shall be available to the Professional Executive Council to answer any questions that may be raised with respect to the recommendation(s).

ARTICLE VIII – PART E
Section 2. Subsequent Action by the Professional Executive Council and Board, and Rights to a Hearing and Appeal

The Professional Executive Council may accept, modify, or reject the recommendation it receives from the Credentials Committee.

(a) If the action of the Professional Executive Council does not entitle the Practitioner to a hearing under these Bylaws, the action shall take effect immediately without action of the Board and without the right of appeal to the Board. A report of the action taken and reasons thereof shall be made to the Board through the Chief Executive Officer and the action shall stand unless modified by the Board:

(b) If the action by the Professional Executive Council is a recommendation that would entitle the Practitioner to a hearing under these Bylaws, such recommendation shall be forwarded to the Chief Executive Officer who shall promptly notify the Practitioner in writing with delivery confirmation. The Chief Executive Officer shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing as provided in Article IX of these Bylaws. At that time, the Chief Executive Officer shall forward the

recommendation of the Professional Executive Council, together with all supporting information, to the Board. The chair of the Professional Executive Council shall be available to the Board to answer any questions that may be raised with respect to the recommendation.

(c) In the event the Board determines to consider modification of the action of the Professional Executive Council, and such modification would entitle the Practitioner to a hearing in accordance with Article IX of these Bylaws, the Board shall so notify the Practitioner, through the Chief Executive Officer, and shall take no final action thereon until the Practitioner has exercised or waived the procedural rights so provided.

(d) If the Professional Executive Council is considering a recommendation contrary to the recommendation of the Credentials Committee, the Professional Executive Council may remand the matter to the Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Professional Executive Council prior to its final recommendation.

(e) If the Professional Executive Council takes an action or makes a recommendation to the Board which is contrary to the recommendation of the Credentials Committee, the Professional Executive Committee shall set forth in its report clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation. The Professional Executive Committee shall forward this report, together with the Credentials Committee's findings and recommendation(s), to the Board through the Chief Executive Officer.

(f) The Chief Executive Officer shall promptly notify the affected Practitioner following any final action taken by the Board under this Part E. Such notice shall be sent via certified mail, return receipt requested.

ARTICLE VIII
PART F. PRECAUTIONARY SUSPENSION OR RESTRICTION
Section 1. Grounds for Precautionary Suspension or Restriction

Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health or safety of any patient, prospective patient, or other person, the Chief of Staff, the Chief Executive Officer, or the Chief Medical Officer (or their duly authorized designee), has the authority to (1) afford a Practitioner an opportunity to voluntarily refrain from exercising privileges pending an investigation, or (2) suspend or restrict all or any portion of a Practitioner's Professional Staff membership or clinical privileges as a precaution. As an alternative to the precautionary suspension or restriction, Organizational Policy 216.00, The Stop the Line Rule (Authority to Intervene to Restore Patient Safety), may be applicable and utilized.

(a) A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Professional Executive Council that would entitle the individual to request a hearing.

(b) Except when unavailable, Hospital legal counsel should be consulted prior to imposing a precautionary suspension or restriction.

(c) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction and shall not give rise to any right to a hearing or appeal.

(d) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer, the Chief

of Staff, the Chief Medical Officer, and the chair of the Credentials Committee or designee, and shall remain in effect unless it is modified by the Board or its designee.

(e) The individual in question shall be notified and provided with a brief written description of the reason(s) for the precautionary suspension or restriction, including the names and medical record numbers of the patient(s) involved (if any), within three days of the imposition of the suspension or restriction.

ARTICLE VIII - PART F
Section 2. Notification of Precautionary Suspension or Restriction

Within one working day of imposition of a precautionary suspension or restriction, the Practitioner shall be provided with written notice of such precautionary suspension or restriction. This written notice shall include a statement of facts generally describing the basis for the precautionary suspension or restriction. The written notice shall inform the suspended or restricted Practitioner of the following:

(a) An investigation has been or will be initiated;

(b) The right to request, in writing, an informal interview with the investigating body;
(c) That the investigation shall not constitute a "hearing", nor shall the procedural rules with respect to hearings or appeals apply, as defined in Article IX;

(d) If applicable, the Practitioner's patients shall be assigned to another Practitioner by the division chief or by the Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute Practitioner;

(e) That the precautionary suspension or restriction may be reportable to the National Practitioner Data Bank, the Minnesota Board of Medical Practice, and/or other regulatory agencies; and

(f) If the investigation is not completed within thirty (30) days, the Practitioner may request to appear before a regularly scheduled Professional Executive Council meeting. The Professional Executive Council and the Practitioner shall only consider the appropriateness of the pace of the investigation.

ARTICLE VIII - PART F
Section 3. Care of the Suspended Practitioner's Patients

Unless otherwise indicated by the terms of the precautionary suspension of privileges, the Practitioner's patients shall be assigned to another Practitioner by the division chief or by the Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute Practitioner.

ARTICLE VIII - PART F
Section 4. Credentials Committee Procedure

(a) The Credentials Committee shall review the matter resulting in a precautionary suspension, restriction (or the individual's agreement to voluntarily refrain from exercising clinical privileges) within a reasonable time under the circumstances, not to exceed fourteen (14) days. Prior to, or as part of, this review, the individual shall be given an opportunity to meet with the Credentials Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients and/or employees, depending on the circumstances. Neither the Credentials Committee nor the individual shall be represented by legal counsel at this meeting.

(b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Credentials Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Credentials Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable). The Credentials Committee (and any Investigating Committee) shall exert its best efforts to complete an investigation of the matter resulting in precautionary suspension or restriction within thirty (30) days of the suspension or restriction. If the investigation is not completed in thirty(30) days, the Credentials Committee shall notify the Chief of Staff and the chair of the Board of the status of the investigation, and, if requested by the individual, the Professional Executive Council shall consider the appropriateness of the pace of the investigation at a regularly scheduled Professional Executive Council meeting, at which the individual shall have the right to appear to only consider the appropriateness of the pace of the investigation. The precautionary suspension or restriction shall remain in force after the appropriate investigation committee (or Credentials Committee) takes responsibility. Upon completion of its review, the investigation committee shall report to the Credentials Committee, or, if no investigation committee was appointed, the Credentials Committee shall prepare a written recommendation which shall be transmitted to the Professional Executive Council. The chair of the Credentials Committee or a designee shall be available to the Professional Executive Council to answer any questions that may arise with respect to the recommendation.

(c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

ARTICLE VIII - PART F
Section 5. Subsequent Action by the Professional Executive Council and Board

Follow procedure in accordance with Article VIII Part E.

ARTICLE VIII
PART G. AUTOMATIC SUSPENSION

Certain events or circumstances are so compelling that no formal decision is needed prior to the suspension of all clinical privileges. A suspension is effective immediately. Matters such as loss of license, exclusion from federal programs, and felony indictment or charges of certain criminal activity are situations where automatic suspension is appropriate.

For the purpose of this section, "all clinical privileges" includes admitting, consulting, surgical and other granted clinical privileges, and the authority to schedule future patient care. However, Practitioners under automatic suspension may complete medical records documenting care delivered prior to suspension.

ARTICLE VIII - PART G
Section 1. Licensure

The Professional Staff Office verifies and documents current licensure for all Qualified Applicants and Practitioners. Licensure is verified with the primary source at the time of appointment to the Professional Staff and initial granting of clinical privileges, reappointment, renewal of clinical privileges or at time of license expiration. In addition, the Professional Staff Office shall establish a system to receive notification of actions of relevant licensing bodies in a timely manner.

(a) Revocation and Suspension: Whenever a Practitioner's license or other legal credential authorizing practice in this state is revoked or suspended, Professional Staff membership and clinical privileges shall be automatically suspended as of the date such action becomes

effective and throughout its term.

(b) Restriction: Whenever a Practitioner's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the Practitioner has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) EXCEPTION – Expiration: Whenever a Practitioner's license or other legal credential authorizing practice in this state has expired, membership and clinical privileges shall be automatically placed on temporary leave of absence[23] as of the date the license is considered expired, and throughout the period of expiration, but no longer than the period allowed under temporary leave of absence.

(d) Lifting of Suspension: In the case of licensure revocation, suspension, or restriction, the conditions of automatic suspension shall be lifted when written verification is received by and is acceptable to the Chair of the Credentials Committee, or, in the absence of the Chair of the Credentials Committee, the most senior officer of the Professional Staff who is available. In the case of license expiration, the conditions of automatic suspension shall be lifted when the licensing agency confirms to the Credentials Office that the license has been renewed.

ARTICLE VIII - PART G
Section 2. Exclusion from Federal Programs (List of Excluded Individuals and Entities [LEIE])

The Professional Staff Office verifies and documents exclusion from federal programs for all Qualified Applicants and Practitioners. Exclusion from federal programs is verified against the List of Excluded Individuals and Entities (LEIE) of the Office of the Inspector General (OIG) at the time of appointment to the Professional Staff and initial granting of clinical privileges, reappointment, and renewal of clinical privileges. The Professional Staff Office also reviews the LEIE on a monthly basis for any changes thereon.

All clinical privileges will be automatically suspended upon exclusion or suspension from participating in Medicare, Medicaid, or any other federal health care program. The Practitioner must notify the Chair of the Credentials Committee, or designee, immediately when he/she learns of such suspension. If the Practitioner has failed to notify the Chair of the Credentials Committee, or designee, of the suspension or exclusion, the Practitioner will be sent written notification of immediate suspension of all clinical privileges with delivery confirmation. The Practitioner must reapply for privileges once the exclusion from Medicare, Medicaid, or any other federal healthcare program has been lifted.

ARTICLE VIII – PART G
Section 3. Felony Indictment or a Charge of Certain Criminal Activity

A Practitioner being indicted for a felony or charged with certain criminal activity, reasonably related to the practice of medicine as determined by the Credentials Committee, including but not limited to, (i) controlled substance; (ii) illegal drugs, (iii) child abuse; or (iv) sexual misconduct, shall be deemed Criteria for Initiation of an Investigation under Article VIII Part C, Section 1. It is the responsibility of the Practitioner to immediately notify the Chair of the Credentials Committee, or designee, in writing of any such charge or indictment. Failure to notify in a timely manner shall be construed as Criteria for Initiation of an Investigation as outlined in Article VIII, Part C, Section 1 (c).
Notice to the Chair of the Credentials Committee, or designee, of such charge or indictment shall have the same effect as a request for investigation under Article VIII Part C. All clinical privileges of the Practitioner shall be on automatic suspension, pursuant to Article VIII during the investigation;

[23] See Policy on Appointment, Reappointment, and Clinical Privileges, Article V, Part C, Section 2. Temporary Leaves of Absence.

except, however, that such automatic suspension shall be immediate.

ARTICLE VIII – PART G
Section 4. Controlled Substances

The privilege to order and to write prescriptions for medications covered by a DEA certificate is the only privilege restricted under the ~~a~~automatic suspension for failure to maintain a valid DEA registration.

(a) Revocation, Expiration, Limitation and Suspension: Whenever a DEA certificate is revoked, expired, limited, or suspended, the Practitioner shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(b) Probation: Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner's right to prescribe such medications shall automatically become subject to the same terms of probation, as of the date such action becomes effective and throughout its term.

ARTICLE VIII – PART G
Section 5. Disqualification by Regulatory Agency

In the case that a Practitioner is disqualified by a regulatory agency, including, but not limited to the Minnesota Department of Human Services, for a position allowing direct contact with, or access to, people receiving services from the Hospital, Professional Staff membership and all clinical privileges shall be automatically subject to the restrictions required by the disqualification as of the date such disqualification becomes effective and throughout its term.

In the case that the disqualification requirements permit the Hospital to choose whether or not to allow the person to continue to provide direct contact services pending a possible reconsideration decision by the regulatory agency, all clinical privileges shall be automatically suspended as of the date the disqualification becomes effective.

(a) Before the Hospital shall consider whether or not to lift the suspension and allow the Practitioner to provide direct contact services with or without condition or limitation, the Practitioner must comply with all prerequisite requirements established by the regulatory agency.

(b) If, after being duly notified of the prerequisite requirements by the Hospital, the Practitioner does not cooperate and/or comply with the requirements within thirty (30) days of notification by the Hospital, the Practitioner may be deemed to have voluntarily resigned his/her clinical privileges (and Professional Staff membership, if he/she is a Member) according to the procedures for Deemed Resignation established in the Policy on Appointment, Reappointment & Clinical Privileges section on Resignations, subsection on Deemed Resignation or Deemed Termination of Clinical Privileges and Membership.

(c) If the Practitioner complies with the prerequisite requirements prior to a deemed resignation being accepted by the Board, the Chief of Staff, in consultation with the Chief Medical Officer and the relevant division chief, shall consider whether or not to allow the exercise of some or all clinical privileges, with or without supervision, at a minimum in accordance with the requirements of the regulatory agency. If the Chief of Staff makes the determination to not allow the Practitioner to provide direct contact services or to add restrictions beyond the scope of those required by the regulatory agency, the automatic suspension shall be lifted to the extent approved by the Chief of Staff, and the matter shall be referred for review at the next regularly scheduled meetings of the Credentials Committee, the Professional Executive Committee, and the Board. The determination of the

Board shall apply, without right to hearing or appeal, until the regulatory agency makes a final determination.

Automatic suspension shall be lifted upon notification that the regulatory agency has removed the disqualification.

ARTICLE VIII - PART G
Section 6. Procedure for Automatic Suspension

It is the responsibility of a Practitioner who fails to maintain continuous qualifications[24] (or any Practitioner who has knowledge of a lapse in continuous qualifications of another Practitioner), as set forth in the Responsibilities of Membership in the Bylaws Article II Part F, Sections 1 through 14 and in the Policy on Appointment, Reappointment and Clinical Privileges, to immediately notify the chair of the Credentials Committee, or designee, in writing of such lapse at or before the time that the lapse occurs. Failure to notify in a timely manner shall be construed as Criteria for Initiation of an Investigation as outlined in the Bylaws Article VIII Part C, Section 1 (c).

Automatic suspension or limitation of privileges (and appointment, if applicable) shall be confirmed by a written notification from the chair of the Credentials Committee, or designee**,** transmitted to the Practitioner with delivery confirmation, which includes a brief description of the reason(s) for the automatic suspension and a description of how to resolve the suspension[25]. Written notification shall be made to appropriate Hospital staff and Professional Staff leaders as soon after the suspension begins as is feasible. This written notification may be faxed to the Practitioner in addition to mailing/electronic transmission, if deemed appropriate. Lifting of the automatic suspension shall also be confirmed by a written notification sent to the Practitioner with delivery confirmation with notification to the appropriate Hospital staff and Professional Staff leaders, as soon after the suspension ends as is feasible. Copies of all notifications of suspension and all notifications of the lifting of suspension that are mailed or electronically transmitted shall be retained in the Practitioner's credentials file. If an automatic suspension is resolved prior to mailing/electronic transmission of the notification of suspension, neither the written notification of suspension nor the written notification of the lifting of the suspension is required, provided the Practitioner is verbally notified that a period of suspension has occurred, and such verbal notification is duly recorded and filed in the Practitioner's credentials file.

It shall be the duty of the Chief of Staff, division chiefs, and the Chief Medical Officer to cooperate in enforcing all automatic suspensions.

At the time of automatic suspension, the suspended Practitioner must notify an alternate Practitioner with clinical privileges to assume the care of patients who are under the suspended Practitioner's care at or for the Hospital. If the individual is unable, or fails to act, the suspended Practitioner's patients shall be assigned to an alternate Practitioner by the division chief or Chief of Staff.

If automatic suspension is not lifted within thirty (30) days of its initiation and there is no current investigation in progress under Article VIII Part C in the Bylaws (or, in the case of disqualification by a regulatory agency, there is no current reconsideration decision pending from the regulatory agency), the Practitioner shall be deemed to have voluntarily resigned his/her clinical privileges (and Professional Staff membership, if he/she is a Member) according to the procedures for Deemed Resignation established in the Policy on Appointment, Reappointment & Clinical Privileges section on Resignations, subsection on Deemed Resignation or Deemed Termination of Clinical Privileges and Membership. Deemed resignation shall not apply to licensure limitation, or restriction, nor to automatic suspension of the privilege to order or write prescriptions for scheduled drugs due to failure to maintain DEA registration.

[24] The requirement to maintain continuous qualifications is defined in the Policy on Appointment, Reappointment and Clinical Privileges, Article III Part A Section 2.
[25] NCQA Standards

ARTICLE VIII
PART H. ADMINISTRATIVE SUSPENSION OR LIMITATION

An administrative suspension differs from an automatic suspension. This type of suspension includes situations that may fall below the state and federal level of reporting. This method of suspension is a way for the Hospital to ensure that there is no lapse in continuous coverage, and Service Standards, Principles of Integrity and Compliance, and expectations for Professional Staff performance are maintained at a high level.

For the purpose of this section, "all clinical privileges" includes admitting, consulting, surgical and other granted clinical privileges, and the authority to schedule future patient care. However, Practitioners under administrative suspension may complete medical records documenting care delivered prior to suspension.

The following are matters that usually fall under the administrative category.

ARTICLE VIII - PART H:

ARTICLE VIII - PART H
Section 1. Protected Health Information

Any Member or Individual with Privileges who inappropriately accesses, uses, or discloses protected health information or otherwise fails to comply with the privacy and/or security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and does so recklessly, inadvertently on multiple occasions, out of curiosity, with malicious intent, or for other unauthorized reasons will be investigated and disciplined in a manner consistent with applicable law, Hospital policy, and these Bylaws.

Administrative suspension of all clinical privileges may be imposed during any such investigation, or as a temporary disciplinary action.

ARTICLE VIII - PART H
Section 2. Professional Liability Insurance

Any Practitioner who fails to maintain professional liability insurance coverage in accordance with the Hospital's Policy on Professional Liability Insurance Requirements will be subject to administrative suspension of all clinical privileges, if the Practitioner does not provide evidence of professional liability insurance acceptable to the Hospital within the time frame established within this Hospital policy.

Administrative suspension of all clinical privileges shall be lifted upon receipt of evidence of current professional liability insurance coverage acceptable to the Hospital.

ARTICLE VIII - PART H
Section 3. Failure to Satisfy Special Appearance Requirement

Failure of a Practitioner without good cause to appear and to satisfy the special appearance requirements pursuant to any such provision of these Bylaws or any such provision of a policy of the Professional Staff shall be grounds for administrative suspension of all clinical privileges.

Administrative suspension of all clinical privileges shall be lifted upon appearance and satisfaction of the special appearance requirements.

ARTICLE VIII - PART H
Section 4. Failure to Participate in an Evaluation and/or Make Results Available

Failure of a Practitioner to participate in an evaluation of his or her qualifications for Professional Staff membership or privileges pursuant to these Bylaws Article VIII Part C, Section 3 (2), or to the Policy on Appointment, Reappointment, and Clinical Privileges, Article V, Part B, (whether an evaluation of physical or mental health, of the ability to exercise privileges, or of clinical management skills) and to make the results available for consideration within a designated reasonable period of time, after being requested to do so in writing, shall be grounds for administrative suspension of all clinical privileges.

Administrative suspension of all clinical privileges shall be lifted when the chair of the Credentials Committee, or designee, has received the evaluation results.

ARTICLE VIII - PART H
Section 5. Failure to Execute a Release and/or Provide Documents

Failure to execute a general or specific release and/or provide documents when requested by the Chief of Staff (or designee) to evaluate competence or credentialing/privileging qualifications may be considered grounds for administrative suspension of all or some clinical privileges

Administrative suspension shall be lifted upon receipt of all duly-executed general or specific releases and documents requested. Failure to comply as requested within thirty (30) days shall be deemed to be a request for resignation of appointment and all clinical privileges.

ARTICLE VIII – PART H
Section 6. Failure to Respond to Peer Review Query

Failure of a Practitioner, without good cause, to respond as requested (written, verbal, etc.) to a peer review query within thirty (30) days of the original request shall meet the criteria for administrative suspension. After the thirty (30) days have passed, a written warning of the administrative suspension shall be sent to the Practitioner at least seven (7) days prior to the imposition of suspension. A peer review query is a request for information related to peer review requested by an individual authorized by the Hospital to make such requests, including, but not limited to the chair or vice chair of the Credentials Committee, the Chief of Staff, a division chief, the chair of a division peer review committee, the chair of an investigation committee, or chair of a hearing committee.

Administrative suspension of all clinical privileges shall be lifted upon receipt by the requestor of an appropriate response in the form requested.

ARTICLE VIII – PART H
Section 7. Misrepresentation, Misstatement or Omission on an Application

(a) Any misrepresentation, misstatement, or omission on an application for appointment or initial clinical privileges is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misrepresentation, misstatement, or omission and permitted to provide a written response. The Chief of Staff (or authorized designee) and Chief Executive Officer (or authorized designee) will review the response and determine whether the application should be processed further.

(b) Any misrepresentation, misstatement, or omission on an application for reappointment, additional clinical privileges or renewal of clinical privileges, that is material to a current appointment or one or more clinical privileges, may be considered grounds for administrative suspension of the current appointment and/or one or more current clinical privileges, pending determination of any other professional review action. Misrepresentations, misstatements, and/or omissions that shall be considered material include, but are not limited to, breaches of integrity, ethics, or professional conduct; that

state or imply that the applicant meets a qualification or criterion or does not have a disqualification.

Administrative suspension may be initiated by the division chief, and shall continue until the next regularly scheduled meeting of the Credentials Committee of the Professional Staff at which time the Credentials Committee shall determine whether the administrative suspension should be lifted, or whether additional professional review action is warranted.

ARTICLE VIII - PART H
Section 8. Procedure for Administrative Suspension

It is the responsibility of a Practitioner who fails to maintain continuous qualifications (or any Practitioner who has knowledge of a lapse in continuous qualifications of another Practitioner) as set forth in the Responsibilities of Membership in the Bylaws Article II Part F, 1 through 14 and in the Policy on Appointment, Reappointment and Clinical Privileges[26] to immediately notify the chair of the Credentials Committee, or designee, in writing of such lapse at or before the time that the lapse occurs. Failure to notify in a timely manner shall be construed as Criteria for an Initiation of an Investigation as outlined in Article VIII Part C, Section 1.

Administrative suspension or limitation of privileges shall be confirmed by written notification from the chair of the Credentials Committee, or designee, transmitted to the Practitioner with delivery confirmation, which includes a brief description of the reason(s) for the automatic suspension and a description of how to resolve the suspension[27]. Written notification shall be made to appropriate Hospital staff and Professional Staff leaders as soon after the suspension begins as is feasible. This written notification may be faxed to the Practitioner in addition to mailing/electronic transmission, if deemed appropriate. Lifting of the administrative suspension shall also be confirmed by written notification sent to the Practitioner with delivery confirmation (with copies to the appropriate Hospital staff and Professional Staff leaders) as soon after the suspension ends as is feasible. Copies of all notifications of suspension and all notifications of the lifting of suspension that are mailed or electronically transmitted shall be retained in the Practitioner's credentials file. If an administrative suspension is resolved prior to mailing/electronic transmission of the notification of suspension, neither the written notification of suspension nor the written notification of the lifting of the suspension is required, provided the Practitioner is verbally notified that a period of suspension has occurred, and such verbal notification is duly recorded and filed in the Practitioner's credentials file.

It shall be the duty of the Chief of Staff, division chiefs, and the Chief Medical Officer to cooperate in The Same process a enforcing all administrative suspensions.

At the time of administrative suspension, the suspended Practitioner must notify an alternate Practitioner with clinical privileges to assume the care of patients who are under the suspended Practitioner's care at or for the Hospital. If the individual is unable, or fails to act, the suspended Practitioner's patients shall be assigned to an alternate Practitioner by the division chief or Chief of Staff. If no alternate Practitioner is immediately available, the Chief Medical Officer (or designee), in consultation with the division chief or Chief of Staff, may permit the suspended Practitioner to provide care until either a suitable alternate Practitioner is available or the medical records are completed.

If administrative suspension is not lifted within thirty (30) days of its initiation, there is no current investigation in progress under Article VIII Part E in the Bylaws, and there is no provision for deemed withdrawal of privileges that applies, the Practitioner shall be deemed to have voluntarily resigned his/her clinical privileges (and Professional Staff membership, if he/she is a Member) according to the procedures for Deemed Resignation established in the Policy on Appointment,

[26] The requirement to maintain continuous qualifications is defined in the Policy on Appointment, Reappointment and Clinical Privileges, Article III Part A Section 2.
[27] NCQA Standards

Reappointment and Clinical Privileges section on Resignations, subsection on Deemed Resignation or Deemed Termination of Clinical Privileges.

ARTICLE VIII
PART I. AUTOMATIC REVOCATION FOR FELONY CONVICTION

A Practitioner who is convicted of a felony shall have their clinical privileges and Professional Staff Membership immediately and automatically revoked without the right of a hearing or an appeal. Conviction means a plea of guilty, a verdict of guilty by a jury, or a finding of guilty by the court. It is the responsibility of the Practitioner to immediately notify the Chair of the Credentials Committee, or designee, in writing of any such conviction. Upon notification of the felony conviction, the Chief Executive Officer (or authorized designee) shall notify the Practitioner of the automatic revocation in writing, including a brief description of the reason(s) for the automatic revocation[28], with documentation of delivery confirmation to the address on file in the Credentials Office.

As soon as reasonably possible after notification of the felony conviction, the Board shall determine the period of time required and the stipulations under which the Practitioner shall be allowed to reapply for Membership or clinical privileges (if ever), and shall notify the Practitioner in writing.

ARTICLE VIII
PART J. OTHER ACTIONS
Section 1. Failure to Satisfy Board Certification Requirements

If a Member fails to become Board Certified within the period of waiver for initial privileging or fails to become recertified by twelve (12) months after the date of expiration[29] of time-limited Board Certification, the Member shall come under special review by the Credentials Committee. For Advanced Practice Registered Nurses, if a state regulatory agency or national certifying board has more stringent renewal criteria, the hospital will adhere to the more stringent standard. The Credentials Committee may recommend a temporary, time-limited waiver of Board Certification based upon the criteria enumerated below.

If the Member has taken the Board Certification or recertification examination and failed the examination on one or more occasions, or if the period of Board Admissibility has expired (as determined by the relevant Board), the Credentials Committee shall make a full review of the Member's evidence of clinical competence, including, but not limited to quality indicators, patient outcomes, case volumes, pediatric case volumes, and professional liability history. If, based on this review, the Member is deemed to meet the standard of care for Board Certified Members of the same specialty or subspecialty, the Credentials Committee may recommend to the Professional Executive Council and to the Board that the Board Certification requirement be either a) waived for a defined period of time to allow the Member to reestablish Board Admissibility (if applicable) and retake the Board examination, or b) be waived indefinitely.

If the Member is deemed to NOT meet the standard of care for Board Certified Members of the same specialty or subspecialty, the Credentials Committee shall recommend to the Professional Executive Council either a) that the Member be required to obtain additional specialty or subspecialty training, b) that the Member be required to provide patient care under special oversight for a period of time to include a minimum number of clinical cases, c) that a portion of the Member's clinical privileges relevant to the specialty or subspecialty in question be terminated, or d) that the Member's

[28] NCQA Standards

[29] If a state regulatory agency or national certifying board has more stringent renewal criteria, the Hospital and Professional Staff will adhere to the more stringent standard. This is currently relevant to Advanced Practice Registered Nurse certification which is required to be current for Minnesota licensure.

appointment and all clinical privileges be terminated for failure to meet the basic qualifications of Board Certification required for continuing membership on the Professional Staff.

ARTICLE VIII – PART J
Section 2. Failure to Satisfy Continuing Education Requirements

Failure to complete mandated continuing education requirements shall be sufficient grounds for refusing to reappoint the Member concerned. Failure for an Individual with Privileges to complete mandated continuing education requirements shall be sufficient grounds for refusing to grant privileges to the individual concerned. Such failure shall be documented and specifically considered by the Credentials Committee and Professional Executive Council when making their recommendations for reappointment and by the Board when making its final decision.

ARTICLE VIII – PART J
Section 3. Refusal or Failure to Respond When On-Call

(a) Refusal or failure to respond in a timely manner, to a request for emergency or urgent consultation while on-call without reasonable justification may be construed as grounds for professional review action as set forth in Article VIII Part C.

(b) Confirmed failure to respond to emergency room call is reportable as an Emergency Medical Treatment Active Labor Act (EMTALA) violation.

ARTICLE VIII – PART J
Section 4. Failure to Cooperate with Focused Professional Practice Evaluation

Failure of a Practitioner, without good cause, to cooperate with focused professional practice evaluation within the defined timeframe, may be considered grounds for deemed voluntary withdrawal of those clinical privileges relevant to the focused professional practice evaluation, which may include all clinical privileges.

Failure of a Practitioner to cooperate with Focused Professional Practice Evaluation shall include, but is not limited to:

(a) Failure to complete FPPE within the defined timeframe when the Practitioner has exercised the privileges under evaluation in a sufficient number of cases to allow the FPPE to have been accomplished during the defined timeframe.

(b) Failure to submit reports requested for documentation of care, treatment and services at other institutions for the purposes of fulfilling FPPE requirements within the defined timeframe.

The division chief (or authorized designee) shall make a determination that a Practitioner has had sufficient opportunity to complete focused professional practice evaluation. Upon this determination, a thirty (30) day notice of impending deemed voluntary withdrawal of the relevant clinical privileges shall be sent to the Practitioner with delivery confirmation. If any Practitioner does not complete all requirements of the focused professional practice evaluation prior to the final day of this period, and if there is no current investigation in progress under Article VIII Part A in these Bylaws, then such Practitioner shall be deemed to have voluntarily withdrawn the clinical privileges relevant to the unfulfilled focused professional practice evaluation requirements according to the procedures for Deemed Withdrawal of Privileges established in the Policy on Appointment, Reappointment and Clinical Privileges section on Resignations, subsection on Deemed Resignation or Deemed Termination of Clinical Privileges.

ARTICLE VIII

PART K. PROCEDURE TO REPORT INVESTIGATIONS, ADVERSE ACTIONS AND CHANGES
Section 1. Reporting Requirements Following Final Adverse Action by the Board

The authorized designee(s) shall report final adverse action(s) to external entities as required by applicable law, regulation, accreditation standards, and/or contract, upon adoption as final action unless otherwise required[30]. The authorized designee(s) shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

ARTICLE VIII – PART K
Section 2. Reporting Requirements of Practitioners and Applicants for Appointment & Reappointment

All Practitioners and applicants for appointment and reappointment are required to report in a timely manner events that may affect their application to, or standing on, the Professional Staff. Such reports must be in writing and be submitted to the chair of the Credentials Committee, or designee, within fourteen (14) days of the event, including but not limited to:

(b) Notice or initiation by another institution that privileges, professional competence, ethics, or personal conduct are being investigated or reviewed in a proceeding which could lead to termination, suspension or limitation of privileges at that institution;

(c) Notice or initiation by any state licensing agency that the Practitioner or applicant is being investigated, or a final adverse action has been made, including but not limited to, suspension, revocation, restriction, limitation of licensure; imposition of limitations or conditions on practice; or revocation or suspension of registration to perform interstate telemedicine;

(d) Notice of expiration of time-limited Board Certification;

(e) Cancellation or restriction of professional liability coverage, or reduction of coverage limits below those required by the Hospital;

(f) Cancellation or restriction of DEA certificate;

(g) Adverse determination by a peer review organization or third party payer reimbursement program concerning quality of care;

(h) Commencement of a formal investigation, the filing of charges, or final determination by the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or of the State of Minnesota, or any other state, including, but not limited to, exclusion from Medicare, Medicaid, or any other federal health care program; and,

(i) Significant change in health status that would be reasonably expected to affect the Practitioner's ability to provide patient care, treatment, and services, with or without accommodation.

ARTICLE VIII
PART L. CONFIDENTIALITY AND REPORTING

1. Any individual or Member of a Professional Staff committee involved in the evaluation and improvement of the quality of care rendered at or for the Hospital must recognize that confidentiality is vital to promoting free and candid discussions and deliberations. Thus, all records, data, and other information (including information stored electronically, information obtained verbally, and what transpired at meetings) generated in connection with and/or as a

[30] NCQA Standard CR7, Element A, Factor 2.

result of professional review activities shall, to the fullest extent permitted by law, be confidential and each individual or Member participating in such review activities shall make no disclosures of any such information except to the extent necessary to carry out one or more purposes defined by this Article (see also Minnesota Statute 145.64).

2. This requirement of confidentiality shall not be construed to limit disclosure of temporary or final actions determined by any authorized individual or body pursuant to carrying out the duties defined by this Article to the extent necessary to assure the safety of patients and other individuals and to meet all regulatory requirements. Allowed disclosures include, but are not limited to, updates to documents, files, and/or electronic systems used to authorize patient care (electronic medical record, etc.), display privileges (privilege inquiry systems, etc.) and/or professional staff membership (credentialing databases, professional staff directories, etc.).

3. This requirement of confidentiality shall not be construed to limit disclosure of patient volumes or types of procedures requested by other institutions with an accompanying authorization and release signed by the individual about whom this information is requested for the purposes of fulfilling regulatory requirements for initial and ongoing professional practice evaluation.

4. This requirement of confidentiality shall not be construed to limit reports of actions taken pursuant to these Bylaws made authorized designee of the Hospital to governmental agencies as may be required by law.

5. This requirement of confidentiality shall not be construed to limit the release by the Hospital or its Professional Staff of non-patient-identified aggregate trend data on medical error and iatrogenic injury or the filing of related reports, analyses, and/or plans as required by law.

6. Any breach of confidentiality by an individual or committee Member may result in a professional review action by an appropriate Professional Staff committee and the Board, and/or may result in appropriate legal action to ensure that confidentiality is preserved, including application to a court of law for injunctive or other relief.

ARTICLE IX: HEARING AND APPEAL PROCEDURES

PART A. INITIATION OF HEARING
Section 1. Grounds for Hearing

(a) Unless otherwise specifically stated in these Bylaws, Rules & Regulations, or Policies of the Professional Staff, a Qualified Applicant, Member, or Practitioner shall be entitled to request a hearing whenever an unfavorable recommendation has been made by the Professional Executive Council regarding the following:

(1) Denial of initial Professional Staff appointment to a Qualified Applicant;

(2) Denial of Professional Staff reappointment to a Qualified Applicant;

(3) Revocation of Professional Staff appointment (except Retired and Honorary Staff, and automatic revocation for felony conviction);

(4) Denial of requested initial clinical privileges (excluding temporary or disaster privileges);

(5) Denial of requested increased clinical privileges (excluding temporary or disaster privileges);

(6) Involuntary reduction or revocation of any clinical privileges (excluding temporary or

disaster privileges);

(7) Suspension of any clinical privileges (excluding temporary or disaster privileges), except as set forth in Precautionary Restriction or Suspension of Clinical Privileges in Article VIII Part F; Automatic Suspension in Article VIII Part G Sections 1-3; Administrative Suspension or Limitation in Article VIII, Part H Sections 1-4; or

(8) Imposition of a mandatory consultation or proctoring requirement following professional review action that restricts the Practitioner's exercise of privileges;

(b) When any Qualified Applicant, Member or Practitioner receives notice of a decision by the Board that will adversely affect his/her appointment to, or status as a member of, the Professional Staff, or his/her clinical privileges, and this decision is not based on a prior recommendation by the Professional Executive Council with respect to which the individual was entitled to a hearing, the individual will be entitled to a hearing before the Board makes a final decision on the matter.

(c) No other recommendations or actions except those enumerated in (a) of this Section shall entitle the Qualified Applicant, Member, or Practitioner to request a hearing. Specifically, the following recommendations or actions, while not inclusive, do not entitle the Qualified Applicant, Member, or Practitioner to request a hearing:

(1) Denial, limitation, restriction, reduction, revocation, or the imposition of mandatory consultation or proctoring with respect to temporary or disaster privileges;

(2) The requirement of a physical or mental examination or evaluation;

(3) Precautionary restriction or suspension of any or all clinical privileges;

(4) A letter of guidance, counsel, warning, or reprimand;

(5) A lapse in temporary privileges or a decision to not grant or not renew temporary privileges;

(6) A requirement for additional training or continuing education that is relatively insubstantial in nature (e.g., less than thirty (30) days of training or continuing education) or does not adversely impact Qualified Applicant, Member, or Practitioner's ability to practice in a material manner;

(7) Denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;

(8) Automatic Suspension of any or all clinical privileges;

(9) Administrative Suspension of any or all clinical privileges;

(10) Expiration of inactive privileges not included in a Physician-Physician Assistant Delegation Agreement including the Notice of Intent to Practice;

(11) Deemed voluntary resignation.

(12) Determination that an application is incomplete;

(13) Determination that an application will not be processed due to misrepresentation,

misstatement, or omission[31].

(d) The Qualified Applicant, Member, or Practitioner shall also be entitled to request a hearing before the Board enters a final decision, in the event the Board should determine, without a similar recommendation from the Professional Executive Council, to take any action set forth in paragraph (a) above.

(e) The hearing shall be conducted in as informal a manner as possible, subject to the rules and procedures set forth in these Bylaws.

(f) In circumstances such as those described in paragraph (c) above, the Qualified Applicant, Member, or Practitioner shall be entitled to submit a written statement or explanation regarding these actions for inclusion in his or her file.

ARTICLE IX
PART B. THE HEARING[32]
Section 1. Notice of Recommendation

(a) When a recommendation is made which, according to this Policy entitles a Qualified Applicant, Member, or Practitioner to request a hearing prior to a final decision of the Board, the Qualified Applicant, Member, or Practitioner shall promptly be given notice by the Chief Executive Officer, in writing, by hand delivery or by mail with delivery confirmation. This notice shall contain:

(1) A statement of the recommendation made and the general reasons for it;

(2) Notice that the Qualified Applicant, Member, or Practitioner has the right to request a hearing on the recommendation within thirty (30) days of the date of delivery of this notice to the Qualified Applicant / Member / Practitioner or to their address on file; and

(3) A copy of this Article outlining the rights in the hearing as provided for in these Bylaws.

ARTICLE IX - PART B
Section 2. Request for Hearing

Such Qualified Applicant, Member, or Practitioner shall have thirty (30) days following the date of the delivery of such notice within which to request the hearing. Said request shall be made by written notice to the Chief Executive Officer. In the event the Qualified Applicant, Member, or Practitioner does not request a hearing within the time period and in the manner set forth herein, he or she shall be deemed to have waived the right to such hearing or appeal to which he or she might otherwise have been entitled, and to have accepted the action involved, and such action shall thereupon become effective immediately upon final Board action. The Board shall deliver copies of the final action to the Qualified Applicant, Member, or Practitioner and to the chair, or designee, of the Credentials Committee and Professional Executive Council, in person or by certified mail, return receipt requested.

ARTICLE IX - PART B
Section 3. Notice of Hearing, Statement of Reasons, and Pre-Hearing Procedures

(a) The Chief Executive Officer (or authorized designee) shall schedule the hearing and the pre-hearing conference and shall give written notice, return receipt requested, to the person who requested the hearing. The notice shall include:

[31] Policy on Appointment, Reappointment & Clinical Privileges, Article I – Part G 7
[32] The Joint Commission – Hospital Accreditation Standards, MS.06.01.09 – EP 5

(1) The time, place and date of the hearing;

(2) The time, place, and date of the pre-hearing conference;

(3) A proposed list of witnesses who will give testimony or evidence in support of the Professional Executive Council or the Board at the hearing;

(4) The names of the proposed slate of hearing panel members/hearing officer, if known;

(5) A statement of the specific reasons for the recommendation as well as the list of patient records and information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information it contains, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the Qualified Applicant, Member, or Practitioner requesting the hearing, and that Qualified Applicant, Member, or Practitioner and the Qualified Applicant's, Member's, or Practitioner's counsel (if any) have sufficient time to study this additional information and rebut it.

(b) The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

(c) Pre-Hearing Procedures.

(1) General Procedures: The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence and procedure do not apply. The pre-hearing conference shall begin as soon as practicable, but no sooner than twenty (20) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

(Continuation of Article IX, Part B, Section 3)

(2) Provision of Relevant Information:

a. Prior to receiving any confidential documents, the individual requesting the hearing must agree in writing that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

b. Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:

(1) Copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) Reports of experts relied upon by the Professional Executive Council;

(3) Copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted): and

(4) Copies of any other documents relied upon by the Professional Executive Council.

c. All information provided pursuant to (2) (b) above shall be redacted as necessary

to:

(1) Protect the confidentiality of individually identifiable Practitioners (other than the Practitioner under review) who provided information in good faith; and

(2) To remove additions to original documents, such as notes by the hospital or medical staff office, notes by the hospital attorney, or cc references to copies sent to a hospital attorney. The provision of the foregoing information is not intended to waive any privilege.

d. The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other Practitioners on the Professional Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

e. Ten (10) days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other with its proposed exhibits.

f. Neither the individual, nor any other person acting on behalf of the individual, may contact hospital employees or professional staff members whose names appear on the Professional Executive Council's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. Hospital will advise the individual who requested the hearing once it has contacted such employees or Professional Staff Member and confirmed their willingness to meet. Any employee or Professional Staff Member may agree or decline to be interviewed by or on behalf of the individual who requested the hearing.

ARTICLE IX - PART B
Section 4. Witness List

The Qualified Applicant, Member, or Practitioner requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on the Qualified Applicant's, Member's, or Practitioner's behalf within ten (10) days after receiving notice of the hearing. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The witness list shall include a brief summary of the anticipated testimony.

ARTICLE IX - PART B
Section 5. Hearing Panel and Presiding Officer, or Hearing Officer

(a) Hearing Panel

(1) When a hearing is requested, the Chief Executive Officer (or authorized designee), acting for the Board and after considering the recommendation of the Chief of Staff (or authorized designee) (and that of the Chair of the Board (or authorized designee), if the hearing is occasioned by a Board determination) shall provide the individual with a list of five to seven (5-7) potential panel members, from which the affected individual may select three (3) members who shall be appointed to a Hearing Panel. The potential panel members shall include, when practicable, at least three (3) individuals in the same discipline as the Qualified Applicant, Member, or Practitioner; an individual in the same or similar specialty as the Qualified Applicant, Member, or Practitioner; and a content expert. In all cases, three (3) voting members shall be appointed, the majority of which

are peers[33] of the affected practitioner[3435]. The Chief Executive Officer (or authorized designee) shall appoint one member of the Hearing Panel as the Hearing Panel Chair.

(2) The majority of the Hearing Panel shall be composed of:

a. Members who shall not have actively participated in the consideration of the matter involved at any previous level (although knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel);

b. Professionals or laypersons not connected with the Hospital; or

c. A combination of such persons.

(3) The Hearing Panel shall not include any individual who is in direct economic competition with the Qualified Applicant, Member, or Practitioner or any such individual who is professionally associated with or related to the Qualified Applicant, Member, or Practitioner. Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving as a member on the Hearing Panel.

(4) All members of the Hearing Panel (including Chair), are entitled to vote.

(5) Recognizing that it may not be possible for all members of the Hearing Panel to be present continually at all sessions of the Hearing Panel, since it is necessary to conduct a

(Continuation of Article IX, Part B, Section 5)

hearing as soon as reasonable after the event or events that gave rise to its necessity, the hearing shall continue even though certain members of the Hearing Panel are not present at all times. The fact that certain Hearing Panel members were not physically present at all times during the hearings will not disqualify them or invalidate the hearing. A Hearing Panel member who is forced to be absent from portions of the hearing must certify that he or she has read that portion of the transcript of the hearing from which he or she was absent before being permitted to vote. The vote shall be by majority of those appointed to the Hearing Panel who are entitled to vote.

(b) Presiding Officer

(1) The Chief Executive Officer (or authorized designee) shall appoint a Presiding Officer.

(2) The Chief Executive Officer (or authorized designee) may appoint an attorney at law as Presiding Officer. Such Presiding Officer may be legal counsel to the Hospital, but must not act as a prosecuting officer, or as an advocate for either side at the hearing. The Presiding Officer who is an attorney may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations. Legal counsel to the Hospital may continue to advise the Board on the matter.

(3) If no attorney is appointed as Presiding Officer, the Chief Executive Officer (or authorized designee) shall appoint the Hearing Panel Chair to serve as the Presiding Officer, and shall continue to be entitled to one vote if appointed as a voting member. If

[33] A peer for the purposes of a Hearing Panel is defined as an individual in the same professional discipline (MD/DO, DDS/DMD, APRN, LP, LICSW, etc.) with qualifications relevant to the issues to be addressed in the Hearing Panel.
[34] The Joint Commission – Hospital Accreditation Standards, MS.10.01.01 – EP 4
[35] NCQA Standards – M+C8 (Element A)

a Hearing Panel Chair is appointed to be the Presiding Officer in lieu of an attorney, all references in this Article to the Presiding Officer shall be deemed to refer to the Hearing Panel Chair, unless the context would clearly otherwise require.

(4) With respect to a Pre-Hearing Conference, the Presiding Officer shall:

a. Require the individual or a representative (who may be counsel) for the individual and for the Professional Executive Council to participate in a pre-hearing conference,

b. Require that all objections to documents or witness be submitted in writing five (5) days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objections demonstrates good cause.

c. At the pre-hearing conference resolve all procedural questions, including any objections to exhibits or witnesses.

d. At the pre-hearing conference, notify all participants that neither spectators (relatives or patients of the affected Qualified Applicant, Member, or Practitioner), nor members of the general Professional Staff who are not substantively involved in the proceeding may attend a Hearing.

e. Stipulate that evidence unrelated to the reasons for the recommendation or to the individuals for qualifications for appointment or the relevant clinical privileges shall be excluded.

f. Establish the time allotted to each witness's testimony and cross-examination.

g. Notify the parties that witnesses may be sequestered and, accordingly, not present for the testimony of other witnesses.

h. It is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven (7) and one half hours to present its case, in terms of both direct and cross examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

(5) With respect to a Hearing, the Presiding Officer shall:

a. Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence;

b. Maintain decorum throughout the hearing;

c. Determine the order of procedure throughout the hearing;

d. Have the authority and discretion, in accordance with this Policy, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;

e. Act in such a way that all information relevant to the continued appointment or clinical privileges of the Qualified Applicant, Member, or Practitioner requesting the hearing is considered by the Hearing panel in formulating its recommendations;

and

f. Act at all times to see that all relevant information is made available to the Hearing Panel for its deliberations and recommendations to the Board; and

g. Be advised by legal counsel to Hospital.

(c) Hearing Officer

(1) As an alternative to the Hearing Panel described in paragraph (a) of this Section, the Chief Executive Officer, after consulting with the Chief of Staff (and Board Chair if the hearing was occasioned by a Board determination) may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Panel. The Hearing Officer shall preferably be an attorney at law (who may also be legal counsel to Hospital) or some other individual capable of conducting the hearing.

(2) The Hearing Officer may not be any individual who is in direct economic competition with the Qualified Applicant, Member, or Practitioner requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the Hearing Panel or Presiding Officer shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

ARTICLE IX
PART C. HEARING PROCEDURE
Section 1. Failure to Appear

Failure, without good cause, of the Qualified Applicant, Member, or Practitioner requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions pending, which shall then become final and effective immediately upon approval by the Board. The Board shall deliver copies of the final action to the Qualified Applicant, Member, or Practitioner and to the chair, or designee, of the Credentials Committee and Professional Executive Council, in person or by mail with delivery confirmation.

ARTICLE IX - PART C
Section 2. Record of Hearing

The Hearing Panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by Hospital, but copies of the transcript shall be provided to the Qualified Applicant, Member, or Practitioner requesting the hearing at that Qualified Applicant's, Member's, or Practitioner's expense. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

ARTICLE IX - PART C
Section 3. Rights

At a hearing both sides shall have the following rights:

(a) To call and examine witnesses to the extent available and willing to testify;

(b) To introduce exhibits;

(c) To cross-examine any witness on any matter relevant to the issues;

(d) Representation by counsel who may call, examine, and cross-examine witnesses and present the case. Both sides shall notify the other of the name of that counsel at least ten (10) days prior to the date of the hearing.

(e) To submit a written a statement at the close of the hearing; and

(f) To submit proposed findings, conclusions and recommendations to the Hearing Panel.

Any Qualified Applicants, Members, or Practitioners requesting a hearing who do not testify in their own behalf may be called and examined as if under cross-examination.

ARTICLE IX - PART C
Section 4. Admissibility of Evidence

Formal rules of law relating to examining witness(es) or presenting evidence shall not apply to the hearing. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Panel or Presiding Officer may request such a memorandum to be filed, following the close of the hearing. The Hearing Panel or Presiding Officer may question the witnesses, call additional witnesses or request documentary evidence if it deems it appropriate.

ARTICLE IX - PART C
Section 5. Official Notice

The Presiding Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of the State of Minnesota. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

ARTICLE IX - PART C
Section 6. Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested by anyone but shall be permitted only by the Hearing Panel, the Presiding Officer or the entity which appointed the Hearing Panel on a showing of good cause.

ARTICLE IX
PART D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS
Section 1. Burden of Proof

(a) The Board or the Professional Executive Council, depending on whose recommendation prompted the hearing initially, shall first come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the Qualified Applicant, Member, or Practitioner who requested the hearing to come forward with evidence.

(b) After all the evidence has been submitted by both sides, the Hearing Panel shall recommend in favor of the Professional Executive Council or the Board unless it finds that the Qualified Applicant, Member, or Practitioner who requested the hearing has proved that the recommendation that prompted the hearing was arbitrary, capricious, with prejudice or not sustained by substantial evidence.

ARTICLE IX - PART D

Section 2. Basis of Decision

The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

(a) Oral testimony of witnesses;

(b) Memorandum of points and authorities presented in connection with the hearing;

(c) Any information regarding the Qualified Applicant, Member, or Practitioner who requested the hearing so long as that information has been admitted into evidence at the hearing and the Qualified Applicant, Member, or Practitioner who requested the hearing had the opportunity to comment on and, by other evidence, refute it;

(d) Any and all applications, references, and accompanying documents;
(e) Other documented evidence, including medical records; and

(f) Any other evidence that has been admitted.

ARTICLE IX - PART D
Section 3. Adjournment and Conclusions

The Presiding Officer may adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

ARTICLE IX - PART D
Section 4. Deliberations and Recommendation of the Hearing Panel

Within thirty (30) days after final adjournment of the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person (except the Presiding Officer, if one is appointed) and shall render a recommendation, accompanied by a written report, which shall contain a concise statement as to the reasons justifying the recommendation made and shall deliver such report and recommendation to the Chief Executive Officer.

ARTICLE IX - PART D
Section 5. Disposition of Hearing Panel Report and Recommendation

Upon its receipt, the Chief Executive Officer shall forward the Hearing Panel's report and recommendation, along with supporting documentation, to the Professional Executive Council for information and comment. The Chief Executive Officer shall also send a copy of the report and recommendation, with delivery confirmation, to the Qualified Applicant, Member, or Practitioner who requested the hearing, and to the Board.

Within ten (10) days after receipt of the Hearing Panel's report and recommendation, the Professional Executive Council shall consider the Hearing Panel's report and recommendation and issue a recommendation to the Board that either concurs with, disagrees with, or suggests modifications to the Hearing Panel recommendation. \The Professional Executive Council shall transmit its recommendation together with the hearing report and recommendation, to the Chief Executive Officer, who shall forward them to the Board.

The recommendation of the Hearing Panel shall be subject to rights of appeal as described in these Bylaws. If neither the Qualified Applicant, Member, or Practitioner or the Professional Executive Council requests an appeal, the Board shall consider the recommendations of the Hearing Panel and Professional Executive Council. The Board shall make such final decision in writing within thirty (30) days after the right to request an appellate review has expired. The Board shall deliver copies of

its final action to the Qualified Applicant, Member, or Practitioner and to the chair, or designee, of the Credentials Committee and Professional Executive Council, in person or by mail with delivery confirmation. If the final decision of the Board results in the denial of any or all privileges, the individual will be informed of the reason for the denial.

In the event that the Board ultimately determines to deny initial Professional Staff appointment, reappointment, and/or one or more clinical privileges to a Qualified Applicant, or to revoke or terminate the Professional Staff appointment /or one or more clinical privileges of a current Member or Practitioner, that Qualified Applicant, Member, or Practitioner may not apply within three (3) years for Professional Staff appointment or for those clinical privileges at or for the Hospital unless the Board provides otherwise.

ARTICLE IX
PART E. APPEAL PROCEDURE
Section 1. Time for Appeal

Within ten (10) days after receipt of the Hearing Panel's recommendation, either the Professional Executive Council or the affected Qualified Applicant, Member, or Practitioner may request an appellate review. The request shall be in writing and shall be delivered to the Chief Executive Officer either in person or by mail with delivery confirmation, and shall include a brief statement of the reasons for appeal. The Chief Executive Officer shall promptly forward the request to the Board Chair. If such appellate review is not requested within ten (10) days as provided herein, both parties shall be deemed to have accepted the recommendation of the Hearing Panel.

ARTICLE IX - PART E
Section 2. Grounds for Appeal

The grounds for appeal shall be that:

(a) There was substantial failure to comply with the Professional Staff Bylaws in the matter which was the subject of the hearing so as to deny due process or a fair hearing;

(b) The recommendations were made arbitrarily, capriciously or with prejudice; or

(c) The recommendations were not supported by substantial evidence.

ARTICLE IX - PART E
Section 3. Time, Place and Notice

Whenever an appeal is requested as set forth in the preceding sections, the Board chair shall, within ten (10) days after receipt of such request, schedule and arrange for an appellate review. The Qualified Applicant, Member, or Practitioner shall be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than ten (10) days, nor more than thirty (30) days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from a Practitioner who is under suspension then in effect the appellate review shall be held as soon as the arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Board chair for good cause.

ARTICLE IX - PART E
Section 4. Nature of Appellate Review

(a) The Board chair shall appoint a Review Panel composed of not less than three (3) persons, either members of the Board or others, including reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made.

(b) The Review Panel may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that any opportunity to admit it at the hearing was denied, and then only at the discretion of the Review Panel.

(c) Each party shall have the right to present a written statement in support of its position on appeal, and in its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument.

(d) Within twenty (20) days of the conclusion of the Review Panel, the Review Panel shall make a recommendation different than the recommendation and action appealed from only if the review panel finds that 1) there was a substantial failure to comply with these Bylaws and/or Hospital Bylaws so as to deny due process of a fair hearing; 2) the recommendation and action were made arbitrarily, capriciously or with prejudice; or 3) the recommendation and action were not supported by its substantial evidence. It is not the task of the Review Panel to substitute its judgment for the Board or determine which side presented the greater weight of evidence.

(e) Within twenty (20) days after the conclusion of the appellate proceedings, the Review Panel shall recommend final action to the Board in writing.

(f) The Board may affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation.

ARTICLE IX - PART E
Section 5. Final Decision of the Board

Within thirty (30) days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing and shall deliver copies thereof to the Qualified Applicant, Member, or Practitioner and to the chair, or designee, of the Credentials Committee and Professional Executive Council, in person or by mail with delivery confirmation.

ARTICLE IX - PART E
Section 6. Further Review

Except where the matter is referred for further review and recommendation in accordance with Section 4(f) of this Part, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred for further review and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate.

ARTICLE IX - PART E
Section 7. Right to One Matter and One Appeal Only

No Qualified Applicant, Member, or Practitioner shall be entitled as a matter of right to more than one (1) appellate review on any single matter that may be the subject of an appeal. In the event that the Board ultimately determines to deny initial Professional Staff appointment, reappointment, and/or one or more clinical privileges to a Qualified Applicant, or to revoke or terminate the Professional Staff appointment and/or one or more clinical privileges of a current Member or Practitioner, that Qualified Applicant, Member, or Practitioner may not apply within three (3) years for Professional Staff appointment or for those clinical privileges at or for the Hospital unless the Board provides otherwise.

ARTICLE X: PEER REVIEW PROTECTION

All data and information, including, but not limited to, minutes, reports, recommendations, communications, and actions made or taken pursuant to any peer review activity as defined by applicable law are deemed to be covered by the provisions of Minn. Stat. Ann. § 145.61 et seq. and the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. § 11101 *et seq.*, or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to these Bylaws, the Rules & Regulations of the Professional Staff, and/or any Professional Staff Policy shall be considered to be acting on behalf of the Hospital and its Board when engaged in such professional review activities and thus shall be deemed to be "professional review bodies" as that term is defined in the HCQIA, 42 U.S.C. § 11151.

ARTICLE XI: RULES AND REGULATIONS OF THE PROFESSIONAL STAFF

PART A. PURPOSE OF RULES AND REGULATIONS.

Professional Staff Rules and Regulations, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws and to maintain a uniform standard of quality patient care, treatment and services, shall be adopted in accordance with this Article. Rules and Regulations shall identify certain requirements to be met by each individual exercising clinical privileges at or for the Hospital, and shall act as an aid to evaluating performance under, and compliance with, these requirements.

ARTICLE XI
PART B. ADOPTION BY PROFESSIONAL EXECUTIVE COUNCIL

The Professional Executive Council is hereby authorized and directed to establish (including adopt, amend or repeal) and maintain Rules and Regulations of the Professional Staff. Rules and Regulations may be adopted, amended, repealed, or added to by vote of the Professional Executive Council at any regular or special meeting, provided that notice of the intent to adopt, amend, repeal, or add to the Rules and Regulations is hand delivered or mailed to the members of the Professional Executive Council, and the Active Staff, Affiliate Staff, and Member Only Staff are notified by one of the following methods: (a) posting on the Professional Staff bulletin board at Children's Hospital – Minneapolis, Children's Hospital – St. Paul, and Children's – Minnetonka, or (b) being sent by mail, fax, email, or other method reasonably calculated to notify the Active Staff, Affiliate Staff, and Member Only Staff, at least ten (10) days prior to the vote using the contact information currently on record at the Professional Staff office. It is further provided that all written comments on the proposed changes from the Active Staff, Affiliate Staff, and Member Only Staff are brought to the attention of the Professional Executive Council before the change is voted upon. If substantive changes are made after the mailing, but prior to the vote of the Professional Executive Council, the Active Staff, Affiliate Staff, and Member Only Staff shall be notified of such changes, in accordance with this Article XI Part B, and an additional ten (10) day comment period shall apply. All proposals for changes to the Rules and Regulations must be reviewed by the Professional Executive Council prior to Board approval[36]. Changes in the Rules and Regulations shall become effective as and when approved by the Board. Neither the Organized Professional Staff nor the Board may unilaterally amend the Professional Staff Rules and Regulations.

ARTICLE XI
PART C. ADOPTION BY ORGANIZED PROFESSIONAL STAFF

Rules and Regulations may also be adopted, amended, repealed, or added to by vote of the Active Staff (Organized Professional Staff) at a regular meeting or special meeting of the Professional Staff called for

[36] The Joint Commission – Hospital Accreditation Standards: MS.01.01.01 EP 9.

that purpose, or by vote of the Active Staff without a meeting, provided that the procedure(s) used n initiating and adopting amendments to these Bylaws is followed as set forth in Article XIV. All such changes shall become effective as and when approved by the Board, and shall be communicated to the Professional Staff and to Individuals with Privileges. Upon becoming effective, all Members, Individuals with Privileges, and the Board shall comply with these Rules & Regulations.

In the case that the Board declines to approve such an amendment receiving sufficient affirmative vote of the Professional Executive Council or the Active Staff (Organized Professional Staff), the Board shall send the amendment back to the Professional Executive Council with a written recommendation for changes to the amendment that would meet Board approval. If deemed advisable by the Chief of Staff or Board Chair, either or both may request the creation of an ad hoc joint conference committee consisting of equal members of the Board and the Professional Executive Council to determine the revised language. The Professional Executive Council shall, in turn, report on the proposed amendment(s) as revised either favorably or unfavorably to the Active, Affiliate, and Member Only Professional Staff and initiate a new vote of the Professional Executive Council or the Organized Professional Staff.

ARTICLE XI
PART D. ADOPTION OF URGENT AMENDMENT[37]

In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the Professional Executive Council may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the Professional Staff. In such cases, the Professional Staff shall be immediately notified by the Professional Executive Council. The Professional Staff shall be provided the opportunity for retrospective review of and comment on the provisional amendment as follows:

1. The Active Staff, Affiliate Staff, and Member Only Staff shall be notified of the opportunity for retrospective review and comment by one of the following methods: (a) posting on the Professional Staff bulletin board at Children's Hospital – Minneapolis, Children's Hospital – St. Paul, and Children's – Minnetonka, or (b) being sent by mail, fax, email, or c) other method reasonably calculated to notify the Active Staff, Affiliate Staff, and Member Only Staff of a retrospective review and comment period of at least ten (10) days using the contact information currently on record at the Professional Staff office.

2. It is further provided that all written comments on the proposed changes from the Active Staff, Affiliate Staff, and Member Only Staff are brought to the attention of the Professional Executive Council before or during its next regularly scheduled meeting.

3. If the written comments received identify no conflict between the Members of the Active Staff and the Professional Executive Council, the provisional amendment stands without further action of the Professional Executive Council or the Board.

4. If substantive conflicts are identified, the process for adopting amendments described in Parts B or C of this Article XI shall apply. If necessary, a revised amendment is then submitted to the Board for action.

ARTICLE XII: POLICIES OF THE PROFESSIONAL STAFF

PART A. PURPOSE OF POLICIES

Professional Staff policies, as may be necessary to implement more specifically the general principles of conduct found in the Bylaws, shall be adopted in accordance with this Article.

[37] The Joint Commission – Hospital Accreditation Standards, MS.01.01.01 EP 11.

ARTICLE XII
PART B. ADOPTION BY PROFESSIONAL EXECUTIVE COUNCIL

The Professional Executive Council is hereby authorized and directed to establish (including adopt, amend or repeal) and maintain at least the following policies:

1. Policy on Appointment, Reappointment and Clinical Privileges

   The Policy on Appointment, Reappointment and Clinical Privileges shall set forth the procedures and additional requirements necessary to accomplish appointment, reappointment, clinical privileging, and professional practice evaluation according to the requirements of these Bylaws, and applicable accreditation standards, law and regulation.

2. Policy on Professional Staff Committees

   This policy shall set forth the policies, procedures, and organizational structures of Professional Staff committees which the Professional Staff shall utilize to accomplish the functions outlined in the Bylaws, Rules and Regulations, and the Policy on Appointment, Reappointment and Clinical Privileges, as well as any other policies, procedures, regulations, guidelines, and requirements which may be adopted from time to time by the Professional Executive Council.

3. Other Policies

   The Professional Executive Council may adopt, amend, repeal, or add any additional policies it deems necessary or desirable for the purpose of implementing the general provisions or principles found in these Bylaws.

The Professional Executive Council is hereby authorized and directed to establish (including adopt, amend or repeal) and maintain as needed all Policies of the Professional Staff. Policies of the Professional Staff may be adopted, amended, repealed, or added by vote of the Professional Executive Council at any regular or special meeting, provided that notice of the intent to adopt, amend, repeal, or add is hand delivered or mailed to the members of the Professional Executive Council, and the Members of the Professional Staff are notified by one of the following methods: (a) posting on the Professional Staff bulletin board at Children's Hospital – Minneapolis, Children's Hospital – St. Paul, and Children's – Minnetonka, or (b) being sent by mail, fax, email, or other method reasonably calculated to notify the Active Staff, Affiliate Staff, and Member Only Staff, at least ten (10) days prior to the vote using the contact information currently on record at the Professional Staff office. It is further provided that all written comments on the proposed changes from the Active Staff, Affiliate Staff, and Member Only Staff are brought to the attention of the Professional Executive Council before the change is voted upon. If substantive changes are made after the mailing, but prior to the vote of the Professional Executive Council, the Active Staff, Affiliate Staff, and Member Only Staff shall be notified of such changes, in accordance with this Article XII B, and an additional ten (10) day comment period shall apply. Changes in these Policies shall become effective as and when approved by the Board. Neither the Organized Professional Staff nor the Board may unilaterally amend the Policies of the Professional Staff.

ARTICLE XII
PART C. ADOPTION BY ORGANIZED PROFESSIONAL STAFF

All Policies of the Professional Staff may also be adopted, amended, repealed, or added by the Active Staff (Organized Professional Staff) at a regular meeting or special meeting of the Professional Staff called for that purpose, or by vote of the Active Staff without a meeting, provided that the procedure(s) used in initiating and adopting amendments to these Bylaws is followed, as set forth in Article XIV. All such changes shall become effective as and when approved by the Board, and shall be communicated to the Professional Staff and to Individuals with Privileges. Upon becoming effective, all Members, Individuals with Privileges, and the Board shall comply with these Policies.

In the case that the Board declines to approve such an amendment receiving sufficient affirmative vote of the Professional Executive Council or the Active Staff (Organized Professional Staff), the Board shall send the amendment back to the Professional Executive Council with a written recommendation for changes to the amendment that would meet Board approval. If deemed advisable by the Chief of Staff or Board Chair, either or both may request the creation of an ad hoc joint conference committee consisting of equal members of the Board and the Professional Executive Council to determine the revised language. The Professional Executive Council shall, in turn, report on the proposed amendment(s) as revised either favorably or unfavorably to the Active, Affiliate, and Member Only Professional Staff and initiate a new vote of the Professional Executive Council or the Organized Professional Staff.

ARTICLE XIII: INTEGRATION OF PROFESSIONAL STAFF DOCUMENTS

The Rules and Regulations adopted under the authority set forth in Article XI of these Bylaws, the Policy on Appointment, Reappointment and Clinical Privileges, and the Policy on Professional Staff Committees, both adopted under the authority set forth in Article XII B of these Bylaws, are intended to support the implementation and interpretation of these Bylaws. The definitions as set forth in these Bylaws are hereby incorporated by reference into the Rules and Regulations, the Policy on Appointment, Reappointment and Clinical Privileges, and the Policy on Professional Staff Committees as though fully set forth therein, unless the content clearly requires otherwise.

ARTICLE XIV: BYLAWS AMENDMENTS – ADOPTION BY ORGANIZED PROFESSIONAL STAFF

Neither the Organized Professional Staff nor the Board may unilaterally amend the Professional Staff Bylaws.

ARTICLE XIV
PART A: INITIATION OF BYLAWS AMENDMENTS

Proposed amendments to these Bylaws may be initiated by:

1. The Professional Staff Bylaws Committee;

4. Written petition signed by at least twenty (20) members of the Active Staff (Organized Professional Staff);

5. The Professional Executive Council; or

6. The Board of Directors.

All proposed amendments to these Bylaws shall be referred to the Professional Executive Council. After communicating proposed amendments to the Professional Executive Council, the Organized Professional Staff may propose one or more of such amendments directly to the Board, if so directed by the vote of the Active Staff (Organized Professional Staff) at a regular meeting or special meeting of the Professional Staff called for that purpose, or by vote of the Active Staff without a meeting[38].

ARTICLE XIV
PART B: ADOPTION BY ORGANIZED PROFESSIONAL STAFF

The Professional Executive Council, or the Board, may elect to refer proposed amendments to the Bylaws Committee for further review and recommendation as needed. For amendments proposed directly to the Board, the Board shall refer proposed amendments to the Professional Executive Council for further

[38] The Joint Commission – Hospital Accreditation Standards MS.01.01.01 EP 8 & 9.

review and recommendation. The Professional Executive Council shall then report on proposed amendments either favorably or unfavorably to the Active, Affiliate, and Member Only Professional Staff (and to the Board, in the case of an amendment proposed directly to the Board). Unless the Organized Medical Staff has previously made a vote consistent with one of the following procedures on an amendment it proposed directly to the Board, the Professional Executive Council shall initiate a vote of the Organized Professional Staff by one of the following procedures:

1. Voting at a Meeting: The Professional Executive Council may report on proposed amendments either favorably or unfavorably at the next regular meeting of the Active Staff (Organized Professional Staff), or at a special meeting of the Active Staff called for such purpose. They shall be voted upon at that meeting (without any further amendments from the floor by the Active Staff at the meeting) provided that notice of the intent to amend these Bylaws (including the written text of the amendment or instructions on how to view the written text electronically, and the favorable or unfavorable recommendation of the Professional Executive Council) has been hand delivered or mailed to the members of the Professional Executive Council, and the Active, Affiliate, and Member Only Staff have been notified of the same by one of the following methods:

   (a) Posting on the Professional Staff bulletin board at Children's Hospital – Minneapolis, Children's Hospital – St. Paul, and Children's – Minnetonka, at least fourteen (14) days prior to the meeting (the date, place, and time of which shall be stated on the notice), or

   (b) Mail, fax, email, or other method reasonably calculated to notify the Active, Affiliate, and Member Only Staff, at least fourteen (14) days prior to the meeting (the date, place, and time of which shall be stated on the notice) using the contact information currently on record with the Professional Staff Office.

   To be adopted, an amendment must receive an affirmative vote by secret ballot of not less than two-thirds (2/3) of the votes cast by members of the Active Staff physically present at the time of the vote who are eligible and do vote provided that at least 20% of the voting members of the Active Staff were present at some time during the meeting prior to the vote.

2. Voting without a Meeting: The Professional Executive Council may elect to obtain the vote of the Active Staff (Organized Professional Staff) by ballot without a meeting, provided that notice of the intent to amend these Bylaws (including the written text of the amendment or instructions on how to view the written text electronically, and the favorable or unfavorable recommendation of the Professional Executive Council) has been hand delivered or mailed to the members of the Professional Executive Council, and the Active, Affiliate, and Member Only Staff have been notified of the same by one of the following methods:

   (a) Posting on the Professional Staff bulletin board at Children's Hospital – Minneapolis, Children's Hospital – St. Paul, and Children's – Minnetonka, at least fourteen (14) days prior to the close of the voting period (which shall be stated on the notice), or

   (b) Mail, fax, email, or other method reasonably calculated to notify the Active, Affiliate, and Member Only Staff, at least fourteen (14) days prior to the close of the voting period (which shall be stated on the notice) using the contact information currently on record with the Professional Staff Office.

   Ballots shall be mailed to each member of the Active Professional Staff using the contact information currently on record with the Professional Staff Office at least fourteen (14) days prior to the close of the voting period (which shall be stated on the ballot). Ballots shall be returned to the Professional Staff Office, in envelopes provided for that purpose, before the close of the voting period.

   Alternatively, the Professional Executive Council may require that balloting occur by a secure

electronic method. If such a method is elected, the Active Professional Staff must be notified of the procedure by mail, fax, e-mail, or other method reasonably calculated to inform the Active Professional Staff member of the electronic procedure and the date and time of the close of the voting period.

To be adopted, an amendment must receive an affirmative vote of not less than two-thirds (2/3) of the votes cast, provided that at least twenty percent (20%) of the Active Staff has voted by the close of the voting period. The ballots shall be opened and counted by individuals appointed by the Chief of Staff.

In the case of amendments proposed directly to the Board for which the vote of the Organized Professional Staff is consistent with one of the above procedures, and Professional Executive Council has reported favorably on the proposed amendment to the Board and to the Active, Affiliate, and Member Only Professional Staff, the Board shall proceed to vote on the proposed amendment.

In the case that the Board declines to approve such an amendment receiving sufficient affirmative vote of the Active Staff (Organized Professional Staff), the Board shall send the amendment back to the Professional Executive Council with a written recommendation for changes to the amendment that would meet Board approval. If deemed advisable by the Chief of Staff or Board Chair, either or both may request the creation of an ad hoc joint conference committee consisting of equal members of the Board and the Professional Executive Council to determine the revised language. The Professional Executive Council shall, in turn, report on the proposed amendment(s) as revised either favorably or unfavorably to the Active, Affiliate, and Member Only Professional Staff and initiate a new vote of the Organized Professional Staff.

Amendments shall be effective as and when approved by the Board and shall be communicated to the Professional Staff and to Individuals with Privileges. Upon becoming effective, all Members, Individuals with Privileges, and the Board shall comply with these Bylaws.

ARTICLE XV: CONFLICT MANAGEMENT

In the event that conflicts arise between the Professional Staff and the Professional Executive Council on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, the provisions of these Bylaws shall apply. In the event, that provisions of these Bylaws are insufficient to resolve or successfully manage the conflict, the Hospital policy on managing conflict between leadership groups shall apply[39]. Nothing in the foregoing is intended to prevent Members of the Professional Staff from communicating with the Board on a rule, regulation, or policy adopted by the Organized Professional Staff or the Professional Executive Committee. The Board shall determine acceptable methods for such communication. 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 Professional Staff or Individuals with Privileges.

ARTICLE XVI: CORRECTIONS & REARRANGEMENTS

These Bylaws, Rules & Regulations, and Policies, or any drafts thereof in the approval process, may be edited at any time, without approval (or reapproval), to make non-substantive changes, including but not limited to, correction of spelling errors, updating internal references or references to external documents, improving document format, or moving language within a document.

[39] The Joint Commission – Hospital Accreditation Manual MS.01.01.01 EP 10 and LD.02.04.01.

Professional Staff Bylaws

Children's Hospitals and Clinics of Minnesota

Documentation of signature(s)

Adopted by the Organized Professional Staff as of August 23, 2016

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Robert M. Segal, M.D., Immediate Past Chief of Staff

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Leonard W. Snellman, M.D., Chief of Staff

Adopted by the Board of Directors on November 3, 2016

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Hayes Batson, Chair, Board of Directors