BYLAWS OF THE MEDICAL STAFF OF REGIONS HOSPITAL

Restated and approved on February 2016, Amended October 2017

TABLE OF CONTENTS

ARTICLE 1: PURPOSE AND AUTHORITY OF THE MEDICAL STAFF 1

A. Purpose. 1

B. Authority. 1

C. Governing provisions; definitions. 1

ARTICLE 2: ORGANIZATION OF THE MEDICAL STAFF 1

A. Appointment 1

B. Categories of membership. 1

1. Active Staff 1

2. Associate Staff. 2

3. Honorary Status 2

C. Officers 2

1. Eligibility 2

2. Election and term of office 3

3. Duties of officers 3

4. Annual performance review. 5

5. Vacancies 5

6. Removal from office 5

D. Divisions and Sections 6

1. Qualifications 6

2. Division Heads 6

3. Section Heads. 7

E. Medical Executive Committee 9

1. Voting members 9

2. Non-voting members 9

3. Eligibility 9

4. Appointment or election; term of office. 9

5. Eligible voters 10

6. Voting procedures 10

7. Duties 10

8. Chair; voting 11

9. Meetings. 11

10. Removal from office.. 12

F. Meetings of the Medical Staff 12

1. Regular meetings 12

2. Special meetings 12

3. Notice of meetings 12

4. Attendance 13

5. Quorum 13

G. Committees 13

1. Standing Committees 13

2. Ad hoc or special committees 13

3. Composition; term 13

4. Accountability 13

H. Accountability of MEC to the Medical Staff and Communication with the Board; conflict resolution. 14

1. Accountability of MEC to the Medical Staff. 14

2. Communication with the Board 14

ARTICLE 3: CREDENTIALING AND PRIVILEGES 14

A. Basic steps 14

B. No entitlement to membership. 14

C. Minimum qualifications. 14

D. Application 15

E. Evaluation of the application and recommended action 15

G. Board consideration 16

1. Favorable action. 16

2. Adverse action. 16

3. Action not in accord with MEC recommendation. 16

4. Board action is final. 16

5. Referral back to MEC. 16

H. Leave of Absence 16

I. Temporary and Disaster Privileges 17

ARTICLE 4: QUALITY IMPROVEMENT AND PEER REVIEW. 17

A. Peer Review Policy. 17

1. Focused Professional Practice Evaluation (FPPE). 17

2. Ongoing Professional Practice Evaluation (OPPE). 18

ARTICLE 5: INVESTIGATIONS AND CORRECTIVE ACTION. 19

A. Definition 19

B. Basic steps of an investigation 19

C. Grounds for corrective action. 20

D. Automatic administrative suspension 21

1. Grounds for administrative suspension. 21

2. Effective date and duration of suspensions 22

ARTICLE 6: FAIR HEARINGS. 22

A. Basic steps 22

B. Definition of Review Organization 22

C. Professional review actions that entitle a Practitioner to request a hearing 22

D. Notice 22

E. Time to request a hearing; waiver 23

F. Procedures when a timely request is made 23

G. Notice of hearing 23

H. Appointment of a Hearing Committee and Presiding Officer. 23

I. Conduct of the Hearing. 23

J. Burden of production and proof 24

K. Decision; report 24

L. Appeal. 24

M. Review and final action; notice 24

N. Only one hearing 24

ARTICLE 7: GOVERNING AND OPERATIONAL DOCUMENTS; AMENDMENTS 24

A. Governing Documents 24

1. Review of Governing Documents 25

2. Amendments to Governing Documents 25

3. Special procedure for regulatory amendments. 26

B. Operational Documents 26

C. Histories and physical examinations. 26

ARTICLE 8: GOVERNING PROVISIONS 27

A. Definitions and acronyms 27

B. General Governing Provisions 27

BYLAWS OF THE MEDICAL STAFF OF REGIONS HOSPITAL

ARTICLE 1: PURPOSE AND AUTHORITY OF THE MEDICAL STAFF

A. Purpose. The purpose of the Medical Staff of Regions Hospital is to oversee, evaluate, and improve the quality of professional services provided by members of the Medical Staff and others at the Hospital, including education, research, and care for the indigent, and to carry out the functions delegated to the Medical Staff by the Regions Hospital Board.

B. Authority. These Bylaws, other Governing Documents, and Operational Documents set forth the means by which the Medical Staff organizes itself to carry out its duties. The Governing and Operational Documents are effective when approved by the Board and are binding on every member of the Medical Staff and all Practitioners.

C. Governing provisions; definitions. Capitalized terms and acronyms in the Bylaws and other Governing Documents not defined in the text are defined in Article 8. All provisions of the Bylaws and other Governing Documents must be interpreted as provided in Article 8.

ARTICLE 2: ORGANIZATION OF THE MEDICAL STAFF

A. Appointment. Every member of the Medical Staff must be appointed by the Board after receiving the recommendation of the MEC, in accord with the Governing Documents and the Bylaws of Regions Hospital.

B. Categories of membership. There are two categories of membership on the Medical Staff: Active and Associate.

1. Active Staff. The Active Staff consists of licensed Physicians who the Board has appointed to the Active Staff and to whom the Board has granted privileges to practice at the Hospital.

a. Appointment. The Board must appoint members of the Active Staff in accord with the Credentialing Policy.

b. Prerogatives. A member of the Active Staff is eligible to:

(1) Attend and vote in Medical Staff meetings and meetings of Divisions and Sections of which he or she is a member;

(2) Serve as an officer of the Medical Staff; and

(3) Serve as a member of and chair any Medical Staff committee, subject to any other criteria set forth elsewhere in the Governing Documents.

c. Responsibilities. A member of the Active Staff must

(1) Contribute to the organizational and administrative affairs of the Medical Staff and the Hospital;

(2) Participate as requested or required in activities and functions of the Medical Staff, including (but not limited to) quality, performance improvement and peer review activities; credentialing; risk and utilization management; medical records completion; timely coding and documentation; and the discharge of other staff functions as required;

(3) Fulfill or comply with Medical Staff Governing Documents and Hospital policies and procedures; and

(4) Pay dues as established by the MEC and approved by the Board.

2. Associate Staff. The Associate Staff consists of Physicians to whom the Board has granted privileges to practice at the Hospital and who are otherwise eligible to be appointed to the Active Staff but have asked to be appointed to the Associate Staff instead.

a. Appointment. The Board must appoint members of and grant privileges to the Associate Staff in accord with the Credentialing Policy.

b. Prerogatives. A member of the Associate Staff has all of the prerogatives of a member of the Active Staff except that a member of the Associate Staff may not vote or serve as an officer of the Medical Staff.

c. Responsibilities. A member of the Associate Staff has the same responsibilities as a member of the Active Staff.

3. Honorary Status. The Board, upon the recommendation of the Medical Staff, may confer Honorary Status on Physicians who wish to maintain a professional affiliation with the Hospital but do not have clinical privileges at the Hospital. Physicians with Honorary Status may attend Medical Staff meetings, meetings of committees, divisions, and sections with the consent of the chair of the meeting, but are not members of the Medical Staff, may not vote, serve as an officer of the Medical Staff, or hold clinical privileges at the Hospital.

C. Officers. The Medical Staff has the following officers: Chief of Staff (COS), Chief of Staff-Elect (COS-E), and Chief of Staff-Past (COS-P).

1. Eligibility. Only a member of the Active Staff may serve as an officer.

a. COS-E. The COS-E must, at the time of being elected, have at least five years of clinical experience and have been a member of the Active Staff for at least two consecutive years immediately prior to being elected.

b. COS. The COS, at the time of entering the office of COS, must have at least seven years of clinical experience and have been a member of the Active Staff for at least two

consecutive years immediately prior to being elected or appointed. (This requirement does not apply to a COS-E who is appointed to fill a vacancy in the office of COS.)

c. COS-P. The COS-P who succeeds to that office after service as COS need not meet any additional eligibility criteria. A COS-P who is appointed to fill a vacancy must have at least seven years of clinical experience and have been a member of the Active Staff for at least two consecutive years immediately prior to being appointed.

2. Election and term of office. The Medical Staff elects a Chief of Staff-Elect every two years. Elections must be held pursuant to the Medical Staff's voting and election policy as enacted by the MEC. The COS-E serves in that office for two years, then succeeds to the office of COS for a two-year term, and then to the office of COS-P for a two-year term.

a. Nominating Committee. Every two years, the COS must convene a Nominating Committee. The Nominating Committee must announce a slate of one or more candidates for the office of COS-E to the Active Staff at least 30 days before the election begins. The Nominating Committee must not nominate a candidate who is not eligible or willing to be nominated and serve in the office if elected. The COS must appoint at least the following persons to the Nominating Committee:

(1) The current COS;

(2) The VPMA;

(3) The COS-P; and

(4) The Division Heads.

b. Nomination by petition. After the Nominating Committee has announced its slate of candidates, any five members of the Active Staff may nominate one or more additional candidates who are eligible to serve by signing a nominating petition and submitting it to the COS at least 14 days before the election begins. A written statement signed by the nominee that the nominee would accept service in the office if elected must accompany the petition.

c. Election. The COS must submit a ballot containing the names of all nominated candidates to all Active Members at least seven days before the election begins. The candidate who receives a plurality of votes is elected.

d. Voting procedures. Members of the Active Staff may vote in person, written ballot, electronic means, or by other means as determined by the MEC in the medical staff's voting and election policy.

3. Duties of officers.

a. Chief of Staff (COS). The Chief of Staff has the following duties:

(1) Provide executive leadership to and be responsible for the organization and conduct of the Medical Staff;

(2) Promote communication between the Medical Staff, Hospital administrators, and the Board;

(3) Chair the MEC and report the MEC's activities and reports to the Board;

(4) Suspend privileges of any Practitioner when necessary to prevent imminent harm to another person.

(5) Mediate grievances and conflicts between members of the Medical Staff, and between members of the Medical Staff and the MEC;

(6) Exercise the responsibilities as a Responsible Person under the Fair Hearing Policy;

(7) Serve as an *ex-offico*, voting member of all Medical Staff committees;

(8) Call and preside at all Medical Staff meetings;

(9) Convey the opinions and concerns of the Medical Staff to the Board;

(10) [Deleted]

(11)Participate in the selection and removal process for Division and Section Heads;

(12) Perform other duties and accountabilities as stated in the Governing Documents;

(13) Serve on the Board if the COS is an *ex officio* member of the Board; and

(14) Participate in other activities as requested by the Hospital.

b. Chief of Staff Elect (COS-E). The Chief of Staff Elect has the following duties:

(1) Co-Chair the Patient Care Committee and report monthly to the MEC;

(2) Serve as a member of the MEC;

(3) Assume the duties of the COS during the absence of the COS and upon removal of the COS from office;

(4) Serve as a member of the Quality Committee of the Board if requested by the Board; and

(5) Participate on other committees as requested by the Hospital.

c. Chief of Staff Past (COS-P). The Chief of Staff Past has the following duties:

(1) Advise the COS as requested;

(2) Assume the duties of COS or COS-E when they cannot perform the duties of their offices;

(3) Serve as a member of the MEC and Peer Review Committee; and

(4) Participate on other committees as requested by the Hospital.

4. Annual performance review. The MEC must conduct a formal review of the COS-E's and COS's performance at least annually. The VPMA is responsible for organizing the review.

5. Vacancies. A vacancy in an office exists if the officer dies, resigns, or is removed from office under subsection 6 below. A temporary inability or unavailability to exercise duties does not create a vacancy. An officer whose term expires continues in office until the officer's successor is qualified and assumes the office.

a. COS. If a vacancy occurs in the office of COS, the COS-E assumes the COS's duties for the remainder of the COS's current term and may subsequently serve his or her own two-year term as COS.

b. COS-E. If a vacancy occurs in the office of COS-E for any reason, the MEC must conduct an election to elect a new COS-E as soon as practicable after the vacancy occurs following the procedures in Article 2.C.2. Until the election can be held, the MEC must appoint a member of the Active Staff to serve as interim COS-E. The interim COS-E may be nominated as a candidate in the election to fill the vacancy.

c. COS-P. If a vacancy occurs in the office of COS-P, the MEC may, but is not required, elect a qualified person to fill the remainder of the term. A person elected in such an election need not have served as COS previously. If the MEC does not elect a person to fill the remainder of the COS-P's term, the COS may assign the COS-P's duties to another person.

6. Removal from office. An officer may be removed from office as follows:

a. Immediate and automatic removal from office. An officer's term ends immediately and automatically without any additional action by the MEC if

(1) The officer ceases to be a member of the Active Staff; or

(2) The officer's professional license is suspended, restricted, or revoked.

b. If officer's clinical privileges are restricted. If an officer's clinical privileges at the Hospital are restricted, limited, or suspended (collectively, "restricted") for any reason and the officer does not resign from office, the MEC must promptly convene and consider whether the restrictions on the officer's clinical privileges interfere with the officer's ability to effectively exercise the officer's duties to the extent that the officer should be temporarily suspended or removed from office. After such consideration, the MEC may

(1) allow the officer to continue to exercise the officer's duties during the time the officer's privileges are restricted, with or without conditions or restrictions;

(2) suspend the officer from exercising some or all of the officer's duties during the time the officer's privileges are restricted, assigning the suspended officer's duties to another officer or other person as appropriate during the suspension; or

(3) remove the officer from office under paragraph c.(2).

c . Removal by vote. If an officer fails to satisfactorily fulfill the responsibilities of the office, the officer may be removed from office by (1) a majority of those voting at a regular or special meeting of the Medical Staff or an election held under the voting and elections policy; or (2) a two-thirds majority vote of the Active Staff who are members of the MEC. The VPMA must give an officer five days written notice prior to any vote to remove the officer from office and the officer must be given an opportunity to address the Medical Staff or the MEC prior to the vote being taken. This opportunity need not take place in a meeting of the Medical Staff or MEC.

D. Divisions and Sections. The Medical Staff, acting through the MEC, may create Divisions and Sections to assist the Medical Staff in carrying out its functions. Each Division and Section is led by a Division or Section Head, respectively.

1. Qualifications. A Division and Section Head must be a member of the Active Staff actively engaged in clinical practice at the Hospital.

2. Division Heads.

a. Appointment; term. The CEO, VPMA, and COS jointly appoint each Division Head for a term of three years.

b. Duties. A Division Head must:

(1) Oversee all clinically related and administrative activities of the Sections in the Division;

(2) Provide leadership and ongoing support for the Section Heads within the Division;

(3) Coordinate and oversee responses to and resolution of patient complaints;

(4) Serve on the MEC; and

(5) Work with and support the Hospital administration in the development and implementation of an annual and strategic plan.

c. Reporting and annual review. A Division Head reports to the VPMA and COS and is accountable to the MEC and Board. The COS is responsible for organizing the Division Head's performance review and must report his or her findings to the MEC.

d. Removal. Any two of the CEO, VPMA, and COS may remove a Division Head for any of the following reasons:

(1) The Division Head fails to satisfactorily fulfill the responsibilities of the position to;

(2) The Division Head's clinical privileges are revoked or suspended, in whole or in part; or

(3) The Division Head is the subject of disciplinary action taken by the Medical Staff, the Hospital, or any licensing or certifying body.

e. Vacancy. If a position as Division Head becomes vacant, the CEO, VPMA, and COS must appoint an interim Division Head to fill any vacancy for the remainder of the Division Head's term. At the conclusion of the term, the CEO, VPMA, and COS must appoint the interim Division Head or other qualified person to a three-year term.

3. Section Heads.

a. Appointment; term. A Section Head is appointed jointly by the CEO, VPMA, COS, and relevant Division Head for a two year term and must be confirmed by a majority vote of the members of the Section who cast a vote.

b. Duties. A Section Head must:

(1) Oversee all clinically related activities of the Section;

(2) Oversee all administrative activities of the Section unless otherwise provided by the Hospital;

(3) Provide oversight of the performance of all individuals in the Section who have been granted clinical privileges;

(4) Recommend to the Medical Staff criteria for requesting clinical privileges relevant to the care provided by the Section;

(5) Recommend clinical privileges for each member of the Section;

(6) Assess and recommend to the MEC and Hospital administration off-site sources for needed patient care services not provided by the Section or the Hospital;

(7) Integrate the Section into the primary functions of the Hospital;

(8) Coordinate and integrate inter-Sectional and intra-Sectional services;

(9) Develop and implement Medical Staff and Hospital policies and procedures that guide and support the provision of patient care services;

(10) Recommend the number of qualified and competent persons necessary to provide patient care and service;

(11) Recommend to the Hospital the qualifications and competence of Section personnel who are not Practitioners and who provide patient care, treatment, and services;

(12) Continuously assess and improve the quality of care, treatment, and services;

(13) Maintain quality control programs as appropriate;

(14) Orient and continuously educate all persons in the Section;

(15) Inform the MEC and Hospital of space and other resources needed by the Section to provide patient care services;

(16) Perform all duties assigned by the Division Head pertaining to the delivery and measurement of quality care, quality improvement, operations, development and implementation of critical care pathways, utilization management, marketing, and patient satisfaction.

(17) Organize conferences required by accredited programs and in order to meet the requirements of accreditation agencies for individual programs and the Hospital at large.

(18) Coordinate the delivery of patient care with residency program directors where applicable.

(19) Provide input and reports regarding credentialing and delineation of privileges as requested by the Division Head or Medical Director of Credentialing.

(20) Work with and support the Hospital administration in the development and implementation of an annual and strategic plan.

(21) Conduct FPPE and OPPE and other peer review activities for Practitioners in the Section.

c. Reporting and annual review. A Section Head reports and is accountable to the Division Head within whose division the Section is located. The Division Head is responsible for organizing an annual review of the Section Head's performance and submit a written report of the review to the VPMA and COS.

d. Removal. Any two of the CEO, VPMA, and COS may remove a Section Head for any of the following reasons:

(1) The Section Head fails to fulfill the responsibilities of the position to the satisfaction of the CEO, VPMA, and COS;

(2) A majority of the entire Section membership votes to remove the Section Head;

(3) The Section Head's medical privileges are revoked or suspended, in whole or in part; or

(4) The Section Head is the subject of disciplinary action taken by the Medical Staff, the Hospital, or any licensing or certifying body.

e. Vacancy. The CEO, VPMA, COS, and relevant Division Head must appoint an interim Section Head to fill any vacancy for the remainder of the Section Head's term. If there is

more than one year remaining in the term, the interim Section Head must be confirmed by a majority vote of the members of the Section who vote. At the conclusion of the term, the CEO, VPMA, and COS must appoint the interim Section Head or other qualified person to a two-year term.

E. Medical Executive Committee. The Medical Executive Committee (MEC) is a standing committee of the Medical Staff.

1. Voting members. The following are voting members of the MEC:

a. Medical Staff Officers;

b. Division Heads;

c. A Physician elected at-large by the Medical Staff who is not an employee of HealthPartners or a HealthPartners related entity ("Independent Representative");

d. A Physician elected by each Division;

e. The Chief Executive Officer of the Hospital (CEO);

f. The Vice-President for Medical Affairs (VPMA);

g. The Medical Director of Credentialing; and

h. A member of the Board appointed by the chair of the Board.

2. Non-voting members. The following are members of the MEC but may not vote:

a. Two practitioners who are not Physicians who are appointed jointly by the VPMA and COS for two-year terms in alternating years.

b. The Vice-President and Executive Director of the HealthPartners Institute for Education and Research;

c. The Vice-President for Patient Care Services (or Chief Nursing Officer);

d. Each member of the Senior Leadership Team, as determined by the CEO; and

e. Medical Directors for Quality.

3. Eligibility. Any member of the Active Staff is eligible to be appointed or elected to the MEC regardless of discipline or specialty.

4. Appointment or election; term of office.

a. Ex officio members. The following members of the MEC are appointed to the committee by virtue of their office or position and are members of the MEC as long as they serve in that office or position, or until the appointment is revoked: COS, COS-E, COS-P, Division Heads, CEO, VPMA, Medical Directors for Credentialing and Quality, and the member of the Board appointed by the Board chair. If an individual qualifies to be a

voting member of the MEC in more than one category (for example, if the CEO is appointed as the Board's representative on the MEC), that individual has only one vote and must not serve on the MEC in more than two roles simultaneously.

b. Elected members. The Physicians elected as representatives of each Division and the Physician elected at-large as the Independent Representative are elected to serve two-year terms. They are nominated and elected as follows:

(1) Prior to an election, the COS must appoint an ad hoc Nominating Committee as provided in Article 2.C.2.a.

(2) The Nominating Committee must select one or more eligible candidates for each of the positions to be filled.

(a) A nominee for the position of Division representative must be a member of the Division being represented.

(b) A nominee for the Independent Representative must not be an employee of HealthPartners or a HealthPartners-related entity.

(3) The Nominating Committee must submit a slate of one or more nominees for Division representative to the members of the respective Division for a vote at least seven days before the vote and a slate of one or more nominees as the Independent Representative to the Active Staff at least 30 days before the vote.

c. Vacancies. If an elected position on the MEC becomes vacant and less than one year remains on the member's current term, the VPMA and COS must jointly appoint a person who is eligible to serve in the position to serve the remainder of the term. If a year or more remains on the term, the Nominating Committee must select one or more eligible candidates and an election must be held to choose the candidate to complete the term.

5. Eligible voters. Only members of the Active Staff are eligible to vote for members of the MEC.

a. Only members of a Division may vote for that Division's representative.

b. Every member of the Active Staff may vote for Independent Physician Representative.

6. Voting procedures. The MEC may provide for detailed election and voting procedures in an Operational Document.

7. Duties. In addition to duties given to the MEC elsewhere in the Governing Documents, the MEC must:

a. Oversee and coordinate the Medical Staff's quality and performance improvement program;

b. Oversee and coordinate the Medical Staff's regulatory compliance functions;

c. Direct and oversee operation of the Medical Staff's Divisions and Sections;

d. Develop, oversee and enforce standards of professional conduct by members of the Medical Staff.

e. Act on behalf of the Medical Staff between Medical Staff meetings;

f. Submit recommendations to the Board on all matters relating to appointment, reappointment, clinical privileges, and corrective action;

g. Review and act on reports from Medical Staff committees, divisions, sections, and other assigned activity groups;

h. Request an evaluation or initiate an investigation of a Practitioner privileged through the Medical Staff process when there is question about the Practitioner's ability to perform privileges requested or currently granted;

i. Make recommendations to the Board concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the fair hearing procedures;

j. Recommend changes or amendments to the Governing Documents to the Medical Staff and Board;

k. Adopt and amend Operational Documents; and

l. Consider and approve the Hospital's entering into an exclusive contract with one or more specialty services to provide certain services to patients.

8. Chair; voting. The COS is the chair of the MEC and presides at its meetings. The COS-E or COS-P, respectively, may serve as chair in the absence of the COS. If neither the COS-E nor the COS-P is available, the COS may designate any other member of the MEC to act as chair during the COS's absence. The chair of the MEC may vote on any matter except for matters that directly and individually affect the chair.

9. Meetings.

a. Regular and called meetings. The MEC must meet regularly on a schedule announced to the Medical Staff in advance. The MEC may also meet in special meetings at the call of the COS, CEO, or VPMA. The person calling a special meeting must give notice of the meeting announcing the time and place of the meeting and its purpose to all members of the MEC at least 24 hours in advance of the meeting. The 24-hour notice may be waived with the written consent of every current MEC voting member either before or after the special meeting.

b. Minutes. The MEC must select one of its members or authorize a Hospital employee to keep minutes of every MEC meeting. Minutes must be available for review by any member of the Active Staff, except that minutes containing information protected by the

peer review privilege or is otherwise confidential must be redacted or withheld from review.

c. Attendance at meetings; executive session.

(1) Voting members of the MEC may attend any meeting of the MEC, except that the MEC may exclude a voting member from a meeting or portion of a meeting where the MEC is considering a matter concerning the individual member.

(2) The CEO or the CEO's designee must attend every MEC meeting. However, the failure of the CEO or the CEO's designee to attend a MEC meeting does not invalidate any otherwise valid action taken at the meeting.

(3) The MEC may allow others (including Hospital employees who provide support to the MEC) to attending any MEC meeting or portion of a meeting if allowing them to attend will assist the MEC in performing its duties.

(4) The MEC may meet in executive session and limit attendance to voting members if doing so will assist the MEC in performing its duties.

(5) Members of the MEC must attend at least two-thirds of all meetings held during any six-month period.

10. Removal from office. An elected member of the MEC who is not an officer may be removed from the MEC by a majority vote of the eligible voters of the constituency that elected the member. A vote to remove an elected member of the MEC must be held within 10 business days of a petition signed by 10% or more of the members of a Division (in the case of a Division representative) or 5% of the members of the Active Staff (in the case of the Independent physician representative) being delivered to the COS.

F. Meetings of the Medical Staff.

1. Regular meetings. The Medical Staff must hold at least one annual meeting.

2. Special meetings. A special meeting of the Medical Staff to consider one or more specific items of business may be called by

a. the COS,

b. the MEC, or

c. a petition signed by 10 or more members of the Active Staff.

3. Notice of meetings. Notice of a regular meeting must be provided to the Active Staff at least ten days prior to the meeting. Notice of a special meeting must be provided at least five days prior to the meeting.

a. Means of notice. Notice may be by publication, posting, electronic means, or other method or methods that the MEC customarily uses to convey important information to

the Active Staff. The MEC may determine the appropriate means of notice. It is not required that each Active Staff member be notified individually.

b. Content of notice. Notice of a regular or special meeting must include the time and place of the meeting, whether the meeting is regular or special, and the proposed agenda. Notice of a special meeting must also include a statement that no business other than that included in the notice may be considered at the special meeting.

4. Attendance. A member of the Active Staff must be counted as having attended a meeting if the member

a. Physically attends the meeting; or

b. Signs a proxy, in a form approved by the MEC, before the meeting authorizing another member in physical attendance at the meeting to cast a vote for the physically absent member; or

c. Casts a vote outside of the meeting in a manner authorized by the MEC.

5. Quorum. The attendance of 20 percent of the Active Staff, or 40 members of the Active Staff, whichever is fewer, constitutes a quorum to conduct business at a regular or special meeting of the Medical Staff.

G. Committees. The Medical Staff may establish committees as appropriate to help it carry out its duties.

1. Standing Committees. Standing committees of the Medical Staff must include:

a. Medical Executive;

b. Credentials; and

c. Peer Review.

2. Ad hoc or special committees. The MEC may establish ad hoc or special committees for a limited time as needed by adopting a resolution establishing the committee, defining its charge, setting its term, and setting other conditions as appropriate. The MEC may authorize the COS to appoint members of ad hoc or special committees.

3. Composition; term. Except for the MEC whose members and terms of office are governed by these Bylaws, the Medical Staff must provide for the composition of standing committees and the terms of office in another Governing or Operational Document.

4. Accountability. All committees are accountable to the Medical Staff through the MEC. All committee reports must be directed to the MEC unless otherwise provided by the MEC.

5. Attendance. A committee's charter or a committee itself by resolution may set forth attendance expectations and provide for the removal of a committee member for failure to meet attendance expectations.

H. Accountability of MEC to the Medical Staff and Communication with the Board; conflict resolution.

1. Accountability of MEC to the Medical Staff. In addition to other provision of these Bylaws under which members of the Medical Staff may hold the MEC accountable, any member of the Medical Staff may communicate with the MEC about a concern the member has with any action or decision made by the MEC, including any failure to act or decide, by submitting a written statement of the concern to the MEC at least two weeks prior to a regular meeting of the MEC. If requested, the member must be given a reasonable amount of time, as determined by the MEC, to personally address the MEC concerning the subject matter of the request. This paragraph does not apply to a member's concern about an action or decision concerning the credentialing of an individual; such concerns must be directed to the appropriate Medical Staff committee rather than the MEC.

2. Communication with the Board. Nothing in these Bylaws is intended to prevent a member of the Medical Staff from communicating with the Board concerning a Governing or Operational Document adopted by the Medical Staff or the MEC. The Board must determine the method by which the communication may be made.

ARTICLE 3: CREDENTIALING AND PRIVILEGES

A. Basic steps. The Medical Staff must evaluate the credentials of Physicians and Practitioners who apply to be appointed to the Medical Staff or for clinical privileges. Based upon these evaluations, the Medical Staff must make recommendations to the Board regarding appointment and privileges. The basic steps of the credentialing process are set forth in these Bylaws and are supplemented by more detailed procedures set forth in the Credentialing Policy which, though set forth as a separate document, has the same force and effect as the Bylaws and must be approved by the Board and amended in the same manner as the Bylaws. The Credentialing Policy may impose additional requirements as long as they are not incompatible with these Bylaws.

B. No entitlement to membership. No person is entitled to membership on the Medical Staff solely by virtue of licensure, membership in any professional organization, or privileges held at any other health care organization.

C. Minimum qualifications. The Credentialing Policy must set forth minimum qualifications that an applicant for appointment to the Medical Staff must have before an application may be accepted. The qualifications must include at least that the applicant:

1. Be a Physician who possesses a current license to practice in Minnesota;
2. Carry professional liability insurance in amounts specified by the Credentialing Policy;

3. Be registered with the U.S. Drug Enforcement Agency in Minnesota, if the Physician prescribes medication;

4. Has successfully completed or is currently enrolled in a residency training program approved by the American College of Graduate Medical Education, American Osteopathic Association, or similar organization;

5. Is board certified, in the process of obtaining board certification, or participating in ongoing maintenance of certification measures with the intent of maintaining board certification. (This criterion does not apply to a Physician whose specialty does not have a certification process);

6. Not be excluded or otherwise ineligible from participation in Federal Health Care Programs, including Medicare and Medicaid; and

7. Meet any additional qualifications set forth in the Credentialing Policy.

D. Application. A Practitioner seeking membership on the Medical Staff or clinical privileges must apply for membership or privileges using standard application forms for these purposes approved by the Credentials Committee.

1. The burden of providing the information required for a complete application is solely on the applicant.

2. The Credentials Committee must not accept an application for membership or privileges until the application is complete. An application is not complete until the Medical Staff has verified information in the application with the primary source of information. The Credentialing Policy may provide that an otherwise complete application may be deemed as incomplete during any time the applicant has not provided the Credentials Committee with additional information requested by the Committee.

E. Evaluation of the application and recommended action. A complete application and accompanying documentation must be evaluated by the relevant Section Head, Division Head, Credentials Committee, and MEC in a manner specified in the Credentialing Policy. Each evaluation must include a recommendation for action on the application and may include a brief explanation of the reason for the recommendation. The MEC must forward its recommendation regarding an application to the Board (or to a committee of the Board, as designated by the Board) for its consideration and final action, except that an adverse recommendation that would entitle a Practitioner to request a hearing must not be forwarded to the Board until the Practitioner has been notified of his or her right to request a hearing and has exercised or waived that right.

F. Criteria. The Section Head, Division Head, Credentials Committee, and the MEC must review and assess each applicant's demonstrated competence in each of the following areas:

1. Medical and clinical knowledge;

2. Technical and clinical skills;

3. Clinical judgment;

4. Interpersonal skills;

5. Communications skills; and

6. Professionalism.

G. Board consideration. The Board or its authorized representative(s) may adopt, reject, or modify a recommendation of the MEC with regard to appointment or privileges, in whole or in part.

1. Favorable action. If the Board approves a recommendation of the MEC to appoint an applicant to the Medical Staff or grant new or expanded privileges, the CEO must promptly notify the new appointee in writing of the Board's action.

2. Adverse action. If the Board approves a recommendation of the MEC to deny and application, in whole or in part, the CEO must promptly notify the Practitioner of the Board's decision.

3. Action not in accord with MEC recommendation. The Board may, on its own initiative, approve an application for membership or privileges contrary to the MEC's recommendation or it may deny or modify, in whole or in part, appointment or privileges that were recommended by the MEC. Under this circumstance, the CEO must promptly notify the Practitioner of any action and, if the Board's decision constitutes adverse action, of any right the Practitioner may have to appeal the Board's decision.

4. Board action is final. Except as provided in the next paragraph, an action by the Board on a credentialing matter is considered final professional review action.

5. Referral back to MEC. The Board may refer the matter to the MEC for further consideration before making a final decision. If the Board refers the matter to the MEC, the Board must indicate the reason for the referral and a brief explanation of what additional information it seeks. This action is not final professional review action.

H. Leave of Absence. The Credentialing Policy may provide a process by which a Practitioner may request and be granted a leave of absence from Medical Staff and clinical responsibilities.

1. A leave may be granted for any purpose approved by the Board, including to improve the Practitioner's physical or mental health, to improve the Practitioner's ability to care for patients safely and competently, to obtain additional education, to provide voluntary medical service, or to fulfill a military obligation.

2. Except for a leave requested to satisfy a military obligation, or as otherwise expressly approved by the Board, a leave must not be for longer than one year.

3. The Credentialing Policy must provide that a request for a leave be reviewed by the MEC and approved by the Board.

4. The Credentialing Policy must require a Practitioner to apply to be reinstated to the Medical Staff and the exercise of clinical privileges by the Board, upon recommendation of the MEC, and that any such reinstatement be subject to Focused Professional Practice Evaluation.

I. Temporary and Disaster Privileges

1. **Temporary privileges: Basic steps.** The Credentialing Policy may permit the CEO to grant a Practitioner temporary privileges (a) to meet an important patient need or (b) while a Practitioner's application for appointment and privileges is awaiting approval by the MEC or the Board. The Policy must state the qualifications a Practitioner must have to be eligible for temporary privileges, the information the Practitioner must provide prior to being granted privileges, how the information will be verified, how the request for temporary privileges will be evaluated, and that temporary privileges may be granted for not longer than 120 days.

2. **Disaster Privileges: Basic steps.** The Credentialing Policy may permit the CEO, VPMA, COS, or Medical Director of Credentialing to grant, on a temporary basis, Disaster Privileges when the Hospital activates its Disaster Plan (Emergency Management Plan) and the Hospital is unable to meet immediate patient needs without granting privileges to non-members of the Medical Staff. The Policy must specify that (a) prior to being granted Disaster Privileges the Practitioner's identity must be verified, (b) the Medical Staff will oversee the performance of a Practitioner granted Disaster Privileges, and (c) that the Practitioner's credentials will be verified as promptly as possible.

ARTICLE 4: QUALITY IMPROVEMENT AND PEER REVIEW.

A. Peer Review Policy. The Medical Staff must undertake and oversee activities that measure, assess, and improve the quality of health care in the Hospital. The Medical Staff must have a Quality Improvement and Peer Review Policy that sets forth the detailed steps of how this process occurs. The Policy must include at least the following:

1. Focused Professional Practice Evaluation (FPPE). The Quality Improvement and Peer Review Policy must provide for Focused Professional Practice Evaluation (FPPE), a time-limited, privilege-specific process of evaluating a Practitioner's ability to competently exercise clinical privileges that are being sought or have been granted. FPPE includes the gathering, review, and evaluation of information about a Practitioner's performance and may include chart review, monitoring of clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of the

Practitioner's patients (including, for example, consulting physicians, assistants at surgery, nursing, and administrative personnel).

a. The Policy must provide that FPPE be used to assess a Practitioner's competence to perform requested privileges at the Hospital immediately following appointment to the Medical Staff, upon the granting a new or expanded privilege, upon reinstatement of privileges after a leave of absence, and any other time the Medical Staff does not have documented, current evidence of the Practitioner's ability to safely and competently exercise a requested privilege at the Hospital.

b. The Policy must define other circumstances under which FPPE of currently held privileges may be initiated, including when there is a single incident or evidence of a clinical practice trend that calls into question the Practitioner's current ability to exercise one or more specific privileges safely and competently at the Hospital.

c. The Policy must provide for monitoring of a Practitioner's performance and must state:

(1) The criteria for conducting performance monitoring;

(2) The method for establishing a monitoring plan specific to the privilege being evaluated;

(3)The method for determining the duration of performance monitoring; and

(4) The circumstances under which additional monitoring by an external source is required.

d. The Policy must specify the measures used to evaluate the Practitioner's competence in performing the specific privilege subject to FPPE.

e. The Policy must provide for effective ways of communicating the results of FPEE and recommendations based on those results to the appropriate parties and for implementing changes to improve the Practitioner's performance.

f. FPPE is not an investigation under Article 5, but may result in an investigation being initiated.

2. Ongoing Professional Practice Evaluation (OPPE). The Quality Improvement and Peer Review Policy must provide for all Practitioners Ongoing Professional Practice Evaluation (OPPE). OPPE is an on-going process of identifying a Practitioner's professional practice trends that affect the quality of care and the safety of patients in the Hospital and improvement of the quality of care.

a. The Policy must specify the information to be used in conducting OPPE. The Policy must provide that the information collected be determined by Section as appropriate for Practitioners who belong to that Section, and approved by the MEC. Examples of information that may be gathered and evaluated as part of OPPE include:

(1) The operative and clinical procedures performed by the Practitioner and their outcomes;

(2) The Practitioner's pattern of blood and pharmaceutical usage;

(3) The tests and procedures requested by the Practitioner;

(4) The length of stay of the Practitioner's patients;

(5) Morbidity and mortality data concerning the Practitioner's patients;

(6) The Practitioner's use of consultants; and

(7) Other relevant information as stated in the Policy.

b. The Policy must specify how the information used in OPPE will be gathered. Sources of information may include, as appropriate,

(1) Periodic review of the Practitioner's patients' medical records;

(2) Direct observation of the Practitioner;

(3) Monitoring of the Practitioner's diagnostic and treatment techniques; and

(4) Discussion with other individuals involved in the care of the Practitioner's patients, including, for example, consulting physicians, assistants at surgery, nursing, and administrative personnel.

c. The Policy must provide that information produced through OPPE be communicated to the Practitioner no less often than once every nine months, and that the information evaluated through OPPE will be used as a factor in determining whether the Practitioner will be reappointed to the Medical Staff and have privileges maintained, revised, limited, or revoked.

d. OPPE is not an investigation under Article 5, but may result in an investigation being initiated.

ARTICLE 5: INVESTIGATIONS AND CORRECTIVE ACTION.

A. Definition. An investigation, for purposes of these Bylaws, means a systematic inquiry by the Medical Staff into an allegation of specific misconduct by a Practitioner that is initiated by the MEC. OPPE, FPPE, collegial intervention, or inquiry made pursuant to an application for membership or privileges are not investigations for purposes of this Article, though any of these activities may lead to an investigation.

B. Basic steps of an investigation. The MEC may initiate and conduct an investigation of any Practitioner according to steps provided in an Investigations and Corrective Action Policy adopted by the MEC and approved by the Board. That policy must, at a minimum:

1. Specify circumstances under which an investigation may be initiated.

2. State that only the MEC may initiate an investigation.

3. Outline how an investigation must be conducted, including specifying the composition of an investigating committee, when notice of an investigation must be given to a subject of an investigation, and what the contents of that notice must include.

4. Require the subject of an investigation to cooperate with the investigation, including meeting personally with the investigating committee and consenting to a mental or physical examination upon request of the committee.

5. Provide that an investigating committee or the MEC may consult with outside experts.

6. Offer the subject of an investigation an opportunity to provide information to the investigating committee prior to the committee making its report to the MEC.

7. Require the investigating committee to report its findings of fact and recommendations for further action to the MEC.

8. Set forth a process for the immediate suspension or restriction of a Practitioner's appointment or privileges prior to completion of an investigation if the alleged conduct, if true, poses an imminent danger to the health of any person.

9. Provide that when the privileges of a subject of an investigation are suspended, the investigation be initiated and concluded as promptly as possible.

C. Grounds for corrective action. Following an investigation, the MEC may impose or propose to the Board corrective action for a Practitioner (including termination or suspension of Medical Staff membership, and termination, suspension, or reduction of clinical privileges) for any of the following reasons:

1. General clinical incompetence;

2. Substandard care or treatment of one or more specific patients, even if the substandard care or treatment did not harm the patient;

3. Violation of any standard of conduct established by the Medical Staff, the Hospital, the Practitioner's professional society, or unit of government;

4. Behavior or conduct that adversely affects or could be reasonably anticipated to adversely affect the safety or welfare of one or more persons associated with the hospital, including patients, staff, and visitors; or

5. Conduct that adversely affects or could be reasonably anticipated to adversely affect the safe and orderly operation of the hospital.

D. Automatic administrative suspension.

1. Grounds for administrative suspension. The Credentialing Policy must provide for the automatic administrative suspension of any Physician on the Medical Staff and the privileges of any Practitioner if any of the following occurs.

a. The Practitioner does not possess a current, valid license to practice in Minnesota, including because a previously valid license has lapsed, expired, or has been suspended or revoked.

b. The Practitioner does not possess a current, valid registration with the Drug Enforcement Agency, including because a previously valid registration has lapsed, expired, or been suspended or revoked.

c. The Practitioner does not currently have professional liability insurance in the amounts required by the Credentialing Policy.

d. The Practitioner does not submit proof of immunization status or testing for tuberculosis or other infectious disease when required.

e. The Practitioner's appointment to the Medical Staff or privileges expire.

f. The Practitioner fails to complete medical records in accord with Governing or Operational Documents or Hospital policy after having been notified of the delinquency.

g. The Practitioner is excluded from participation in a federal or state health care program.

h. The Practitioner fails to pay Medical Staff dues and special assessments within 30 days of being notified that the payment is due.

i. The Practitioner is 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.

j. The Practitioner fails to appear at a meeting at which a special appearance is required.

k. The Practitioner fails to participate in an evaluation of the Practitioner's qualifications, including if the Practitioner refuses to undergo a mental or physical examination when requested by the Credentialing Committee or the MEC.

l. The Practitioner fails to execute releases, consents, or other documents as required by the Governing Documents or the MEC.

m. The Practitioner's ability to access or use the Hospital's medical record system is suspended or revoked.

n. The Practitioner does not have adequate cross-coverage for the patients when the Practitioner is not available.

2. Effective date and duration of suspensions. The Credentialing Policy must provide a process for determining the effective date of an administrative suspension, its duration, and the means by which it may be lifted and the Practitioner restored to membership and privileges.

ARTICLE 6: FAIR HEARINGS.

A. Basic steps. This Article sets forth the basic steps regarding eligibility for and the conduct of hearings to review certain adverse professional review actions recommended by the MEC or taken by the Board with regard to a Practitioner. The basic steps of the fair hearing process are set forth in this Article and are supplemented by more detailed procedures set forth in the Fair Hearing Policy which, though set forth as a separate document, has the same force and effect as the Bylaws and must be approved by the Board and amended in the same manner as the Bylaws. The Fair Hearing Policy may impose additional substantive and procedural requirements as long as they are not incompatible with these Bylaws. The Fair Hearing Policy may provide for different procedures for a hearing requested by a Practitioner who is a member of the Active or Associate Staff than are provided to a Practitioner who is not a member of the Active or Associate Staff.

B. Definition of Review Organization. For purposes of this Article, “Review Organization” means either the MEC or the Board, whichever proposed the action that is the subject of a hearing under this Article.

C. Professional review actions that entitle a Practitioner to request a hearing. A Practitioner is entitled to request a hearing under this Article only if a Review Organization proposes to take an action that meets both of the following criteria:

1. The proposed action would adversely affect the Practitioner’s ability to practice independently in the Hospital for more than 14 days; and
2. The proposed action is based on the Practitioner’s clinical competence or professional conduct.

D. Notice. When the Review Organization proposes adverse professional action that entitles a Practitioner to request a hearing, the Review Organization must give the Practitioner prompt, written notice of the proposed action. The Fair Hearing Policy must require that the notice of proposed action include at least the following:

1. A description of the professional action that the Review Organization has proposed to take;
2. A brief statement of the reasons for the action;

3. A statement notifying the Practitioner of his or her right to request a hearing to review the proposed action before it becomes final; and

4. A summary of the rights the Practitioner would have at the hearing.

E. Time to request a hearing; waiver. The Fair Hearing Policy must set a reasonable time period after receiving the notice (but not fewer than 30 days) within which the Practitioner must submit a request for a hearing and specify the information the request must include. If the Practitioner does not request a hearing within the time period, the Practitioner waives his or her right to a hearing and the Board may proceed to take final action on the proposed action.

F. Procedures when a timely request is made. The Fair Hearing Policy must provide that, if a Practitioner makes a timely request for a hearing, the hearing must be held no sooner than 30 days from receipt of the request, except that a request for a hearing by a Practitioner whose membership or privileges are suspended may be scheduled more quickly with the consent of the Practitioner. The Fair Hearing Policy may provide a mechanism for altering these time limits by agreement of the parties.

G. Notice of hearing. The Fair Hearing Policy must provide that the Review Organization give the Practitioner written notice of the hearing at least 30 days before the scheduled hearing (unless mutually agreed otherwise) that Includes at least the following:

1. Notice that a professional review action has been proposed to be taken against the Practitioner;

2. The reasons for the proposed action;

3. A statement that the Practitioner has the right to request a hearing on the proposed action;

4. The time limit (of not less than 30 days) within which the Practitioner must request a hearing; and

5. A summary of the rights the Practitioner will have in the hearing.

H. Appointment of a Hearing Committee and Presiding Officer. The Fair Hearing Policy must provide one or more methods for appointing an impartial Hearing Committee to conduct the hearing and of appointing a Presiding Officer to preside over the hearing. The Hearing Panel must be composed of individuals who are impartial and capable of understanding and interpreting the evidence that is anticipated to be presented.

I. Conduct of the Hearing. The Fair Hearing Policy must provide procedural rules for the conduct of the hearing that give the Review Organization and the Practitioner the basic due process protections of notice and a fair opportunity to be heard. The rules for conduct of the hearing must include at least the following:

1. The hearing will be held before an impartial person or panel;

2. The hearing may be terminated and the Practitioner's right to a hearing waived if the Practitioner does not appear;

3. The Practitioner has a right to be represented at the hearing by an attorney or other person of the Practitioner's choice;

4. A record of the hearing must be made and the Practitioner is entitled to purchase a copy of the record for the reasonable cost of producing it;

5. The Practitioner may call, examine, and cross-examine witnesses and offer relevant documentary or other evidence; and

6. The Practitioner may submit a written statement at the conclusion of the hearing.

J. Burden of production and proof. The Review Organization bears the initial burden of producing evidence at the hearing which, if not refuted, would constitute grounds to sustain the decision under review. Once this burden is satisfied, the burden is on the Practitioner to prove by clear and convincing evidence that the adverse recommendation or action (1) lacks any substantial factual basis or (2) is arbitrary or capricious.

K. Decision; report. The Hearing Committee must deliberate and make a written report of its findings of fact, conclusions, and recommendations. It must base its report on the evidence admitted in the hearing and the applicable burden of production and proof. The Hearing Committee must forward its final report, along with the hearing record, to the Board for final action.

L. Appeal. The Fair Hearing Policy must provide the Practitioner and the Review Organization an opportunity to appeal the Hearing Committee's report and recommendation to the Board before the Board takes final action. An appeal must be based on the hearing record.

M. Review and final action; notice. The Board must consider the Review Organization's recommended action, the Hearing Panel's report, and any appeal and take final action within 30 days of receiving the report or appeal documents, whichever is later.

N. Only one hearing. Notwithstanding any other provision of this or any other Governing Document, a Practitioner is entitled as a right to no more than one evidentiary hearing with respect to an adverse recommendation or proposed action.

ARTICLE 7: GOVERNING AND OPERATIONAL DOCUMENTS; AMENDMENTS

A. Governing Documents. The Medical Staff may propose and adopt documents to assist it in carrying out its functions as provided in this Article. Governing Documents must be promulgated and amended in the same manner as the Bylaws, have the same force and effect as the Bylaws and are effective only when approved by the Board. Governing Documents are the following:

- The Medical Staff Bylaws;

- The Credentialing Policy;
- The Fair Hearing Policy;
- The Peer Review Policy;
- The Investigation and Corrective Action Policy; and
- Standards of Professional Conduct.

1. Review of Governing Documents. The Medical Staff must review Governing Documents at least every two years and formulate and recommend to the Board any new Governing Documents or amendments that it finds necessary or advisable.

2. Amendments to Governing Documents. The MEC has the authority to propose and recommend new Governing Documents or amendments to Governing Documents to the Board as provided in this section.

a. Notice by MEC of proposed amendment; request for a vote. The COS must provide written notice to the Medical Staff of the MEC's intention to recommend that the Board adopt a new Governing Document or an amendment to a Governing Document. The notice must be given at least 10 days before submitting the proposal to the Board.

(1) If, before the expiration of the notice period, the COS receives a written petition signed by five or more members of the Active Staff asking for a vote on the proposed amendment, the MEC must arrange for a vote on the proposed amendment. The proposed amendment will be deemed approved by the Medical Staff unless a majority of the entire Active Staff votes against the amendment.

(2) If no petition signed by the required number of members is filed during the notice period, the MEC's proposed amendment will be deemed approved by the Medical Staff and forwarded to the Board for final action. The amendment is not effective until approved by the Board.

b. Amendments proposed by Active Staff. Any member of the Active Staff may propose an amendment to a Governing Document directly to the MEC by presenting a proposed amendment to the MEC in writing. If the MEC approves the amendment, either as originally proposed or as modified by the MEC, the proposed amendment must be forwarded to the Board for approval in accord with section A.2.a of this Article.

c. Adopting amendment over MEC's objection. If the MEC does not approve the proposed amendment, 10 or more members of the Active Staff may call a special meeting of the Medical Staff to vote on recommending the proposed amendment to the Board. If a meeting is called and a majority of the entire Active Staff votes in favor of the proposed amendment, it must be forwarded to the Board for its consideration with a recommendation of approval.

3. Special procedure for regulatory amendments. Notwithstanding the previous section A.2, the MEC may submit a proposed amendment of any Governing Document other than these Bylaws to the Board without providing prior notice to the Medical Staff when the amendment is required by law, regulation, or other authority and it is not practical to provide notice and the opportunity for a vote by the Medical Staff before forwarding the amendment to the Board. In such a case, the MEC may submit the proposed amendment to the Board and notify the Medical Staff as soon as practicable. If the Board approves and adopts the amendment, it is effective. Any member of the Active Staff who opposes the amendment may subsequently propose to repeal or amend the amendment under the procedures in this Article.

B. Operational Documents. The Medical Staff delegates to the MEC the authority to enact Operational Documents.

1. Operational Documents include rules, regulations, policies, procedures, guidelines, protocols, and other documents, however named, adopted by the Medical Staff that apply to the Medical Staff and Practitioners and are not Governing Documents.

2. Operational Documents become effective upon approval of the MEC and do not require Board approval.

3. The MEC must provide at least 10 days written notice to the Medical Staff of its intention to adopt or amend an Operational Document. Any member of the Active Staff, and any Practitioner directly affected by the proposal, may submit written comments or objections to the MEC. The MEC must consider any such comments or objections before adopting an Operational Document or amendment to an Operational Document.

4. Notwithstanding the previous paragraph, the MEC may adopt an amendment to an Operating Document without providing prior notice to the Medical Staff when the amendment is required by law, regulation, or other authority and it is not practical to provide notice and the opportunity for a vote by the Medical Staff. In such a case, the MEC may adopt the amendment, effective upon adoption, and must notify the Medical Staff as soon as practicable of the amendment. Any member of the Active Staff who opposes the amendment may subsequently propose to repeal or amend the amendment under the procedures under section A.2 of this Article. An amendment adopted by the MEC under this paragraph remains effective until changed.

C. Histories and physical examinations. Pursuant to 42 C.F.R. § 482.22(c)(5), the Medical Staff's policy governing completion of a medical history and physical examination (H&P) of patients admitted to the Hospital must provide that a Physician or other Practitioner must complete an H&P for each patient admitted to the Hospital no more than 30 days before or 24 hours after admission, but prior to surgery or a procedure requiring anesthesia services. The H&P must be placed in the patient's medical record within 24 hours after admission. When an H&P has been completed within 30 days before admission, a Physician or other Practitioner

must complete an updated medical record entry documenting an examination for any changes in the patient's condition since the last H&P. The updated examination must be completed and documented in the patient's medical record within 24 hours after admission, but prior to surgery or a procedure requiring anesthesia services.

ARTICLE 8: GOVERNING PROVISIONS

A. Definitions and acronyms. The following terms and acronyms used in these Bylaws or Governing Documents have the meanings given here, unless they are defined differently in the Governing Document.

"Board" means the Board of Directors of Regions Hospital.

"Business day" means any day other than a Saturday, Sunday, or holiday recognized by the Hospital.

"Day" means a calendar day.

"CEO" means the Chief Executive Officer of the Hospital.

"COS" means the Chief of Staff.

"COS-E" means the Chief of Staff – Elect.

"COS-P" means the Chief of Staff-Past.

"FPPE" means Focused Professional Practice Evaluation.

"Governing Document(s)" means document adopted by the MEC and approved by the Board that relate to the governance of the Medical Staff and are listed in Article 7.A.

"Hospital" means Regions Hospital.

"MEC" means the Medical Executive Committee.

"OPPE" means Ongoing Professional Practice Evaluation.

"Operational Documents" means any document, however denominated, that is adopted by the Medical Staff pursuant to Governing Documents and applies to the Medical Staff and Practitioners.

"Physician" means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, and a doctor of podiatric medicine who is licensed to practice in Minnesota.

"Practitioner" means an individual who has applied for appointment or reappointment to the Medical Staff, and an individual who has applied for new or expanded privileges.

"VPMA" means the Vice President for Medical Affairs of the Hospital.

B. General Governing Provisions.

1. The provisions of the Governing Documents must be interpreted and applied in a manner that further the purpose of the provisions and which favor substance over form.

2. The word "including" means "including but not limited to."

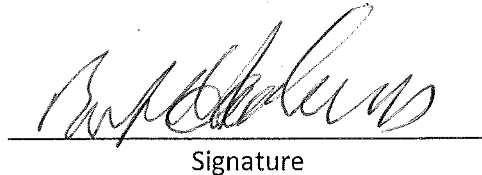
3. Any apparent discrepancy or conflict between the Bylaws and any other Governing or Operational Document must be resolved by giving effect to both documents as far as possible. If not possible, then the Governing or Operational Document must be interpreted in light of the Bylaws.

4. Unless specified otherwise, whenever a duty is assigned to an individual, the duty may be performed by that individual's designee.

5. Unless specified otherwise, whenever a Governing Document refers to a body or group of individuals taking some action by vote, it means a majority of those present and voting.

6. Any time limit referred to in these Bylaws or any other Governing Document is advisory only and not mandatory unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

7. These Bylaws, other Governing Documents, and Operational Document must be interpreted consistent with the Hospital's Bylaws and policies as adopted by the Board.

Approved by Bylaw Revision Committee	 Signature	September 8, 2017 Date
Approved by MEC	Signature	September 11, 2017 Date
Approved by Board	Signature	October 25, 2017 Date

Amendment history:

Approved and Restated by Board: February 24, 2016

Amended and approved by Board: October 25, 2017 (amending Article 7.C.)