

**BYLAWS
OF
THE MEDICAL STAFF
OF
MAPLE GROVE HOSPITAL**

APPROVED:

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ATTACHMENTS

- A – Credentialing and Discipline Policy
- B – Fair Hearing Policy
- C – Rules and Regulations
- D – Glossary

**BYLAWS OF
THE MEDICAL STAFF**

**MAPLE GROVE HOSPITAL
MAPLE GROVE, MINNESOTA**

PREAMBLE

WHEREAS, Maple Grove Hospital (“Hospital”) is a hospital owned in partnership (“Partnership”) of North Memorial Health Care (“North Memorial”) and Fairview Health Services (“Fairview”) and is a Minnesota not-for-profit corporation; and

WHEREAS, the purpose of the Hospital is to serve as a hospital providing patient care; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge its responsibility, subject to the authority of the Board of Directors, and that the cooperative efforts of the Medical Staff, the Chief Executive Officer, the Chief of the Medical Staff, and the Board of Directors are necessary to fulfill the Hospital’s obligations to its patients; and

WHEREAS, the Hospital is an integral component of the partner organizations and the Medical Staff desires to assure adequate coordination between the partner hospitals in matters such as credentialing, corrective action, and performance improvement;

NOW, THEREFORE, the Physicians, Dentists, and Podiatrists practicing in the Hospital hereby organize the activities and governance of the Medical Staff of Maple Grove Hospital and do hereby adopt the following Bylaws.

ARTICLE 1 - NAME AND PURPOSE

1.1 Name. The name of this organization shall be the Medical Staff of Maple Grove Hospital (“Medical Staff”).

1.2 Purpose. The purposes of the Medical Staff are:

- A. To ensure that all patients admitted to or treated in any of the facilities of the Hospital shall receive quality medical and health care services that are consistent with recognized community standards of care, regardless of age, race, gender, color, creed, or any other basis prohibited by law;
- B. To assist in the continuing education of all members of the Medical Staff;
- C. To ensure an appropriate level of professional performance of all members of the Medical Staff through the delineation of clinical privileges and an ongoing review and evaluation of each Medical Staff member’s performance in the Hospital;

To provide an appropriate educational setting that will maintain professional standards, assist in the continuing education of all members of the Medical Staff, and lead to continuous advancement in professional knowledge and skill as well as scientific and educational standards;

D. To initiate and maintain the policies for self-governance of the Medical Staff;

E. To participate in and promote activities designed to improve and protect the general health of the community served by the Hospital;

F. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff in a cooperative manner with the Chief Executive Officer, Chief of the Medical Staff or the appropriate governing body or board; and

G. To review and evaluate the services of all Practitioners in relation to quality, factors necessary to meet accreditation and licensure standards, federal and state law, peer review standards, and cost-effectiveness, and to report regularly to the Board of Directors through the Chief Executive Officer or Chief of the Medical Staff.

ARTICLE 2 - MEMBERSHIP

2.1 Members. Membership on the Medical Staff is a privilege which shall be extended only to those individuals who are competent in their respective fields and who continuously meet the standards and requirements set forth in the Bylaws, Rules, and policies of the Medical Staff. All Practitioners who admit patients or provide medical or health-related services in the Hospital must be members of the Medical Staff and shall be subject to these Bylaws and the Rules and policies of the Medical Staff. Only Medical Staff members and Licensed Independent Practitioners (when granted the right to do so under the Credentialing and Discipline Policy) may admit patients to the Hospital.

2.2 Classes of Membership.

A. Active Staff. The Active Medical Staff shall consist of Practitioners who are regularly involved in the clinical or administrative activities of the Hospital, as may be further defined in the Credentialing and Discipline Policy. Members of the Active Medical Staff shall be eligible to vote on matters submitted to the Medical Staff, hold office, and serve as voting members of Medical Staff committees.

B. Provisional Staff. The Provisional Staff shall consist of Practitioners who are being considered for advancement to the Active or the Courtesy Staff. Except as set forth below, all new members of the Medical Staff shall initially serve as members of the Provisional Staff for a period of not less than one nor more than two years, during which time their clinical and professional work shall be evaluated. Following such period, a Provisional Staff member must select a class of membership for which he or she is eligible, and the individual will be considered for appointment to such class. Failure to be eligible for another class of the Medical Staff or to be appointed to such class shall result in automatic relinquishment of membership and clinical

privileges. Provisional Staff members may not hold office. Provisional Staff members may serve as voting members on any and all Medical Staff Committees but may not vote on matters submitted to the Medical Staff.

C. Courtesy Staff. The Courtesy Staff shall consist of Practitioners otherwise eligible for staff membership as herein provided, who only occasionally provide care for patients at the Hospital and who are not significantly involved in administrative activities at the Hospital, as may be further defined in the Credentialing and Discipline Policy, or whose patients' primarily receive inpatient care at Hospital. Courtesy Staff members are encouraged to participate in quality improvement and peer review activities in the Hospital. Upon request, they shall provide written verification of their participation in quality improvement and peer review activities at another hospital or clinic if they do not participate in such activities at this Hospital. Exceptions to this requirement may be granted by the Medical Executive Committee. Courtesy Staff members may not hold office. Courtesy Staff members may serve as voting members on any and all Medical Staff committees but may not vote on matters submitted to the Medical Staff.

2.3 Physicians in Training. Residents or fellows participating in a training program at the Hospital shall not hold appointments to the Medical Staff. All residents participating in ACGME-approved training programs with a formal agreement with the Hospital shall be permitted to provide care to patients in the Hospital in accordance with their training program, under the supervision of a member of the Medical Staff holding an appropriate appointment with the training program and holding clinical privileges at the Hospital reflective of the patient care responsibilities given the residents or fellows that the Medical Staff member is supervising. Residents or fellows and supervising Medical Staff members shall comply with all applicable policies or guidelines established by the Medical Executive Committee. Residents participating in a program that either i) is not ACGME-approved, and/or ii) does not have a formal agreement with the Hospital, must receive specific permission from the Chief Executive Officer, or his/her designee, before providing care in the Hospital. If such permission is granted, these residents shall comply with the requirements described above with regard to their provision of care in the Hospital. Physicians in training may not hold office; may not vote on matters submitted to the Medical Staff; and may not serve as voting members of Medical Staff committees, although they may be appointed to any and all Medical Staff committees.

2.4 Honorary Staff. The Honorary Staff shall consist of Practitioners who are not active in the Hospital or who are honored by emeritus positions. These may be individuals who have active hospital practices in other hospitals or Practitioners of outstanding reputation, not necessarily residing in the community. Honorary Staff members are not eligible to admit patients, order tests or procedures, vote, hold office, or serve on Medical Staff committees. Appointment to the Honorary Staff is not contingent on meeting the qualifications described in Section 3.7.

2.5 Allied Health and Professional Staff. The term "Allied Health Staff" and "Professional Staff" includes the professionals or paraprofessionals who are not members of the Medical Staff, and, unless granted the right to do so under the Credentialing and Discipline Policy, are not allowed admitting privileges. An Allied Health Professional is permitted to perform services for patients specific to his or her individual license and scope of practice in accordance with the Credentialing and Discipline Policy.

2.6 Telemedicine Staff.

A. The Board will determine the clinical services that may be provided through telemedicine after considering the recommendations of the appropriate Department Chairs, the Credentials Committee, and the Medical Executive Committee. Clinical privileges granted to Medical Staff members and other Practitioners may be exercised through telemedicine for patients of the Hospital if those clinical services have been previously approved by the Board to be provided through telemedicine. In addition, qualified applicants may be granted telemedicine privileges without requiring membership on the Medical Staff or Professional Staff. Applicants for telemedicine privileges shall meet all qualifications required for Medical Staff or Professional Staff membership and all qualifications required for clinical privileges outlined in these Bylaws and associated policies, except that applicants for telemedicine privileges are not required to meet the qualifications relating to geographic residency, coverage arrangements, and emergency call responsibilities. In addition, physician applicants seeking telemedicine privileges who are not licensed to practice medicine in Minnesota are eligible to apply for telemedicine privileges if they are duly registered with the Minnesota Board of Medical Practice to practice interstate telemedicine.

B. Applications for telemedicine privileges in which membership on the Medical Staff or the Professional Staff is sought will be processed in accordance with these Bylaws and associated policies. In processing applications for telemedicine privileges only and not membership on the Medical Staff or the Professional Staff, the Hospital may rely on the credentialing and privileging process conducted by the applicant's primary hospital, provided that there is a written agreement between the Hospital and the distant-site hospital that states the following:

1. The distant-site hospital is a Medicare-participating hospital, and it is the responsibility of the distant-site hospital's governing body to meet the requirements of 42 C.F.R. § 482.12(a)(1)-(7) with regard to its physicians providing telemedicine services;
2. The distant-site hospital is a contractor of services to the Hospital and furnishes the contracted services in a manner that permits the Hospital to comply with all applicable requirements for the contracted services;
3. The applicant is credentialed and privileged at the distant-site hospital, and the hospital provides a current list of the applicant's privileges;
4. The applicant holds a license issued or recognized by the State of Minnesota; and
5. The Hospital will conduct an internal review of the applicant's performance of telemedicine privileges and will send the distant-site hospital such information for use by the distant-site hospital in the periodic appraisal of the applicant. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the applicant to the Hospital's patients and all complaints the Hospital has received about the

Practitioner.

C. Telemedicine privileges, if granted, shall be for a period of not more than two years. Applications for renewal of telemedicine privileges will be processed the same as initial applications. Telemedicine privileges granted in conjunction with a contractual arrangement shall be incident to and coterminous with the agreement. Individuals granted telemedicine privileges shall be subject to the Hospital's quality improvement and peer review activities as applicable to the telemedicine privileges granted.

2.7 Terms of Appointment.

A. An appointment to the Medical Staff shall be made by the Board upon recommendation of the Medical Staff.

B. Appointments shall be for a period of two (2) years or less.

C. Appointment to the Medical Staff shall confer on the appointee only membership to the applicable class of Medical Staff. The granting of membership does not carry with it the accordance of clinical privileges. Application for delineated clinical privileges must be pursued according to the pertinent provisions of these Bylaws, Credentialing and Discipline Policy, Fair Hearing Policy, and Rules and Regulations.

D. In the event all of a Medical Staff member's privileges are resigned, revoked or suspended, Medical Staff membership shall be automatically relinquished.

E. A Medical Staff member's membership shall be automatically relinquished upon suspension or termination of his or her state license through action of the State Board of Medical Practice or State Board of Dentistry, or other applicable State Board.

F. A Medical Staff member's membership shall be automatically relinquished if their employment contract with the Hospital or an affiliate of Maple Grove Hospital Corporation is no longer in force.

2.8 No Discrimination. The Medical Staff shall act in a manner which does not discriminate against members of any protected category. This principle shall be applicable to all decisions subject to challenge under Article 9 of these Bylaws, as well as to proceedings governed by the Fair Hearing Policy of the Medical Staff.

2.9 Eligibility.

A. All applicants shall be bound by the consent and waiver set forth on the application and the statement of immunity and obligations set forth in the Medical Staff Bylaws and Policies.

B. All applicants must submit any requested documentation of his or her background, relevant training and experience, current clinical competence, adherence to the ethics of his or her profession, good reputation, ability to work with others and, if requested, health status, with sufficient adequacy to meet the requirements of the Medical Staff and the Board. The process for appointment to the Medical Staff and granting of clinical privileges is set forth in the Credentialing and Discipline Policy;

C. To be eligible to apply for initial appointment, reappointment or clinical privileges, an applicant must meet all of the following threshold eligibility criteria:

1. have a current, unrestricted license to practice in Minnesota that is not subject to any restrictions, probationary terms, or conditions, including a decree of censure not generally applicable to all licensees, and have not had a license to practice in any jurisdiction revoked, restricted, conditioned, or suspended by any state licensing agency;
2. have a current, unrestricted DEA registration and state controlled substance license;
3. while providing services, be located (office and residence) close enough to fulfill Medical Staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital;
4. have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
5. have not been, and are not currently, excluded or precluded from participation in and Medicare or Medicaid, or other federal or state governmental health care program;
6. be a participating provider who is enrolled in and in good standing with Minnesota Medical Assistance and Minnesota Health Care Programs;
7. be permitted to order and refer items and services for Medicare patients;
8. have not been disqualified by the Minnesota Department of Health or Minnesota Department of Human Services from direct contact with persons receiving services at licensed facilities;
9. have had no adverse professional review actions regarding appointment or clinical privileges by any healthcare facility.
10. have not had medical staff or allied health staff appointment or clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;
11. have not resigned medical staff or allied health staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including this Hospital;
12. not currently be under any criminal investigation or indictment and have not been required to pay a civil money penalty for governmental fraud or program abuse or been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare,

Medicaid or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse;

13. not currently be under investigation by any federal or state agency or healthcare facility for reasons related to clinical competence or professional conduct;
14. agree to fulfill all responsibilities regarding emergency call as designated by the applicable department;
15. have an appropriate coverage arrangement (as determined by the Credentials Committee or Hospital policy) with other members of the Medical Staff for those times when the individual will be unavailable;
16. document compliance with all applicable training and educational protocols that may be adopted by the Medical Executive Committee, including, but not limited to, those involving electronic medical records or patient safety;
17. meet any current or future eligibility requirements that are applicable to the clinical privileges being sought or granted;
18. if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract;
19. demonstrate clinical activity in their primary area of practice during the last two years;
20. document compliance with any applicable health screening requirements (e.g., health examinations, TB testing, mandatory flu vaccines, and infectious agent exposures);
21. have successfully completed a residency and, if applicable, fellowship training program approved by the Accreditation Council for Graduate Medical Education, American Osteopathic Association, Royal College of Physicians and Surgeons or other applicable professional society approved by the Medical Executive Committee in the specialty in which the applicant seeks clinical privileges;
 - a) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association; or
 - b) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association.
22. be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons, the American Board of Oral and Maxillofacial

Surgery, the American Dental Association, the American Board of Foot and Ankle Surgery, or American Board of Podiatric Surgery, as applicable. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years will be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training;

23. maintain board certification in their primary area of practice at the Hospital and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements (recertification will be assessed at reappointment);
24. physically and mentally able to provide quality medical care under the privileges which may be granted by the Board; and
25. if seeking to practice as an Allied Health Professional, must have a written agreement with a Collaborating/Supervising Physician, which agreement must meet all applicable requirements of state law and Hospital policy.

D. Failure to meet one or more of the threshold eligibility criteria in Section C above does not constitute a denial of membership and/or clinical privileges and does not entitle the applicant to a fair hearing under the Fair Hearing Policy. An applicant who does not meet one or more of the threshold criteria above may apply to the Medical Executive Committee for a waiver of one or more threshold criteria requirements. An applicant is not entitled to a waiver, and failure to grant a waiver does not give rise to the right to a hearing under the Fair Hearing Policy. All waivers will be reviewed at reappointment.

E. After a practitioner has been appointed to the Medical Staff, if at any time they no longer meet any of these threshold criteria, then the practitioner's membership shall be automatically relinquished.

2.10 Basic Obligations of Individual Staff Membership. Each member of the Medical Staff, regardless of assigned staff category, each Practitioner exercising temporary privileges under these Bylaws, and each Professional Staff and Allied Health Staff, as applicable, shall:

- A. provide patients with continuous care at the generally recognized professional level of quality and efficiency;
- B. abide by the Medical Staff Bylaws, Policies and Procedures, Rules and Regulations and by all other standards, policies, and rules of the Hospital;
- C. discharge staff, committee, and Hospital functions for which the Practitioner is responsible by staff category assignment, appointment, election, or otherwise;

- D. provide services to patients who do not have a personal physician at the Hospital in accordance with protocols which may be adopted by the Medical Staff delineating responsibilities for services to such patients;
- E. prepare and complete in a timely fashion the medical and other required records for all patients he or she admits or in any way provides care to in the Hospital;
- F. abide by the principles of medical ethics adopted by the American Medical Association, the American Osteopathic Association or the American Dental Association, the American Dental Association, or the American Board of Podiatric Surgery, or other applicable board or association;
- G. work effectively and appropriately with other Medical Staff members and with Hospital personnel, administration, and others, and behave in a manner that does not adversely affect patient care in the Hospital;
- H. agree to be subject to review as part of the Hospital's quality assessment and improvement programs and to comply with the Hospital's Corporate Bylaws and any policies or rules adopted by the Board;
- I. be in compliance and provide documentation demonstrating such compliance, with the continuing medical, dental, and podiatric education requirements of the Minnesota State Board of Medical Practice, Minnesota State Board of Dentistry, Minnesota State Board of Podiatric Medicine, or other licensing agency as applicable;
- J. notify the Medical Staff Office of any adverse action by any licensing board, peer review organization, third party payor, clinic, hospital, medical staff, or any health-related agency or organization within 5 days of the adverse action, including:
1. the reduction, restriction, suspension, revocation, denial, non-renewal, or voluntary surrender of his/her professional license by any state;
 2. the reduction, restriction, suspension, revocation, denial, non-renewal, or voluntary surrender of medical staff membership or clinical privileges at any hospital or other health care institution;
 3. the commencement of a formal investigation, the filing of charges, or final action by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or any state;
 4. the filing of any suit against the Practitioner alleging professional liability; or
 5. any final judgments or settlements regarding any litigation or claims, have and maintain professional liability insurance in adequate amounts, as established from time to time by resolution of the Board of Directors, to cover claims and suits arising from alleged professional negligence in the Hospital;
- K. promptly notify the Medical Staff Office of any change in practice address, phone numbers or pager number;

L. work with and provide supervision for residents as needed for high quality patient care and graduate medical education;

M. maintain the confidentiality of patient clinical information and of the minutes, records, and work product of Medical Staff committees engaged in the peer review process. This provision shall not prohibit mandatory disclosures under state or federal law, nor disclosures made for a permitted purpose of a peer review organization, in accordance with applicable law;

N. refrain from performing any procedures, assuming any patient care responsibilities, or applying for or exercising any specific privileges for which such individual is not licensed, currently trained, and currently qualified;

O. Participate in a cooperative manner in the Medical Staff's efforts to review and improve the quality, efficiency and appropriateness of care provided by Medical Staff members, including full participation in the review of patient encounters with the Medical Staff's peer review process. Participation includes submission of review forms in a timely manner;

P. Notify the Medical Staff Office of any arrest or charged with any offense including, but not limited to, any substance-abuse related issue (including driving under the influence, impaired driving, or driving while intoxicated), as well arrests for domestic abuse, child abuse or maltreatment, or maltreatment of a vulnerable adult. Reports are required within five days of such an arrest or within 5 days of being charged with such offense. The Practitioners shall be required to meet with the Vice President of Medical Affairs after such report; and

Q. Obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood and/or urine test) or a complete physical, mental, and/or behavioral evaluation, as set forth in these Bylaws and associated policies.

2.11 Emergency Call Duty. By applying for appointment to the Active Medical Staff, all Active Medical Staff licensed Physicians (M.D. and D.O.) agree to participate in on-call coverage arrangements, including but not limited to coverage for the Emergency Department and for obstetrics. The schedule for this on-call duty shall be established by the Medical Staff in collaboration with Hospital leadership. When appropriate, an Active Medical Staff member may apply for a waiver of this duty to the Medical Executive Committee, who may grant such waiver request in its sole discretion. A waiver must be approved by the Medical Executive Committee and the Board in order to be effective.

2.12 Leaves of Absence.

A. Any member of the Active or Provisional Medical Staff who will not practice in the area for which he or she is credentialed for a period of more than 180 days shall notify the Medical Executive Committee. This period shall constitute a leave of absence.

B. Practitioners are not permitted to exercise their clinical privileges during a leave of absence.

C. A leave of absence that lasts longer than one year requires a reapplication

for clinical privileges. The reapplication shall be reviewed in the normal course. The Practitioner shall provide an explanation of his or her professional activities during the leave of absence and shall provide evidence and an explanation of any material change in any information submitted as part of the appointment and credentialing process, as set forth in the Credentialing and Discipline Policy.

D. If a Practitioner does not actively practice in their specialty outside of the Hospital during a leave of absence, the Vice President of Medical Affairs, Chief of the Department and the Chief of Staff, in conjunction with the Credentials Committee and the Medical Executive Committee shall determine if proctoring or retraining is necessary.

E. Any member of the Medical Staff who does not practice in their specialty for greater than 30 days because of health reasons must notify the Medical Executive Committee. This shall not constitute a leave of absence unless it exceeds the 180-day period. The returning member must meet with the Vice President of Medical Affairs, Chief of the Department or the Chief of Staff who shall determine their return to practice in the hospital will interfere with their medical condition will interfere with their ability to practice medicine safely.

2.13 Dues. All persons appointed to the Active, Courtesy, Provisional Medical Staff, or Allied Health Staff (except those on approved leave of absence) shall pay annual staff dues to the Medical Staff account. The Medical Executive Committee shall determine the staff dues for the succeeding year. A member's membership on the Medical Staff, Professional Staff or Allied Health Staff and clinical privileges shall be automatically relinquished if the member fails to pay dues within 90 days of the due date.

ARTICLE 3 - MEETINGS

3.1 General Medical Staff Meetings. General Medical Staff meetings shall be held at least once a year on a schedule to be established by the Medical Executive Committee. The primary objective of the meetings shall be to report on the activities of the Medical Staff and to conduct such other business as may be on the agenda. One of the meetings shall be designated as the annual Medical Staff meeting, and the medical directors/advisors and committee membership may be appointed at this meeting.

3.2 Departmental Meetings. Departments shall meet with such frequency and at such times as the Department may determine to consider the findings resulting from the ongoing monitoring and evaluation of quality assessment and improvement activities, and to discuss other matters concerning the Department. All departmental meetings are open to every member of the Medical Staff.

3.3 Meeting Requirements. Medical Staff members are strongly encouraged but not required to attend meetings of the Medical Staff. In addition, Departments may establish attendance requirements for Department meetings.

3.4 Special Meetings. Special meetings of the Medical Staff may be called by the Board, Chief of Staff, or in his or her absence by the Vice Chief of Staff, or by a written call signed by 15% of the members of the Active Staff. Such a meeting shall be convened within 30 days of the receipt of the formal written request for a special meeting. The Chief of Staff shall provide notice of any special meetings in writing to all members of the Active Staff at

least five days prior to the meeting. No business may be transacted at any special meetings of the Medical Staff, except for those matters which have been included in the written call and the written notice issued for the meeting.

3.5 Communications with Medical Staff/Professional Staff. General communication with Medical Staff and Professional Staff will take place via email except as otherwise required by these Bylaws and Medical Staff policies and procedures, or when it is determined necessary by the Vice President of Medical Affairs or the Chief of Staff to communicate in a different way in a particular circumstance. It is the responsibility of each provider to notify the Medical Staff Office or his/her current email address and any changes to that email address.

3.6 Election and Action Requirements. Election and action requirements for the transaction of business shall be as follows:

A. Election of officers shall be by emailed ballot. The process for nomination and election of officers shall be as described in Article 4 of the Medical Staff Bylaws.

B. Those members of the Active Medical Staff present at a duly called meeting shall constitute a quorum. A majority vote of those present shall be required to approve an action, except as provided in Section 9.2 with regard to amendment of the Medical Staff Bylaws.

C. A majority of Medical Executive Committee members shall constitute a quorum of the Medical Executive Committee. For all other committees and for Departments, those Practitioner members present at a duly called meeting shall constitute a quorum. In committees and Departments, a majority vote of those present at a meeting at which a quorum is present shall determine an action.

D. The Medical Staff may take action by written or email ballot. Any member of the Active Medical staff present at a duly called meeting of the full Medical Staff may request a written ballot of the membership of the entire Active Staff on any question lawfully coming before the meeting. Twenty-five percent of those present must vote to approve this request. In addition, the Medical Executive Committee may at its discretion order a ballot on any issue properly coming before the Medical Staff. Ballots shall be sent to all Active Medical Staff members and provide a final return date not less than 30 days from the date of the ballot sent date. Those ballots returned as of the return date shall constitute a quorum and a majority of those voting shall determine the action.

3.7 Records. Complete and accurate minutes of all meetings required to be held under this Article shall be maintained. Such minutes shall, at a minimum, include a record of attendance of the members, the facts considered, and the conclusions, recommendations and actions taken at the particular meeting. The minutes shall be signed by the presiding officer. Each committee and Department shall maintain a permanent file of the minutes of each meeting. All minutes shall be kept in a permanent file.

3.8 Executive Session. Executive session is a meeting of a Medical Staff committee, department or section which only the voting Medical Staff members may attend, along with the Vice President of Medical Affairs and/or other senior Hospital Management. Executive sessions may be called by the presiding officer or the Vice President of Medical Affairs and are intended to be utilized to discuss peer review issues, personnel issues or any other issues requiring confidentiality. The conduct and activities of the committee, department or service

while in executive session shall be consistent with the duties and responsibilities of the committee, department or service. In addition, they shall be conducted in a manner consistent with applicable federal and state law which includes maintaining the strict confidentiality of the proceedings.

ARTICLE 4 - OFFICERS

4.1 Officers. The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Credentials Committee Chair and Chair of the Multispecialty Peer Review Committee. No person may hold more than one office at a time.

4.2 Election and Term.

A. Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during their term of office.

B. Officers shall be elected bi-annually by electronic ballot. Only members of the Active Medical Staff shall be eligible to vote. Ballots will list the candidates nominated by the Nominating Committee and approved by the Medical Executive Committee, and will provide space to reject the names or to write in other names. Each nominated candidate shall be elected unless rejections or write-ins returned within 30 days of the initial mailing of the ballots amount to more than 15% of the ballots mailed out.

C. If a candidate is rejected, the Nominating Committee shall select at least one other candidate. A new ballot will be mailed out in the same manner as the original ballot, and the election or rejection process for the new slate shall be as described in Section 4.2(C).

D. The Nominating Committee shall be appointed by the Medical Executive Committee from among the Active Medical Staff members. The Nominating Committee shall offer one nominee for Chief of Staff and one nominee for Vice Chief of Staff.

E. All officers shall serve two-year terms. Officers shall take office on the first day of the Medical Staff year.

4.3 Qualifications. Officers and Department Chairs must meet the following qualifications, unless waived by the Medical Executive Committee:

A. Have no past or pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

B. Not currently be serving as a Medical Staff officer, Board member or department chair at another hospital system;

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

D. Attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;

- E. Have demonstrated an ability to work well with others; and
- F. Not have any financial relationship with an entity that competes with the Hospital or one of its affiliates.

4.4 Chief of Staff.

A. The Chief of Staff shall preside at all meetings of the Medical Staff and the Medical Executive Committee. He or she shall serve ex officio as a member of all committees of the Medical Staff. The Chief of Staff, in conjunction with the Vice Chief of Staff and Vice President of Medical Affairs, shall be responsible for Medical Staff activities with respect to the accreditation by the Hospital's accrediting agency, and any appropriate state or federal agencies and shall act in coordination and cooperation with the Administrator in all matters of mutual concern with the Hospital. The Chief of Staff shall appoint committee members and chairs to special Medical Staff committees, except the Medical Executive Committee. The Chief of Staff shall be the spokesperson of the Medical Staff in its external professional and public relations; and represent the views, policies, needs, and grievances of the Medical Staff to the Board and to the Administrator. The Chief of Staff shall be responsible for the educational activities of the Medical Staff, subject to policies of the Board. The Chief of Staff shall receive and interpret the policies of the Board to the Medical Staff and report and interpret to the Board in return, on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care. The Chief of Staff shall be responsible for the conduct and organization of the Medical Staff. The Chief of Staff shall be responsible for the enforcement of the Medical Staff Bylaws, Credentialing and Discipline Policy, Rules and Regulations, for implementation of sanctions where these are stipulated for noncompliance, and for presentation to the Medical Executive Committee in those instances where corrective action may be recommended by the Board of Directors. He or she shall perform all duties incident to the office of Chief of Staff, and such other duties as may from time to time be prescribed by the Medical Staff. If necessary, the Chief of Staff shall fulfill the role or function of a Department Chair or appoint another Active Staff member to fulfill such role or function, due to the absence of, or inability, or refusal of a Department Chair to fulfill such role or function and the unavailability of a Department Vice Chair. The Chief of Staff shall act as Secretary/Treasurer. He or she shall perform all duties incident to the office of Secretary/Treasurer, and such other duties as may from time to time be prescribed by the Medical Staff or the Medical Executive Committee.

B. The Chief of Staff shall serve for a term of two years and may be re-nominated to serve one additional consecutive two-year term. Nominees for the position of Chief of Staff must be current or past members of the Medical Executive Committee.

C. The immediate past Chief of Staff may serve on the Credentials Committee or the Multispecialty Peer Review Committee.

4.5 Vice Chief of Staff. The Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff in the event of the Chief's temporary inability to perform due to illness, being out of the community, or being unavailable for any other reason. The Vice Chief of Staff shall serve on the Medical Executive Committee as a voting member. The Vice Chief of Staff shall perform such duties as are assigned by the

Chief of Staff. The Vice Chief of Staff shall be considered by the Nominating Committee to succeed the Chief of Staff upon the completion of the Chief of Staff's term, but the Nominating Committee shall not be obligated to nominate the Vice Chief of Staff to become the Chief of Staff, and the selection of the Chief of Staff shall be conducted as set forth in Section 5.2. The Vice Chief of Staff shall automatically succeed the Chief for the remainder of the Chief's term when the Chief cannot complete his or her term for any reason.

4.6 Credentials Committee Chair. The Credentials Committee Chair shall preside over meetings of the Credentials Committee and be responsible for coordinating its activities. The Credentials Committee Chair shall be elected to serve a term of two years. The Credentials Committee shall serve on the Medical Executive Committee as a voting member.

4.7 Chair of the Multispecialty Peer Review Committee. The Chair of the Multispecialty Peer Review Committee shall preside over meetings of the Multispecialty Peer Review Committee and be responsible for coordinating its activities. The Chair of the Multispecialty Peer Review Committee shall be elected to serve until removal or resignation. The Chair of the Multispecialty Peer Review Committee shall serve on the Medical Executive Committee as a voting member.

4.8 Removal

A. Removal of an elected officer or a member of the MEC may be effectuated by a two-thirds vote of the MEC, or by a two-thirds vote of all members of the Active Staff (for officers and MEC members), two-thirds of department or section (for department chiefs as applicable), or by the Board. Grounds for removal shall be:

1. failure to comply with applicable policies and Bylaws;
2. failure to perform the duties of the position held;
3. conduct detrimental to the interests of the Hospital and/or its Medical Staff;
4. an infirmity that renders the individual incapable of fulfilling the duties of that office; or
5. failure to continue to satisfy the qualifications for the position.

B. Prior to scheduling a meeting to consider removal, a representative from the Medical Staff, Medical Executive Committee or the Board will meet with and inform the individual of the reasons for the proposed removal proceedings.

C. The individual will be given at least ten days' special notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the Medical Executive Committee, the Active Staff, department, or the Board, as applicable, prior to a vote on removal.

D. Removal will be effective when approved by the Board.

4.9 Vacancies. A vacancy in any office during the Medical Staff year shall be filled as follows: A vacancy in the office of Chief of any Department or Section shall be filled by the Chief elect of such Department or Section, if any. Any vacancy in the office of Chief of Staff shall be filled by the Vice Chief of Staff. In the event of a vacancy in any other office of the Medical Staff, the Medical Executive Committee shall select an acting officer to fill such vacancy, who will serve until the Nominating Committee can present a slate of candidates before a meeting of the Medical Staff for filling the vacancy. Upon accession or election of an officer to fill a vacancy in an office, the new officer shall fill the unexpired term of the person whose office was vacated.

4.10 Resignation. Any officer may resign at any time by giving written notice to the Medical Executive Committee. Such resignation, which may or may not be made contingent on formal acceptance, shall take effect on the date of receipt or any later time specified in the written notice.

ARTICLE 5 - DEPARTMENTS

5.1 Departments. The Departments shall be specified in the Rules and Regulations of the Medical Staff.

5.2 Assignment to Department. The Medical Executive Committee, upon the recommendation of the Department, shall recommend the final Department assignment of each applicant and reapplicant to the Medical Staff, subject to Board approval.

5.3 Functions of Departments.

A. Each Department shall be responsible for maintaining quality patient care by continuing observation and evaluation of the professional performance of the Medical Staff with privileges in its Department.

B. Each Department shall establish its own criteria for recommending clinical privileges. Clinical privileges must be delineated for each Department Medical Staff member in a comprehensive manner and must be commensurate with the individual's documented training, experience and current clinical competence. Through regular review, each Department will endeavor to assure that all individuals with privileges provide services within the scope of those privileges granted.

C. In the event privileges are requested in more than one Department, the recommendation regarding privileges will be made by chair of the primary Department after consultation with the other Department(s) to determine whether the applicant demonstrates competence for the requested privileges.

D. The Department will perform regular reviews and evaluations of the quality and appropriateness of patient care. Minutes shall be maintained and shall include topics discussed and actions taken. All minutes shall be forwarded to the Medical Executive Committee.

E. Department policies and regulations shall be reviewed periodically by the Department. All policies and regulations adopted by a Department shall be subject to approval by the Medical Executive Committee and shall bear the date of such approval.

F. Each Department shall be responsible for the delineation of privileges for all Professional and Allied Health Staff being supervised by the members of that Department. Recommendations of the Department shall be referred to the Medical Executive Committee for approval.

5.4 Department Organization.

A. The Department Chair and Department Vice Chair shall be Active Medical Staff members qualified by training, experience, and demonstrated ability, and elected by the Active Medical Staff members of the Department, except that each initial Department Chair and Department Vice Chair shall be selected by the Board of Directors upon recommendation from the Hospital Administrator. Terms of service shall be two years, unless such term of service is changed or modified as determined by the individual Department. The Department Chair and Department Vice Chair may be re-elected for multiple successive terms. In the absence of the Department Chair, the Department Vice Chair will assume all duties of the Department Chair including chairing the Department and representing the Department in the Medical Executive Committee.

B. The Department Chair or Department Vice Chair may be removed from office if he or she fails to perform the duties of the office. The Medical Executive Committee shall review the performance of the person in question and may remove him or her from office by a majority vote. The officer in question shall not have a vote.

C. In the event that a Department Chair is unable, unwilling, or ineligible to perform the duties of the office or is removed from office, such office shall be declared vacant by the Medical Executive Committee. Such vacancy shall be filled by the Department Vice Chair. If the Department Vice Chair is unable to fill the vacancy, then the office shall be filled by the Chief of Staff.

5.5 Functions of Department Chairs. Department Chairs shall serve as members of the Medical Executive Committee and perform all duties incident to the office of Department Chair and such other duties as may from time to time be prescribed by the Chief of Staff, Medical Executive Committee or Medical Staff as a whole. Each Department Chair is responsible for the following:

- A. all clinically related activities of the Department;
- B. all administratively related activities of the Department, unless otherwise provided for by the Hospital, including acting as the liaison between the Department and the Medical Staff;
- C. continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;
- D. recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department;
- E. recommending clinical privileges for each member of the Department;

- F. reviewing applications and reapplications for privileges in the Department;
- G. assessing and recommending to the relevant Hospital authority off-site sources for needed patient care treatment and services not provided by the Department or the organization;
- H. the integration of the Department or service into the primary functions of the Hospital;
- I. the coordination and integration of interdepartmental and intradepartmental services;
- J. the development, review, and implementation of policies and procedures that guide and support the provision of care, treatment, and services;
- K. the recommendation for a sufficient number of qualified and competent persons to provide care, treatment and services;
- L. the determination of the qualifications and competence of Department or service personnel who are not Licensed Independent Practitioners and who provide patient care, treatment, and services;
- M. the continuous assessment and improvement of the quality of care, treatment, and services;
- N. the maintenance of utilization, review and quality control programs, as appropriate;
- O. the orientation and continuing education of all persons in the Department or service;
- P. recommendations for space and other resources needed by the Department or service;
- Q. membership on the Medical Executive Committee and regular attendance at Medical Executive Committee meetings; and
- R. other duties as outline in the current accreditation standards for Department chairs.

5.6 Jurisdictional Disputes. Disputes or conflicts in jurisdiction between the Departments shall be submitted to the Medical Executive Committee for determination and resolution.

ARTICLE 6 - SECTIONS

6.1 Medical Staff Sections. Medical Staff Sections shall be established to perform functions relating to various clinical specialties providing services at the Hospital. Sections may be created, disbanded, or changed from time to time by the Medical Executive Committee. The Sections are listed below:

6.2 Section Duties. The Section Chief shall be appointed by the relevant Department Chair. The Section Chief shall perform the necessary functions determined by the Department Chair, including assistance with credentialing, for the proper operation of the Section.

ARTICLE 7 - COMMITTEES

7.1 Committee Structure. The Medical Staff and its committees and Sections shall perform the Medical Staff's peer review responsibilities, including, but not limited to monitoring and evaluating the quality of patient care rendered by all Departments and their members; performing credentialing activities; providing programs of continuing education; developing policies, rules and regulations; and performing such other functions as are required to ensure quality of care. Unless otherwise provided, the Chief of Staff shall select committee chairpersons from the membership of the Medical Staff. Committees other than the Medical Executive Committee may include participation of physicians and staff who are not members of the Medical Staff. Participants who are not members of the Medical Staff may be members of committees, except the Medical Executive Committee, and are eligible to vote. Members of the Medical Staff shall be assigned to committees by the Chief of Staff for terms to coincide with the election of Medical Staff Officers. The Medical Executive Committee may, from time to time, appoint such other committees as determined to be appropriate, and subject to approval by the Board, and may prescribe the functions and duties of such committees and the terms of membership of committee members.

7.2 Medical Executive Committee. The Medical Executive Committee shall be comprised of the members of the Active Medical Staff and shall be comprised of the Chief of Staff, the Vice Chief of Staff, the Past Chief of Staff, the elected Department Chairs and Vice Chairs, and representative(s) from each of the hospital-based services, and the Professional Staff Credentials Chair, as well as at-large members. The at-large members shall be elected by the Medical Staff for two-year terms. For sake of clarity, the Allied Health Professionals Professional Staff Credentials Chair shall be a full voting member on all issues before the Medical Executive Committee. In addition, the Administrator or his or her designee, the Chief Nursing Officer (CNO)/Nurse Executive or his or her designee shall also serve ex-officio as a non-voting member of the Medical Executive Committee. The Medical Executive Committee shall be scheduled to meet as needed to coordinate the activities and policies of the Medical Staff and shall act on behalf of and under the limitations imposed by the Medical Staff as a whole. The Medical Executive Committee may meet as a body or via use of any other confidential manner currently available, i.e., conference call or e-mail. The functions of the Medical Executive Committee include, but are not necessarily limited to, the following:

- A. Reporting at each regular meeting of the Medical Staff on actions taken by the Medical Executive Committee since the last preceding Medical Staff meeting;
- B. Performing the duties and acting on behalf of the Medical Staff in the interim between regular meetings of the Medical Staff, in accordance with the authority delegated to the Medical Executive Committee by the Medical Staff, which authority may be delegated, revised or removed by an action of the Medical Staff taken in accordance with Article 4.5;

- C. Receiving and acting upon and sharing with the Board of Directors the reports and recommendations from Medical Staff committees, Departments, Sections, and assigned activity groups regarding at least the following: medication management oversight, infection prevention and control oversight, tissue review, utilization review, medical record review, and quality management.
- D. Developing and implementing policies of the Medical Staff that are not otherwise the responsibility of the individual committee;
- E. Recommending to the Board all matters relating to the structure of the Medical Staff, credentialing, appointments and reappointments, staff categorization, Department assignments, clinical privileges, and corrective action, except where such recommendation is a function of the Medical Staff as a whole;
- F. Recommending to the Board of Directors the organized medical staff structure;
- G. Fulfilling the Medical Staff's accountability to the Board for the quality of the overall care, treatment and services rendered to the patients in the Hospital;
- H. Preparing the annual Medical Staff budget and submitting it to the Medical Staff for information;
- I. Initiating and pursuing corrective action when warranted, in accordance with these Bylaws;
- J. Requesting evaluations of a Practitioner's privileges, when there is doubt as to the ability of an applicant or Medical Staff member's ability to perform the privileges requested;
- K. Taking all reasonable steps to insure professional ethical conduct and competent clinical performances on the part of all members of the Medical Staff, including the initiation and/or participation in medical corrective or review measures when warranted;
- L. Addressing issues which involve unusual occurrences and/or claims involving allegations of malpractice within the Hospital;
- M. Informing the Medical Staff of all accreditation programs and the accreditation status of the Hospital; and
- N. Organizing quality improvement activities of the Medical Staff as well as evaluation and review of such activities.

7.3 Credentials Committee. The Credentials Committee shall include the Chief of Staff and five or more members appointed by the Chief of Staff with approval of the Medical Executive Committee to serve as permanent members until they choose to resign or are removed by the majority vote of the Medical Executive Committee. The Vice President of Medical Affairs shall act as an ex-officio non-voting member of the Credentials Committee. The Chair or designee of the Professional Staff Credentials Committee shall act as an ex-officio full voting member on all issues before the Credentials Committee. The Medical

Executive Committee shall appoint one member of the Credentials Committee to serve as chair of the committee and shall give consideration for the position of chair to the immediate past Chief of Staff. The Medical Staff Credentials Committee and its subcommittee, the Professional Staff Credentials Committee, shall perform the functions ascribed to them in these Bylaws and in the Credentialing and Discipline Policy, and shall perform such other duties as may be established by the Medical Executive Committee.

7.4 Professional Staff Credentials Committee The Professional Staff Credentials Committee shall be chaired by a credentialed member of the Professional Staff at Maple Grove Hospital. In addition, a Nurse Clinician, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, Nurse Practitioner, Physician's Assistant, Clinical Leader, Patient Care Director, Practicing Physician (present member of the Medical Staff Credentials Committee), representative from Human Resources, other disciplines (depending on issues) shall serve as voting members on the Professional Staff Credentials Committee. The Vice President of Medical Affairs and the Executive Director of Patient Care Services shall act as ex-officio non-voting members. The Professional Staff Credentials Committee shall perform the functions ascribed to it in these Bylaws and in the Credentialing & Discipline Policy, and such other duties as may be established by the Medical Executive Committee.

7.5 Multispecialty Peer Review Committee: The Multispecialty Peer Review Committee ("MSPR Committee") shall be voluntary members representing each Department from the Medical Staff. The MSPR Committee shall perform the functions described in the Maple Grove Hospital Peer Review Policy, including: determination of whether appropriate care was provided with the hospital; determination of whether physician review or auditing, education, conversation, or other remedial measures are warranted; oversight of other peer review committees; reporting to the MEC on peer review actions; and reporting to MEC immediately in the case of egregious or emergent situations.

7.6 Nominating Committee. The Nominating Committee shall be comprised of the recent Chiefs of Staff who are active members of the Medical Staff and the current Chief of Staff. The Chief of Staff shall appoint one member of the Nominating Committee to serve as chair of the committee and shall give consideration for the position of chair to the immediate past Chief of Staff. The Nominating Committee shall present a slate of at least one candidate for each office of the Medical Staff which is to be filled by election.

7.7 Minutes. Each committee of the Medical Staff shall keep regular minutes or other records of its proceedings, which shall be maintained permanently.

ARTICLE 8 - POLICIES AND PROCEDURES; RULES AND REGULATIONS

8.1 Credentialing and Discipline Policy. Policies respecting Medical Staff membership and privileges for Practitioners and others credentialed by the Medical Staff shall be set out in the Credentialing and Discipline Policy adopted by the Medical Staff and the Board of Directors and attached hereto and by this reference made a part of these Bylaws.

8.2 Fair Hearing Policy. Policies establishing a fair hearing and review process and suspension rules for Practitioners subject to adjudicative decisions of the Medical Staff shall be set out in the Fair Hearing Policy adopted by the Medical Staff and the Board of Directors and attached hereto and by this reference made a part of these Bylaws.

8.3 Rules and Regulations. The Medical Executive Committee may promulgate such other rules and regulations as it determines necessary for the effective administration of the Medical Staff and to implement the general provisions or principles found in these Bylaws, Credentialing and Discipline Policy, and Fair Hearing Policy. Such rules and regulations must be consistent with the Medical Staff Bylaws. Only Medical Staff rules and regulations adopted by the Medical Executive Committee, Medical Staff and the Board of Directors are binding upon the Medical Staff and its members. The Medical Staff Rules and Regulations are attached hereto and by this reference made a part of these Bylaws. The Rules and Regulations may be amended by a majority vote of the Medical Executive Committee with the approval of the Medical Staff and the Board of Directors.

8.4 Other Policies and Procedures. The Medical Executive Committee may promulgate such other policies and procedures or amendments to such, as it determines necessary for the effective administration of the Medical Staff. Such policies and procedures must be consistent with the Medical Staff Bylaws.

8.5 Member Challenge. Any member of the Medical Staff may raise a challenge to any rule or policy established by the Medical Executive Committee. In the event a rule, regulation or policy is felt to be inappropriate, any member may submit a petition signed by 15% of the members of the Active Staff. The Medical Executive Committee shall review any such petition and shall have the authority to determine whether any change to a rule or policy is needed.

8.6 Action by Medical Staff. Regardless of whether the Medical Executive Committee is empowered to act on behalf of the Active Staff on a given issue, the Medical Staff as a whole may, through action taken in accordance with Article 9, adopt amendments to the Medical Staff Bylaws, rules and regulations, and policies and procedures and propose such amendments directly to the Board for the Board's approval.

8.7 Departmental Rules and Regulations. Each Department of the Medical Staff shall promulgate its own rules and regulations for the effective administration of such Department. All such rules and regulations must be approved by the Medical Executive Committee and the Board of Directors. The rules and regulations for each Department shall include, but are not limited to, provisions for the following:

- A. Statement of purpose and objectives;
- B. Qualifications for Physician, Dentist, or Podiatrist membership in the Department;
- C. Procedures and criteria for the granting and delineation of privileges;
- D. Organization of the Department, including selection of committee members, appointment of officers, and duties of the Chief;
- E. Meetings and meeting requirements;
- F. Specialized policies and protocols of the Department; and
- G. Qualifications and privileges of Professional Staff and Allied Health Professionals assigned to the Department.

ARTICLE 9 - ADOPTION, AMENDMENTS AND PERIODIC REVIEW

9.1 Adoption. These Bylaws together with the appended Credentialing and Discipline Policy, Fair Hearing Policy, and Rules and Regulations, or other policies adopted in accordance with Article 9, shall be adopted at any regular or special meeting of the Active Medical Staff by electronic ballot and shall become effective when approved by the Board of the Hospital.

9.2 Amendment. Amendments to these Bylaws of the Medical Staff must be approved by a two-thirds majority of the Medical Staff Executive Committee and then submitted to the Medical Staff by emailed ballot. Amendments shall pass unless 30% of mailed ballots that are received with 30 days reject the amendments. Amendments so made shall be effective when approved by the Board.

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in the committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within sixty (60) days of adoption by the Medical Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Medical Executive Committee. Immediately upon adoption, such amendments shall be sent to the Administrator and posted for review by the Medical Staff for fourteen (14) days.

9.3 Periodic Review. The Bylaws, and rules, regulations and policies and procedures promulgated in accordance with the Bylaws, shall be reviewed from time to time, at least every three years, by the Medical Executive Committee.

ARTICLE 10 - MISCELLANEOUS

10.1 Captions. The captions and section-headings used in these Bylaws are for organizational and informational purposes only. They shall not be deemed to modify or abrogate the content of any terms or provisions contained in these Bylaws.

10.2 Medical Staff Role in Exclusive Contracting. The Hospital may consult with the Medical Staff regarding issues of quality of care associated with the establishment of exclusive arrangements for physician and/or professional services, and the Medical Executive Committee may independently report on such issues to the Board of Directors as it deems appropriate, all in keeping with the responsibility of the Medical Staff to work to improve the quality of care in the Hospital.

10.3 Effect of the Bylaws. Upon adoption and approval as provided in these Bylaws in consideration of the mutual promises and agreements contained in these Bylaws, the Hospital and the Medical Staff, intending to be legally bound, agree that these Bylaws shall constitute part of the contractual relationship existing between the Hospital and the Medical Staff members, both individually and collectively.

10.4 Indemnification. The Hospital shall defend (or cover the costs incurred for the defense by), and cover settlements, judgments, and damages amounts on behalf of any member of the Medical Staff serving on or assisting any Hospital or Medical Staff

committee, or assisting in peer review or quality management activities involving care provided at the Hospital, involved in claims arising out of such activities, so long as the member acted in good faith.

Adopted by the Medical Staff of Maple Grove Hospital on:

Date:

Chief of Staff

Approved by the Board of Directors of Maple Grove

Hospital on:

Date:

President of the Board of Directors

65311238

ATTACHMENT A
CREDENTIALING AND DISCIPLINE POLICY
OF
MAPLE GROVE HOSPITAL

APPROVED:	
Medical Executive Committee	February 26, 2013
Medical Staff	April 6, 2013
Board of Directors	May 15, 2013
Medical Executive Committee	April 26, 2016
Medical Staff	July 21, 2016
Board of Directors	August 24, 2016
Medical Executive Committee	July 18, 2017
Medical Staff	July 20, 2017
Board of Directors	September 13, 2017
Medical Executive Committee	June 26, 2018
Medical Staff	August 19, 2018
Board of Directors	December 10, 2018

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PREAMBLE

This Credentialing and Discipline Policy is adopted by the Medical Staff of Maple Grove Hospital pursuant to the authority set forth in the Medical Staff Bylaws and is made a part of the Medical Staff Bylaws. Terms used in this Credentialing and Discipline Policy that are not otherwise defined herein shall have the meaning set forth in the Medical Staff Bylaws.

ARTICLE 1 – APPOINTMENT OF PHYSICIANS, DENTISTS AND PODIATRISTS

- 1.1 Procedure. The Board of Directors in conjunction with the Medical Staff shall determine what privileges are offered at the Hospital. If a Practitioner indicates an interest in joining the Medical Staff, the Medical Staff, through its delegated officers and committees, may first apply any rules setting forth the privileges currently offered at the Hospital to determine whether an application for membership and privileges will be offered, and what requests for privileges will be entertained.
- 1.2 Application. Application for Medical Staff membership shall be made on the prescribed form and shall state the qualifications and references of the applicant. The applicant shall also request specific clinical privileges at that time. Applicants who are members of hospital-owned clinics must also submit a separate request for clinic privileges. Applications for Medical Staff membership, privilege forms and criteria for granting of specific privileges will be developed by the Credentials Committee in consultation with the appropriate Departments or Sections, and such forms shall be subject to approval of the Medical Executive Committee and the Board of Directors. An application for membership and accompanying privileges must be accompanied by payment of the application fee, if any, imposed by the Medical Staff. By signing the application form, the applicant signifies his or her agreement to abide by and to be bound by the Bylaws of the Medical Staff, this Credentialing and Discipline Policy, the Fair Hearing Policy, and such policies and procedures and rules and regulations as may from time to time be promulgated hereunder. Completed applications for Medical Staff membership must be submitted electronically per Hospital policy, or mailed or delivered to:

Maple Grove Hospital
Medical Staff Office
9875 Hospital Drive
Maple Grove, MN 55369

A member who desires to modify his/her privileges must provide the Medical Staff Office with a written request for the requested privileges and documentation of appropriate training and experience. Such request will be considered in accordance with this Policy.

- 1.3 Burden of Producing Information; Contents of Application. In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications for the clinical privileges and Medical Staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall constitute an incomplete application that will not be acted upon by the Medical Staff Office.

As part of the application process, the Medical Staff may request, and the applicant agrees to provide all of the following information, any all additional documentation or information requested:

- (a) Documentation showing that the applicant has successfully completed the professional education, including medical, dental, or podiatric school, specialty training, and continuing education, and has the experience required by the Medical Staff for the privileges for which the applicant is applying;
- (b) Evidence of current competence including information from training programs or the primary site of the applicant's clinical activities;
- (c) Evidence of current board certification in any required specialty or specialties or active participation in the examination process (with achievement) of board certification within 5 years of completion of training;
- (d) A complete description of current and former Medical Staff membership and clinical privileges at other hospitals;
- (e) References from physicians, dentists, or podiatrists who are knowledgeable and can attest to the high standards with respect to the applicant's competence and personal and ethical character;
- (f) Evidence that the applicant maintains a current and unrestricted, unlimited, and unconditioned license to practice medicine, dentistry, or podiatry and the status thereof;
- (g) Complete malpractice claims experience, including details with respect to the applicant's involvement in any malpractice actions, including claims which may have been litigated, settled or submitted to arbitration;
- (h) Status of professional liability insurance, with limits and deductibles required by the Medical Staff (every member of the Medical Staff and every member of the Professional Staff who has practice privileges must maintain professional liability insurance written by a reputable insurance carrier with limits of not less than \$1,000,000 per occurrence, \$3,000,000 annual aggregate; however, the Medical Executive Committee may authorize a lesser amount in certain exceptional situations, and has the discretion to require higher limits when determined necessary in the Medical Executive Committee's sole discretion);
- (i) Evidence of current Federal Narcotics Registration Certificate (DEA) number, if applicable to applicant's practice;
- (j) Complete history and explanation of any hearing on, challenge to, inquiry about, voluntary or involuntary loss, suspension, curtailment or termination of professional licensure or registration or of DEA registration in any state or other jurisdiction; privileges or membership on the medical or professional staff of any hospital; or of status or privileges in any professional organization;

- (k) A complete history and explanation of any civil or administrative enforcement action, criminal proceeding, charge or indictment other than a minor traffic violation or other similar offense.
- (l) Evidence that the applicant is currently participating and in good standing in Minnesota Medical Assistance and Minnesota Health Care Programs and that the applicant has not opted out of such programs;
- (m) Evidence that the applicant has not been excluded from or barred from participation in any state or federal health care program;
- (n) Evidence that the applicant is eligible to order and refer items and services for Medicare patients;
- (o) A signed statement consenting to the inspection by the Hospital through its designated representatives or agents, of records and documents pertinent to licensure, specific training and experience, current competence and health status of the applicant;
- (p) A waiver and release signed by the applicant, waiving any and all claims arising out of or relating to the investigation by the Hospital, its Medical Staff or their agents, representatives or employees, of the applicant's professional qualifications, clinical competence, character, current mental or emotional stability, current physical condition, ethics or any other matter that might directly or indirectly have an effect on patient care, and releasing any and all persons, hospitals, professional corporations, professional trade organizations, or any other entity or individual, from civil liability for participating in or supplying information in response to questions or inquiries arising out of this investigation and the verification of the information contained in the applicant's application for Medical Staff membership and request for privileges;
- (q) A signed acknowledgment that, if admitted to the Medical Staff, the applicant agrees to read and be bound by the Medical Staff Bylaws, Rules and Regulations and Policies or joint policies of the Hospital and Medical Staff;
- (r) A signed acknowledgment that all of the information contained in the application is true and that any misstatement, refusal to answer questions, or the provision of false or misleading information constitutes grounds to stop processing the application and relinquishment of Medical Staff membership and privileges at the time of discovery in accordance with Section 1.5
- (s) A signed statement of accountability of Medical/Allied Health Staff;
- (t) Agreement to appear for an interview to clarify any questions on the application; and
- (u) A complete employment history; and
- (v) A request for privileges.

- 1.4 Applicant Review. Applicants may review their applications and information from publicly available documents at any time during the verification process and correct erroneous information.
- 1.5 Incomplete Application. An application will only be considered “complete” after all supporting documentation has been supplied, all information must have been verified from primary sources, and all concerns must have been resolved. An application may become “incomplete” at any time if the need arises for new, additional, or clarifying information. An incomplete application will be deemed to have been withdrawn if any requested information is not received within 30 days from the date of notice to provide the missing information. Withdrawal of an application for incompleteness will not entitle the applicant or member to a fair hearing or appeal.
- 1.6 Misstatements and Omissions:
- (a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Vice President of Medical Affairs and Chief of Staff will review the response and determine whether the application should be processed further.
 - (b) If appointment has been granted prior to the discovery of a misstatement or omission, the individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The individual will also have an opportunity to meet with the Credentials Committee, Vice President of Medical Affairs, or Chief of Staff to explain the misstatement or omission. The Vice President of Medical Staff and Chief of Staff will review the response and determine whether appointment and privileges should be deemed to be automatically relinquished pursuant to these Bylaws.
 - (c) No action taken pursuant to this Section 1.5 will entitle the applicant or member to a fair hearing or appeal.

1.6 Waiver of Threshold Eligibility Criteria:

- (a) Any applicant who does not satisfy one or more of the threshold eligibility criteria may request that it be waived. Waivers of threshold eligibility criteria will not be granted routinely. The applicant requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) A request for a waiver must be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant department chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant.

- (c) The Credentials Committee will forward its recommendation, including the basis for such, to the Medical Executive Committee. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (d) The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation regarding whether to grant or deny the request for a waiver. The recommendation of the Medical Executive Committee will be reviewed by and acted on by the Board.
- (e) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the individual who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.

1.7 Procedure. Each application for Medical Staff membership and request for privileges shall be reviewed in the following fashion:

- (a) Each application shall be examined for completeness and shall be compared to any rules established under Section 1.1 limiting the clinical privileges offered at the Hospital. If the application is not complete, it shall be returned to the applicant and shall not go forward. If the credentialing rules would prevent the grant of some or all of the requested privileges, the Chief of Staff of the Hospital or his or her designee, shall inform the applicant and the application may be deemed modified, to the extent possible, to conform to such credentialing rules. The modification of the application shall not entitle the applicant to a hearing under the Fair Hearing Policy.
- (b) Each completed application shall be reviewed by the Chief of the Department from which the applicant has requested privileges. The Department Chief shall promptly review the application and supporting information, and shall undertake such inquiry as it is necessary to prepare a report on the applicant and request for privileges. The Department Chief shall provide a report and appraisal of qualifications for the privileges requested to the Credentials Committee on each application and request for privileges at the next regular meeting of the Credentials Committee. If the Department Chief recommends that fewer than all requested privileges be granted, the Department Chief shall state his or her reasons to the Credentials Committee.
- (c) The Credentials Committee shall review the completed application and the Department Chief's report, along with supporting documentation, at its next regularly scheduled meeting. The supporting information shall include material provided by the National Practitioner Data Bank in response to a proper query by an authorized representative of the Hospital, and a review by Hospital staff of the OIG exclusion database to verify that the applicant is not excluded from federal healthcare programs. A completed application

shall be acted upon within 120 days of submission. The Credentials Committee may require that the applicant submit to an interview to clarify any questions in their application. The Credentials Committee shall report to the Medical Executive Committee with a recommendation on each application and request for privileges. If the Credentials Committee recommends that fewer than all requested privileges be granted, the Credentials Committee Chair shall state the reasons in its report to the Medical Executive Committee.

- (d) The Medical Executive Committee shall review the application and request for privileges and recommend to the Board of Directors that it approve the application, deny the application, or remand the matter to the Department Chief or to the Credentials Committee for further study and another recommendation. In making its decision, the Medical Executive Committee is not required to follow the recommendation of the Department Chief or Credentials Committee; provided, however, that if the Medical Executive Committee recommends that the Board modify or reject the recommendation or impose other conditions or limitations, then it shall prepare a written statement of the reasons for its action. The Medical Executive Committee may require that the applicant submit to an evaluation of his or her physical and/or mental health status by a physician or physicians acceptable to the Committee or Board, as a prerequisite to the further processing of his or her application for appointment. If the applicant fails to undergo such evaluation, the application shall be withdrawn for being incomplete. If the application is approved, the Medical Executive Committee shall also act on the request for privileges.
- (e) In the event that the Medical Executive Committee recommends that the application be denied or fewer privileges be granted than are requested by the applicant or imposes restrictions on requested privileges, the Medical Executive Committee shall state its reasons for the action and shall notify the applicant of his or her right to a hearing, as provided in the Fair Hearing Policy.
- (f) Applications that are recommended by the Medical Executive Committee shall be presented to the Board of Directors or a committee designated by the Board (as set forth in Section 1.8 below) for such purpose and consisting of at least two board members and such other persons as Board designates for final action.
- (g) If the Medical Executive Committee recommends that the application not be approved, or that fewer or more restricted privileges be granted than those requested by the applicant, and if it is determined that such action will require a report to the Board of Medical Practice or National Practitioner Data Bank, the Medical Executive Committee shall recommend language to make such a report. This language shall be included in the notice of the proposed action to the applicant.
- (h) All initial privileges are granted on a temporary basis. Review of all Medical Staff members with Provisional Staff status is performed after one

year (no more than two years) of Provisional Staff membership. Criteria to be used for review of Provisional Staff privileges and for granting of Active Staff or Courtesy Staff status are as follows: Upon completion of two years' service as Provisional members of the Medical Staff. Provisional Staff shall be evaluated by the Department Chief. The Department Chief shall make a report to the Medical Executive Committee regarding advancement from Provisional to Active or Courtesy Medical Staff status. If the Department Chief or the Medical Executive Committee determine that advancement is not appropriate for the Provisional member, the Provisional Staff member's Medical Staff membership shall terminate, and the Provisional Staff member shall notify the Provisional Staff member of their right to a hearing in accordance with the Fair Hearing Policy.

- 1.8 Expedited Board Approval. To expedite appointment, the Board may delegate the authority to render appointment and related credentialing decisions to a committee consisting of at least two Board members (the "Board Committee"). Following a positive recommendation from the Medical Executive Committee on an application, the Board Committee shall review and evaluate the qualifications and competence of the applicant and shall render its decision. A positive decision by the Board Committee results in the status or privileges requested. The full Board shall consider and, if appropriate, ratify all positive Board Committee decisions at its next regularly scheduled meeting. If the Board Committee's decision is adverse to an applicant, the matter is referred back to the Medical Executive Committee and shall follow the process provided in Section 1.8 above.

An applicant is usually ineligible for the expedited process if at the time of appointment, any of the following has occurred;

- (a) The applicant submits an incomplete application;
- (b) The Medical Executive Committee makes a final recommendation that is adverse or with limitation;
- (c) There is a current challenge or a previously successful challenge to licensure or registration;
- (d) The applicant has received an involuntary termination of medical staff membership at another organization;
- (e) The applicant has received an involuntary limitation, reduction, denial, or loss of clinical privileges; or
- (f) There has been a final judgment adverse to the applicant in a professional liability action unless previously reviewed and recommended by the Credentials Committee.

- 1.9 Criteria. All recommendations and decisions on applications for Medical Staff membership and requests for privileges must be based on the standards set forth in

the Medical Staff Bylaws, Policies and Rules and Regulations. A recommendation or decision may be based on information contained in the application, as well as any relevant information from any other source. In no event will applicant's status as a member of a protected category, including, without limitation, the applicant's age, sex, color, race, religion, creed, or national origin be considered in making decisions regarding Medical Staff membership or the grant or delineation of privileges.

1.10 Proctoring. Before granting unrestricted privileges to perform certain procedures, the Medical Staff may require the monitoring of a reasonable number of consecutive procedures. Monitoring may include direct observation of the performance of the procedure. The number of procedures to be observed will be defined in the criteria for granting the privilege requested.

- (a) The permission to perform procedures under a proctoring requirement is a limited and provisional grant of privileges. The requesting Practitioner is not eligible for the requested privileges on an unconditional basis until the proctoring requirement has been met and the remaining criteria for the grant of privileges, including Medical Executive Committee and Board of Directors approval, have been met.
- (b) Practitioners who are privileged to perform the requested procedure may be requested to assist in monitoring of the requesting Practitioner, including observation of performance. Practitioners on the Medical Staff are encouraged to assist in proctoring/monitoring but may decline for good cause. The proctor/monitor is an observer. The proctor/monitor will offer advice or assist in the performance of the procedure in cases where failure to do so would place the patient at risk.
- (c) If a Medical Staff member is not available to monitor performance, it will be the responsibility of the requesting Practitioner to obtain the services of a non-staff physician, dentist, Professional Staff member or podiatrist, acceptable to the Department, to perform the proctoring. The non-staff physician, podiatrist, Professional Staff member or dentist must also be approved by the Credentials Committee.
- (d) As a part of the proctoring process, the form which has been approved by the Medical Executive Committee will be used to document each proctoring episode. The proctor form will be given to the proctor by the requesting practitioner at the conclusion of the procedure and is due in the Medical Staff Office in a timely manner.
- (e) When appropriate, clinical performance criteria for the procedure may be developed to assist in the evaluation of competence.
- (f) The Practitioner seeking privileges shall obtain informed consent for the procedure and disclose the role of the proctor to the patient.

1.11 Board Action on Application. At each regular and annual meeting of the Board of Directors, or at such other time or times as are designated by the Board of Directors, the Board shall act on Medical Staff applications that have been forwarded

by the Medical Executive Committee. The Board shall by a majority vote either approve or deny each application or return it to the Medical Executive Committee for further information. Within ten (10) days of a decision by the Board to approve or deny an application, such decision will be communicated to the applicant. In the event that the Board denies an application, then the applicant shall immediately be notified of their right to a hearing under the Fair Hearing Policy.

1.12 Credentialing Verification. The Medical Staff may designate a credentials verification organization to act as a centralized clearing house for credential information for new applicants to the Medical Staff. By making application to the Medical Staff and by agreeing thereby to abide by these Bylaws, each applicant authorizes the use of the designated credentials verification organization in the credentialing process.

1.13 Staff Status. Each Member shall be assigned to a Medical Staff category as set forth in the Medical Staff Bylaws.

ARTICLE 2 – REAPPOINTMENT

2.1 Reappointment. Each member of the Medical Staff shall be reviewed for reappointment every two (2) years. In addition, if a Medical Staff member is on a leave of absence, the member's review for reappointment shall be delayed until the member returns from the leave of absence. The reappointment appraisal shall be performed by the Department Chief. In addition to the information and considerations which are considered at the time of application for appointment to the Medical Staff (see Section 1.3 of this Policy), the following factors that may be considered with respect to each member seeking reappointment include, but are not limited to:

- (a) Professional and clinical performance, including relevant technical skills, and the exercise of professional judgment;
- (b) Professional and clinical performance in light of data and other information generated as part of the Hospital's quality improvement and utilization review programs;
- (c) Current health status, including mental and emotional stability. The Medical Executive Committee may require that the staff member submit to an evaluation to their physical and/or mental health status by a physician or physicians acceptable to the Medical Executive Committee or Board. This requirement of an evaluation shall not invoke rights under the Fair Hearing Policy;
- (d) Current privileges and the basis for any requested modification;
- (e) Evidence of current licensure, primary source verification of current licensure, specialty certification, DEA number (if required);
- (f) Timely completion of medical records in compliance with the policies of the Hospital and the Medical Staff Bylaws, including the Rules and

Regulations;

- (g) Observance of and compliance with Hospital and Medical Staff policies and procedures which may directly or indirectly affect patient care;
- (h) Material provided by the National Practitioner Data Bank in response to a proper query by an authorized representative of Maple Grove Hospital;
- (i) Current participation and in good standing in Minnesota Medical Assistance and Minnesota Health Care Programs, including whether the Practitioner has opted out of such programs or been excluded from such programs, and eligibility to order and refer items or services for Medicare patients;
- (j) Conviction of a crime related to fraud and abuse or imposition of civil - - - - - monetary penalties related to fraud and abuse; and
- (k) Any other matter of consideration which may directly or indirectly affect patient care.

2.2 Active Staff. The level of clinical activity necessary to establish Active Staff status shall be determined as follows:

- (a) Members of specialties with a significant procedural component will have their total number of procedures reported. In general, to maintain or qualify for Active Staff status a minimum of 15 patient encounters must have been performed at Maple Grove Hospital during the prior year. The Medical Executive Committee, in consultation with the Departments, may establish minimum numbers of certain procedures for Active Staff status in specific specialties.
- (b) Members of specialties without a significant procedural component will have the total number of cases on which they were either the attending or consulting physician reported.
 - 1. In general, to maintain or qualify for Active Staff status, the Practitioner must have a minimum of 15 patient encounters at Maple Grove Hospital during the prior year except for those specialties which normally have minimal hospital activity. Active Staff status may be granted based upon the Practitioner's participation in Medical Staff committees or by providing care to a significant number of clinic-based patients and who routinely hospitalize their patients at Maple Grove Hospital if hospitalization is needed.
 - 2. The Medical Executive Committee, in consultation with the Departments, may establish minimum numbers of certain procedures for Active Staff status in specific specialties.
- (c) As provided in the Bylaws, Active Staff status may also be established through significant administrative activity. If a member does not meet the

above tests for significant clinical activity, the Chief of Staff may determine, at his or her discretion, to confer Active Staff status on a member based on such administrative activity.

2.3 Competence: Physicians, Dentists, and Podiatrists with Significant Activity at Maple Grove Hospital. At the time of reappointment, assessment of a Medical Staff member's current clinical competence will be based on objective criteria related to clinical activity and quality improvement records at the Hospital.

- (a) In general, "significant activity" at Maple Grove Hospital shall mean the performance of at least 15 cases (for specialties with a significant procedural component) or 15 patient encounters (for specialties without a significant procedural component).
- (b) The Medical Executive Committee in consultation with Departments may establish different minimum levels of clinical activity for each Department. Members who fulfill the criteria for minimum clinical activity shall be evaluated on the basis of compliance with quality improvement criteria for their specialty.
- (c) Members who fulfill the criteria for minimum clinical activity but whose records fail to indicate compliance with the quality improvement criteria for their specialty may have their clinical activity at the Hospital submitted to review under applicable policies.
- (d) Members of the Medical Staff who do not meet the minimum level of activity at Maple Grove Hospital will be evaluated according to the procedure outlined in Section 2.4.

2.4 Competence: Physicians, Dentists, and Podiatrists with Less Activity at Maple Grove Hospital. Members of the Medical Staff who have a level of hospital clinical activity at Maple Grove Hospital less than the minimum established as provided above shall be required to provide evidence of service at another hospital with a record of a satisfactory quality assurance record from their site of primary inpatient clinical activity. Notwithstanding such evidence of service, clinical competence for members of the Medical Staff who do not meet the minimum level of activity referenced in Section 2.2 at Maple Grove Hospital or at another hospital, so that examination of inpatient clinical activity at another hospital is unavailable, will be assessed based upon receipt of at least one peer reference from a physician, dentist, or podiatrist on the Medical Staff at Maple Grove Hospital who is knowledgeable with respect to the member's competence and ethical character.

2.5 Failure to Complete Reappointment Application. In the event that a Practitioner fails to complete and submit the reappointment application materials described in Section 2.1, this failure will be considered a request for resignation and the Practitioner's membership shall be deemed a voluntary resignation. If the Practitioner returns the reappointment application materials within 30 days of such resignation, membership shall be restored immediately upon completion and review of delinquent materials.

2.6 Credentialing Committee Review. If on review by the Department Chief it appears

that the member may meet less than all requirements for membership, the Department Chief may refer the reappointment materials to the Credentials Committee, which shall review the application and determine whether to refer the matter immediately to the Medical Executive Committee with a recommendation or to obtain additional information from the applicant before referring it to the Medical Executive Committee. The Credentials Committee may recommend the imposition of specific conditions related to behavior, health, or clinical issues. The Credentials Committee may also recommend that appointment be granted for less than two years in order to permit closer monitoring of the applicant's compliance with any condition.

- 2.7 Medical Executive Committee Review. The Medical Executive Committee shall review the application for reappointment and recommend to the Board of Directors that it approve the application or shall deny the application or remand the matter to the Department Chief or to the Credentials Committee for further study and another recommendation. In making its recommendation, the Medical Executive Committee will address whether the status of the member should be Active Staff, Courtesy or Professional Staff status.
- 2.8 Adverse Recommendation. In the event that the Medical Executive Committee recommends that the reappointment application not be accepted or approved or that fewer privileges be granted than are requested by the member, or imposes restriction on requested privileges, the reappointment application shall be dealt with as provided in Section 1.8(e) for a new applicant.
- 2.9 Circumstances for Special Review. In the event that at any time a material question arises as to the ability of a Practitioner to continue to perform the functions for which such Practitioner has been privileged by the Medical Staff, which question may, but need not be, the result of an interruption in the practice of such Practitioner by a significant medical problem, the Chief of Staff may request that the Practitioner provide some or all of the information described in Section 2.1 hereof, and other similar information necessary to demonstrate that the Practitioner is able to perform all the essential functions necessary for such privileges. Failure to provide such information when requested shall result in automatic relinquishment of clinical privileges.
- 2.10 Records. The appointment and reappointment process with respect to each applicant or member of the Medical Staff shall be documented, and complete and accurate records shall be maintained.
- 2.11 Report to Board of Medical Practice. In the event of an adverse determination on credentialing or reappointment pursuant to the procedure outlined in this Article 2, which requires a report to the Board of Medical Practice or the National Practitioner Data Bank, the Board of Directors or its designee shall report such action when it becomes final, after applicable hearing rights have been exhausted or waived, in the form prescribed by the Board of Directors consistent with the Medical Staff Bylaws, Rules and Regulations and other applicable policies.
- 2.12 Expedited Approval. To expedite reappointment or renewal or modification of clinical privileges, the Board may delegate the authority to render reappointment or renewal or modification of clinical privileges to a committee consisting of at least two Board members (the "Board Committee"). Following a positive

recommendation from the Medical Executive Committee on an application, the Board Committee shall review and evaluate the qualifications and competence of the Practitioner applying for reappointment or renewal or modification of clinical privileges and render its decision. A positive decision by the Board Committee results in the status or privileges requested. The full Board shall consider and, if appropriate, ratify all positive Board Committee decisions at its next regularly scheduled meeting. If the Board Committee's decision is adverse, the matter is referred back to the Medical Executive Committee as provided in Section 2.8 above.

An applicant is usually ineligible for the expedited process if since the time of reappointment, any of the following has occurred;

- (a) The applicant submits an incomplete application;
- (b) The Medical Executive Committee makes a final recommendation that is adverse or with limitation;
- (c) There is a current challenge or a previously successful challenge to licensure or registration;
- (d) The applicant has received an involuntary termination of medical staff membership at another organization;
- (e) The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; or
- (f) There has been a final judgment adverse to the applicant in a professional liability action unless previously reviewed and recommended by the Credentials Committee.

2.13 Board Action on Reappointment, Renewals or Modifications of Clinical Privileges. At each regular and annual meeting of the Board of Directors, or at such other time as are designated by the Board of Directors, the Board shall act on Medical Staff reappointments, renewal or modifications of clinical privileges that have been forwarded by the Medical Executive Committee. The Board shall by majority vote either approve or deny each reappointment, renewal or modification of clinical privileges or return it to the Medical Executive Committee for further information. Within 10 days of a decision by the Board to approve or deny a reappointment or renewal or modification of clinical privileges, such decision shall be communicated via email. In the event that the Board denies a reappointment, renewal or modification of clinical privileges, the applicant shall be immediately notified of their right to a hearing under the Medical Staff Fair Hearing Policy.

ARTICLE 3 – PRIVILEGES

3.1 Delineation of Privileges. Subject to any limitation contained in applicable policies and procedures and these Medical Staff Bylaws setting forth the privileges offered at the Hospital, and subject to the provisions of applicable agreements between the Hospital and Practitioners which are consistent with the Medical Staff Bylaws, clinical privileges shall be granted to each applicant (and/or renewed for each Practitioner)

commensurate with his or her training, experience, current competence, judgment, character, and current capabilities, in accordance with the criteria and procedures set out in this Article 3. Practitioners may only perform those procedures for which they have been granted privileges. No Practitioner may perform a service or procedure in the Hospital unless he or she is privileged to do so as provided herein. When a new procedure is developed, the appropriate Department shall recommend whether to delineate a clinical privilege for the procedure, if so, shall recommend appropriate criteria for granting such privilege.

3.2 Temporary Privileges. Temporary privileges may be granted by the CEO or designee, upon recommendation of a member of the Medical Executive Committee, the applicable clinical Department Chair or the Chief of Staff, for a period of up to 120 days, if the results of the National Practitioner Data Bank query and OIG Medicare/Medicaid exclusion database have been obtained and evaluated; and applicant for Medical Staff membership or privileges:

- A. has no current or previously successful challenge to licensure or registration;
- B. has not been subject to involuntary termination of medical staff membership at another organization;
- C. has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges;
- D. has not had any final judgments adverse to the applicant in a professional liability action unless previously reviewed and recommended by the Credentials Committee; and
- E. there is a complete application and verification of the items in 1.3.

3.3 Temporary Consulting Privileges. In order to allow members of the Medical Staff and Professional Staff to obtain appropriate consulting services for patients at North Memorial Health Hospital, temporary consulting privileges of one (1) week's duration may be granted by the President or designee on the recommendation of a member of the Medical Executive Committee, the applicable Department Chief, or the Chief of Staff to physicians, dentists, or podiatrists who are not members of the Medical Staff.

- A. In situations where a patient has been admitted to the Hospital, temporary consulting privileges will be granted if:
 - 1. the patient's condition requires the services of a physician, dentist, or podiatrist who has cared for the patient in the past or the patient's condition requires a physician, dentist, or podiatrist with expertise not provided by a member of North Memorial Health Hospital's Medical Staff; and
 - 2. if there is a request for the services of such physician, dentist, or podiatrist by a physician, dentist, or podiatrist on the Medical Staff at North Memorial Health Hospital.
- B. Temporary consulting privileges will not be granted until the Medical Staff Office has verified that the applicant is on the active staff in good standing at another

Minnesota hospital and has been granted the privilege requested as well as current license, insurance, DEA, board status and the individual's statements relative to:

1. physical, mental health or chemical dependency;
 2. past or pending professional liability cases and if coverage has ever been canceled;
 3. license or registration limitations, suspensions, investigations, voluntary relinquishments or revocations;
 4. refusal of membership on a hospital Medical Staff;
 5. denial, suspension, revocation of clinical privileges;
 6. denial, exclusion from certification or past action in any private, federal (i.e. Medicare, Medicaid) or state health insurance program;
 7. denial of membership or disciplinary action in any medical organization;
 8. felony or misdemeanor convictions.
- C. When the Medical Staff is not available to confirm the above, such as weekends or nights, these privileges may be granted for a period of up to 72 hours by the President or in his/her absence another administrative designee on the recommendation of the Chief of Staff, the Past Chief of Staff, or in their absence, the Vice President Medical Affairs. The Chief of Staff, Past Chief of Staff or the Vice President Medical Affairs shall contact the Department Chief, Chief of Staff or Vice President Medical Affairs at the individual's primary hospital to verify that he or she is in good standing and has privileges to perform the requested procedure. If such documentation is unavailable, the application will be denied.
- D. Physicians, dentists, and podiatrists granted temporary consulting privileges will be asked to wear an I.D. badge for identification purposes.
- E. Once granted, these privileges may be renewed for two (2) additional seven-day periods if requested by the North Memorial Medical Staff member attending the patient.
- F. Physicians, dentists, or podiatrists who are granted these privileges more than two (2) times within a calendar year will be required to apply for Medical Staff membership. Physicians, dentists, or podiatrists who fail to do so will not be granted privileges.
- G. Denial of temporary consulting privileges is a non-appealable decision.

3.4 Scope of Practice for Residents. Resident practitioners shall be governed by this Section. Interns or residents participating in a program that either 1) is not ACGME approved, or 2) does not have a formal agreement with the Hospital, must receive specific permission from the Chief Executive Officer before providing care in the Hospital. They must provide care in accordance with the Intern and Resident

Scope of Practice adopted by the Medical Executive Committee, other requirements set by the Chief Executive Officer and under the supervision of a member of the Medical Staff holding an appropriate appointment with the training program and holding clinical privileges reflective of the patient care responsibilities given the residents that they are supervising.

Resident practitioners who are members of an approved residency program affiliated with Maple Grove Hospital shall be governed by the following:

- (a) They must be members in good standing of the residency program in question;
- (b) They must demonstrate the qualifications, ability and judgment to exercise resident practitioners scope of practice;
- (c) The scope of practice shall extend to the care of patients whom the resident has admitted and for whom the residency program supervisor is attending practitioner, as well as to the writing of patient care orders for the care of other patients;
- (d) The scope of practice shall extend to services performed by residents while directly participating in the approved residency program. In addition, the scope of practice shall extend to services performed outside the approved residency program under the supervision of a member of the Medical Staff;
- (e) The residents shall at all times be subject to the quality improvement activities conducted by the Hospital, and any resident's scope of practice may be limited, modified, suspended or terminated by the Medical Executive Committee, based upon data and findings generated as part of said quality improvement activities, or for any other justified reason contemplated under these Bylaws; and
- (f) Residents shall at all times be supervised in accordance with Medical Staff Policy and Procedure on Residents.
- (g) Residents may serve as non-voting members on Medical Staff committees.

3.5 Emergency Privileges. In an emergency, any Medical Staff member with clinical privileges is "temporarily privileged" to provide any type of patient care necessary as a lifesaving measure or to prevent serious harm regardless of his or her current clinical privileges if the care provided is within the scope of the individual's license. Properly supervised residents may provide such emergency care.

3.6 Emergency Privileges for Disasters. Privileges may be granted upon recommendation of incident commander and the individual filling the medical staff role in the HICS structure to practitioners on an emergency basis in times of local, regional or national disasters where additional practitioner help is needed (refer to Disaster Policy).

3.7 Scope of Practice for Moonlighting Residents

- a) For purposes of this Section 3.5 a “moonlighting” resident is a resident who is (1) licensed under Minnesota law as a physician and (2) is performing services at the Hospital within the scope but outside the auspices of his or her approved GME program;
- b) Residents must be credentialed through the Medical Staff process as required by the Medical Executive Committee;
- c) Residents must be members in good standing in an ACGME-approved residency program;
- d) Residents must demonstrate the qualifications, ability, and judgment to exercise resident physician, dentist, or podiatrist scope of practice;
- e) The Medical Program Director of the residency program in question shall certify to the Medical Executive Committee and/or Chief Executive Officer that the above requirements have been met;
- f) The scope of practice for moonlighting residents shall extend to services performed under the general supervision of a member of the Medical Staff holding clinical privileges reflective of the patient care responsibilities given the resident(s) that he or she is supervising; and
- g) Residents shall at all times be subject to the quality improvement activities conducted by the Medical Center, and any resident’s scope of practice may be limited, modified, suspended, or terminated by the Medical Executive Committee, based upon data and findings generated as part of said quality improvement activities, or for any other justified reason contemplated under the Bylaws, Rules and Regulations of the Medical Staff.

ARTICLE 4 – PROFESSIONAL STAFF

4.1. General: Professional Staff members are individuals qualified by academic and clinical training to practice in advanced or specialty practice roles as specified further in Section 4.2. Professional Staff members are permitted to provide patient care services within the scope of their individual licenses and applicable law and/or pursuant to a collaborative agreement with a member of the Medical Staff (see section 4.6). Professional Staff members may provide services as permitted in the Medical Staff Bylaws and Policies, Medical Staff rules and regulations, Hospital policy, and department specific Rules and Regulations. Professional Staff members may serve as voting members on any and all Medical Staff committees, but may not vote on matters submitted to the Medical Staff. Professional Staff members may not hold Medical Staff Office.

4.2 Categories: Professional Staff are grouped into 2 categories:

- A. Advanced Practice Providers (APP), which include:
 - 1. Physician Assistants (PA)

2. Nurse Practitioners (NP)
 3. Certified Registered Nurse Anesthetists (CRNA)
 4. Clinical Nurse Specialists (CNS)
 5. Certified Nurse Midwives (CNM)
- B. Mental Health Providers (MHP) which includes;
1. Licensed Independent Clinic Social Workers (LICSW)
 2. Licensed Professional Counselors (LPCC)
 3. Licensed Psychologists (LP).

4.3 Eligibility:

A. All applicants shall be bound by the consent and waiver set forth on the application and the statement of immunity and obligations set forth in the Medical Staff Bylaws and Policies.

B. All applicants must submit any requested documentation of his or her background, relevant training and experience, current clinical competence, adherence to the ethics of his or her profession, good reputation, ability to work with others and, if requested, health status, with sufficient adequacy to meet the requirements of the Medical Staff and the Board.

C. To be eligible to apply for initial appointment or reappointment to the Professional Staff, an applicant must meet all of the following threshold eligibility criteria:

1. Be a graduate of a recognized and accredited school or have completed a requisite course of study and training in his or her discipline;
2. Maintain board certification in their primary area of practice at the Hospital and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements (recertification will be assessed at reappointment);
3. have a current, unrestricted license to practice in Minnesota that is not subject to any restrictions, probationary terms, or conditions, including a decree of censure not generally applicable to all licensees, and have not had, a license to practice in any jurisdiction revoked, restricted, conditioned, or suspended by any state licensing agency;
4. have a current, unrestricted DEA registration and state controlled substance license, if applicable;
5. have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

6. have not been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
7. be a participating provider who is enrolled in and in good standing with (Medical Assistance and Minnesota Health Care Programs);
8. be permitted to order and refer items and services for Medicare patients;
9. have not been disqualified by the Minnesota Department of Health or Minnesota Department of Human Services from direct contract with persons receiving services at licensed facilities without supervision;
10. have had no adverse professional review actions regarding appointment or clinical privileges by any healthcare facility;
11. have not had professional staff appointment or clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;
12. have not resigned professional staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including this Hospital;
13. not currently be under any criminal investigation or indictment and have not been required to pay a civil money penalty for governmental fraud or program abuse or been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse;
14. not currently be under investigation by any federal or state agency or healthcare facility for reasons related to clinical competence or professional conduct;
15. document compliance with all applicable training and educational protocols that may be adopted by the Medical Staff or Hospital, including, but not limited to, those involving electronic medical records or patient safety;
16. meet any current or future eligibility requirements that are applicable to the appointment and/or clinical privileges being sought or granted;
17. if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract;

18. demonstrate clinical activity in their primary area of practice during the last two years;
19. document compliance with any applicable health screening requirements (e.g., health examinations, TB testing, mandatory flu vaccines, and infectious agent exposures);
20. physically and mentally able to provide quality patient care under the privileges which may be granted by the Hospital;
21. Complete all privileging forms required by the Medical Staff and have in place a written agreement with a collaborating or supervising physician, if such written agreement is required by applicable Department rules and regulations, Hospital policy, and/or state law; and
22. Submit any requested documentation of his or her background relevant training and experience, current clinical competence, adherence to the ethics of his or her profession, good reputation, ability to work with others and, if requested, health status, with sufficient adequacy to meet the requirements of the Medical Staff and the Board of Directors.

D. Failure to meet one or more of the threshold eligibility criteria in Section 4.3(C) above does not constitute a denial of membership and/or clinical privileges and does not entitle the applicant to a fair hearing under the Fair Hearing Policy. An applicant who does not meet one or more of the threshold criteria above may apply to the Medical Executive Committee for a waiver of one or more threshold criteria requirements. An applicant is not entitled to a waiver, and failure to grant a waiver does not give rise to the right to a hearing under the Fair Hearing Policy. All waivers will be reviewed at reappointment.

E. After a practitioner has been appointed to the Professional Staff, if at any time they no longer meet any of these threshold criteria, then the practitioner's membership and privileges shall be automatically relinquished.

4.4 Basic Obligations of Individual Staff Membership. Each member of the Professional Staff, regardless of assigned staff category, and each Practitioner exercising temporary privileges under these Bylaws, shall:

- A. provide patients with continuous care at the generally recognized professional level of quality and efficiency;
- B. abide by the Medical Staff Bylaws, Policies and Procedures, Rules and Regulations and by all other standards, policies, and rules of the Hospital;
- C. work effectively and appropriately with other Medical/Professional Staff members and with Hospital personnel, administration, and others, and behave in a manner that does not adversely affect patient care in the Hospital;

- D. agree to be subject to review as part of the Hospital's quality assessment and improvement programs and to comply with the Hospital's Corporate Bylaws and any policies or rules adopted by the Hospital, Medical Staff, or the Board;
- E. prepare and complete in a timely fashion documentation of services provided in Hospital in accordance with Hospital's requirements;
- F. be in compliance and provide documentation demonstrating such compliance, with the continuing education requirements of the Minnesota State Board or other licensing agency as applicable;
- G. notify the Medical Staff Office of any adverse action by any licensing board, peer review organization, third party payor, clinic, hospital, medical staff, or any health-related agency or organization within 5 days of the adverse action, including:
 - 1. the reduction, restriction, suspension, revocation, denial, non-renewal, or voluntary surrender of his/her professional license by any state;
 - 2. the reduction, restriction, suspension, revocation, denial, non-renewal, or voluntary surrender of medical staff membership or clinical privileges at any hospital or other health care institution;
 - 3. the commencement of a formal investigation, the filing of charges, or final action by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or any state;
 - 4. the filing of any suit against the Practitioner alleging professional liability; or
 - 5. any final judgements or settlements regarding any litigation or claims.
- H. have and maintain professional liability insurance in adequate amounts, as established by the Hospital, to cover claims and suits arising from alleged professional negligence in the Hospital;
 - 1. promptly notify the Medical Staff Office of any change in practice address, phone numbers or pager number;
 - 2. work with residents as needed for high quality patient care and graduate medical education;
 - 3. maintain the confidentiality of patient clinical information and of the minutes, records, and work product of Medical/Professional Staff committees engaged in the peer review process. This provision shall not prohibit mandatory disclosures under state or federal law, nor disclosures made for a permitted purpose of a peer review organization, in accordance with applicable law;
 - 4. refrain from performing any procedures, assuming any patient care responsibilities, or applying for or exercising any specific privileges for

which such individual is not licensed, currently trained, and currently qualified;

5. participate in a cooperative manner in the Professional Staff's efforts to review and improve the quality, efficiency and appropriateness of care provided by Professional Staff members, including full participation in the review of patient encounters with the Professional Staff members peer review process. Participation includes submission of review forms in a timely manner.
6. notify the Medical Staff Office of any arrest or charged with any offense including, but not limited to, any substance-abuse related issue (including driving under the influence, impaired driving, or driving while intoxicated), as well arrests for domestic abuse, child abuse or maltreatment, or maltreatment of a vulnerable adult. Reports are required within five days of such an arrest or within 5 days of being charged with such offense. Professional Staff shall be required to meet with the Vice President of Medical Affairs after such report.
7. obtain, upon Hospital's request, an evaluation and/or testing to determine fitness for practice, which may include diagnostic testing (such as blood and/or urine test), or a complete physical, mental, and/or behavioral evaluation.
8. abide by the principles of ethics established by the profession, by law and applicable hospital policies.

4.5 Application Procedure for Professional Staff: Each applicant for Professional Staff membership shall submit a delineation of privileges.

A. Application Procedure for Professional Staff. Except as provided in the Bylaws, associated policies, and Hospital policy, complete applications shall be processed in the same manner as an application for appointment and privileges and renewal of appointments for Professional Staff membership.

B. Term of Appointment. All new Professional Staff shall be appointed provisionally for a period of not less than one and no more than two years during which time their clinical and professional work shall be evaluated.

C. Re-Appointment. Professional Staff shall be reviewed for renewal of his or her privileges every two years according to the procedures set forth in Article 2.

D. Once an application is complete and all required information is received and verified, the application shall be reviewed at the next regular meeting of the Professional Staff Credentials Committee.

E. The Professional Staff Credentials Committee shall evaluate the applicant's credentials and qualifications.

F. When appropriate, input concerning the credentials of the applicant and the requested delineation of privileges will be sought from other individuals, including departments in which the applicant is seeking to practice, and other

committees.

G. The Professional Staff Credentials Committee shall refer the application and its recommendation on the request for appointment and privileges to the Department Chief, who shall make a recommendation and send the report to the Medical Staff Credentials Committee. The Medical Staff Credentials Committee shall make a recommendation to the Medical Executive Committee. The Medical Executive Committee will approve or deny the request, or refer the application back to the Professional Staff Credentials Committee for additional information. The decision of the Medical Executive Committee will be reviewed by the Board, which shall be the final authority.

4.6 Collaboration: Each APP assigned to a hospital-based department shall function in a collaborative role with a credentialed Medical Staff member. An APP who is required by state law or department rules and regulations to have collaboration or delegation agreement will provide a copy of such agreement to the Medical Staff. If the privileges of the collaborating or supervising Medical Staff member under such collaboration or delegation agreement are terminated, administratively suspended, or otherwise affected adversely, the privileges of any Professional Staff members with whom the Medical Staff member has a collaboration or delegation arrangement as required by Department rules and regulations or policy or state law are suspended unless and until a new collaboration or delegation agreement with another Medical Staff member is in place.

4.7 Performance Evaluation of Professional Staff: The Medical Staff is responsible to the Board for the medical quality of care. The quality of care provided by a Professional Staff member shall be reviewed on an ongoing basis through the established peer review, Ongoing Professional Practice Evaluation (OPPE) and quality improvement programs of the Hospital. Concerns regarding the quality of care provided by a Professional Staff member identified as part of ongoing quality effort shall be referred to the appropriate committee.

4.8 Professional Staff: Suspension, Modification or Termination of Privileges:

B. Each Professional Staff member is subject to inquiry, discipline and corrective action, and his or her privileges may be suspended, modified or terminated, as provided in Article 6 of this Policy, or as otherwise specifically provided in the Bylaws, or the Policies, Rules and Regulations of the Medical Staff, as amended from time to time.

C. An investigation into activities and professional conduct of the Professional Staff members are subject to this Section and may be requested whenever questions arise concerning the grounds for action delineated in Section 6.1. Any person may bring a concern regarding a member of the Professional staff to the attention to the Hospital Quality Department, the Professional Staff Credentials Committee, the Multispecialty Peer Review Committee, the Medical Executive Committee, or the Vice President of Medical Affairs. The Medical Executive Committee will determine whether to conduct an inquiry, whether as a full committee or by appointing an investigative subcommittee, and shall engage a representative of the Professional Staff Credentials Committee during such inquiry.

- D. It is the responsibility of every Professional Staff member to cooperate with any investigation. The refusal or failure to provide necessary information shall be independent grounds for suspension or termination or delineation of privileges without the right to a Fair Hearing.
- E. Prior to final action, the Professional Staff member under investigation shall have the opportunity for an interview with the Professional Staff Credentials Committee.
- F. The results of an inquiry or investigation of a Professional Staff member will be communicated, and recommendation will be made to the Medical Executive Committee. The Professional Staff member shall have the opportunity to request a Fair Hearing as provided in the Fair Hearing Policy.
- G. A decision to suspend, modify or terminate the appointment and/or privileges of an Professional Staff member who is an employee of North Memorial Health shall be referred to Human Resources/Provider Services for evaluation of its effect on that Professional Staff members employment status. Action taken pursuant to this Section shall not in any way effect the employment options otherwise available through Human Resources/Provider Services.

4.9 Professional Staff Privileges and Delineation of Privileges: The granting of privileges and the assignment of professional activities to Professional Staff shall at all times be in writing and shall be subject to any conditions or limitations stated therein. In addition to the foregoing, the following requirements shall apply:

As provided in the Medical Staff Rules and Regulations, Certified Nurse Midwives have independent hospital admitting privileges for obstetric patients provided they have a consultative and surgical back-up agreements in place with two Obstetrician/Gynecologists who are members of the Medical Staff. No other Professional Staff members are allowed to independently admit patients to the Hospital.

- H. The privileges and appointments of the Professional Staff member shall be subject to the same criteria and standards of review, biennial review and privilege delineation as outlined in Articles 1, 2, and 3 of this Policy.
- I. A Professional Staff member may make independent daily visits to patients as permitted or outlined in the Medical Staff Rules & Regulations and applicable Hospital Policy and outlined by their delineation of privileges.
- J. A Professional Staff member shall document care according to applicable Medical Staff, Hospital, and Department Documentation Policies.

4.10 Professional Staff Credentials Committee: The Professional Staff Credentials Committee oversees the activities of Professional and Allied Health Staff as described and ascribed to in the Medical Staff Bylaws, and such other duties as may be established by the Medical Executive Committee. The committee shall meet as

needed. The committee reports to the Medical Executive Committee.

- 4.11 Dues: Dues or fees, if any, for Professional Staff with privileges at North Memorial Health shall be as established from time to time by the Medical Executive Committee. Failure of Professional Staff member to pay dues within 90 days of the designated date of payment shall constitute grounds for automatic relinquishment of privileges.
- 4.12 Professional Ethics: The professional conduct of each Professional Staff member shall be governed both by the principles of ethics established by the profession, by law and applicable hospital policies.

ARTICLE 5 – ALLIED HEALTH STAFF

5.1 General: Allied Health Staff (AHS) are individuals qualified by academic and clinical training to practice in a medical support role providing medical services under the supervision of a member of the Medical Staff. AHS may provide services only as permitted in the Medical Staff Bylaws and associated Policies and applicable Hospital policies and only in keeping with all applicable Rules and Regulations of the departments to which they are assigned and approved by the Medical Executive Committee. AHS are not members of the Medical Staff.

5.2 Categories: This category includes, but is not necessarily limited to, the practitioners listed below:

- (a) Registered Nurses w/delineated protocols
- (b) Surgical Technicians
- (c) First Assistants
- (d) Orthotists
- (e) Prosthetists
- (f) Audiologists

5.3 Eligibility:

- A. All applicants shall be bound by the consent and waiver set forth on the application and the statement of immunity and obligations set forth in the Medical Staff Bylaws and Policies.
- B. All applicants must submit any requested documentation of his or her background, relevant training and experience, current clinical competence, adherence to the ethics of his or her profession, good reputation, ability to work with others and, if requested, health status, with sufficient adequacy to meet the requirements of the Medical Staff and the Board.
- C. To be eligible to apply for initial appointment or reappointment to the Allied Health Staff, an applicant must meet all of the following threshold eligibility criteria:

- (a) Be a graduate of a recognized and accredited school or have completed a requisite course of study and training in his or her discipline;
- (b) Have a current, unrestricted license and/or certification to practice in the given discipline in the State of Minnesota that is not subject to any restrictions, probationary terms, or conditions, including a decree of censure not generally applicable to all licensees, and have not had a license to practice in any jurisdiction revoked, restricted, conditioned, or suspended by any state licensing agency;
- (c) Be sponsored/supervised by a member of the Medical Staff;
- (d) Be physically and mentally able to provide quality medical care under the appointment approved by the Board;
- (e) Have current, valid professional liability insurance in a form and in amounts satisfactory to the Hospital;
- (f) Demonstrated clinical activity in their primary area of practice during the last two years;
- (g) Have not been, and are not currently, excluded or precluded from participation in Medicare or Medicaid, or other federal or state governmental health care program
- (h) Have not been disqualified by the Minnesota Department of Health to Minnesota Department of Human Services from direct contact with persons receiving services at licensed facilities without supervision;
- (i) Be permitted to order and refer items and services for Medicare patients;
- (j) Have had no adverse professional review actions regarding appointment or clinical privileges by any healthcare facility;
- (k) Have not had medical staff or allied health staff appointment or clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;
- (l) Have not resigned medical staff or allied health staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including this Hospital
- (m) Be willing to submit any requested documentation of his or her background relevant training and experience, current clinical competence, adherence to the ethics of his or her profession, good reputation, ability to work with others and, if requested, health status, with sufficient adequacy to meet the requirements of the Medical Staff and the Board of Directors;
- (n) Not currently be under any criminal investigation or indictment and have not been required to pay a civil money penalty for governmental fraud or program abuse or

been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse;

- (o) Not currently be under investigation by any federal or state agency or healthcare facility for reasons related to clinical competence or professional conduct;
 - (p) Document compliance with all applicable training and educational protocols that may be adopted by the Medical Staff or Hospital, including but not limited to those involving electronic medical records or patient safety;
 - (q) Meet any current or future eligibility requirements that are applicable to the appointment being sought or granted;
 - (r) Document compliance with any applicable health screening requirements (e.g., health examinations, TB testing, mandatory flu vaccines, and infectious agent exposures);
- D. Failure to meet one or more of the threshold eligibility criteria in Section 5.3(C) above does not constitute a denial of membership and does not entitle the applicant to a fair hearing under the Fair Hearing Policy.
- E. After a practitioner has been appointed to the Allied Health Staff, if at any time they no longer meet any of these threshold criteria, then the AHS's membership shall be automatically relinquished.

5.4 Basic obligations of Allied Health Staff appointment: Each member of the AHS shall;

- (a) Be in compliance with the continuing education requirements of the discipline's Minnesota licensing board or other licensing agency as may be applicable;
- (b) Abide by the Medical Staff Bylaws, Policies and Procedures, Rules and Regulations and by all other standards, policies and rules of the Hospital;
- (c) Work effectively and appropriately with other Medical and Professional Staff members and with Hospital personnel, administration and others, and behave in a manner that does not adversely affect patient care in the Hospital;
- (d) Agree to be subject to review as part of the Hospital's quality assessment and improvement programs and to comply with the Hospital's Corporate Bylaws and any policies or rules adopted by the Hospital, Medical Staff, or the Board;
- (e) Prepare and complete in a timely fashion documentation of services provided in Hospital in accordance with Hospital's requirements;
- (f) Have and maintain professional liability insurance in amounts satisfactory to the Hospital to cover claims and suits arising from alleged professional negligence in the Hospital;

- (g) Promptly notify the Medical Staff Office of any change in practice address, phone numbers or pager number;
- (h) Notify the Medical Staff Office of any arrest or charged with any offense including, but not limited to, any substance-abuse related issue (including driving under the influence, impaired driving, or driving while intoxicated), as well arrests for domestic abuse, child abuse or maltreatment, or maltreatment of a vulnerable adult. Reports are required within five days of such an arrest or within 5 days of being charged with such offense;
- (i) Obtain, upon Hospital's request, an evaluation and/or testing to determine fitness for practice, which may include diagnostic testing (such as blood and/or urine test), or a complete physical, mental, and/or behavioral evaluation;
- (j) Refrain from performing any procedures or assuming any patient care responsibilities for which such individual is not licensed, currently trained, and currently qualified;
- (k) Notify the Medical Staff Office of any adverse action by any licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization within 5 days of the adverse action, including but not limited to:
 - i. the reduction, restriction, suspension, revocation, denial, non-renewal, or voluntary surrender of his/her professional license by any state;
 - ii. the reduction, restriction, suspension, revocation, denial, non-renewal, or voluntary surrender of Allied Health Staff appointment at any hospital or other health care institution;
 - iii. the commencement of a formal investigation, the filing of charges, or final action by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or any state;
 - iv. the filing of any suit against the Practitioner alleging professional liability; or
 - v. any final judgements or settlements regarding any litigation or claims.

5.5 Application: Each applicant for AHS appointment (except those excluded by virtue of Section 5.8 below) shall submit an application containing the information required of AHS in a manner consistent with Section 1.3 of this Policy.

5.6 Application Procedure for Allied Health Staff:

- (a) Application Procedure for Allied Health Staff. Except as provided in the Bylaws, associated policies, and Hospital policy, complete applications for Allied Health Staff shall be processed in the same manner as an application for and renewals of appointments for Medical Staff membership.

- (b) Term of Appointment. All new Allied Health Staff shall be appointed for a period of not less than one and no more than two years.
- (c) Re-Appointment. Each Allied Health Staff shall be reviewed for renewal of his or her appointment every two years according to the procedures set forth in Article 2.
- (d) Once an application is complete and all required information is received and verified, the application shall be reviewed at the next regular meeting of the Professional Staff Credentials Committee.
- (e) The Professional Staff Credentials Committee shall evaluate the applicant's credentials and qualifications.
- (f) When appropriate, input concerning the credentials of the applicant or the requested protocol, if applicable, will be sought from individuals or committees within departments in which the applicant seeks to provide services.
- (g) The Professional Staff Credentials Committee shall refer the application and its recommendation on the request for appointment to the Department Chief, who shall make a recommendation and send the report to the Medical Staff Credentials Committee. The Medical Staff Credentials Committee shall make a recommendation to the Medical Executive Committee. The Medical Executive Committee will approve or deny the request, or refer the application back to the Professional Staff Credentials Committee for additional information. The decision of the Medical Executive Committee will be reviewed by the Board, which shall be the final authority.

5.7 Supervision of Allied Health Staff: Each AHS shall be supervised by a Medical Staff member of a Department that represents the practice/service requested by the Allied Health Staff. The AHS staff must identify the supervising Medical Staff member.

Sponsoring/supervising Medical Staff members must:

- (a) Co-sign the delineated protocols;
- (b) Employed or be closely associated with the AHS in a supervisory relationship;
- (c) Be at all times responsible for overseeing the duties of the AHS;
- (d) If the supervising Medical Staff member's membership or privileges are terminated, suspended, or otherwise affected adversely, the practice of all AHS supervised by such individual shall also be suspended unless and until supervision is assumed by another qualified member of the Medical Staff.

5.8 Exclusions for Employed Allied Health Staff: Allied Health Staff who are employed directly by North Memorial Health or Maple Grove Hospital ("Employed Supervised Practitioners") to provide patient care shall be excluded

from the process set forth in this Policy and subject to the policies and procedures of North Memorial Health or Maple Grove Hospital, with the exception of RNs with delineated protocols.

- 5.9 Performance Evaluation of AHS: The Medical Staff is responsible to the Board of Directors/Trustees for the medical quality of care. The supervising Medical Staff member shall be responsible for the quality of care provided by the AHS. Concerns regarding the quality of care provided by the AHS identified as part of ongoing quality effort shall be referred to the supervising Medical Staff member.
- 5.10 Allied Health Staff: Suspension, Modification or Termination of Practice:
- (a) AHS will practice in accordance with the policies and procedures and rules and regulations of the Hospital, the Medical Staff, and the applicable Departments.
 - (b) Allied Health Staff may be investigated by the Hospital or the Medical Staff, including with the cooperation of the supervising Medical Staff member, and such investigation may result in suspension, limitation, or termination of the Allied Health Staff's appointment.
 - (c) It is the responsibility of every AHS to cooperate with an investigation. The refusal or failure to provide necessary information shall be independent grounds for suspension, limitation, or termination of appointment to the Allied Health Staff.
 - (d) Prior to final action, the AHS under investigation shall have the opportunity for an interview with the Professional Staff Credentials Committee.
 - (e) The Professional Staff Credentials Committee may recommend to the Medical Executive Committee the suspension, limitation, or termination of the Allied Health Staff's membership, and such recommendation will be reviewed by the Medical Executive Committee, with final authority resting with the Board. The Medical Executive Committee or its designee may independently recommend the suspension, limitation, or termination of the Allied Health Staff's membership, with final approval by the Board.
 - (f) Under no circumstance does the investigation of an Allied Health Staff or the suspension, limitation, or termination of Allied Health Staff's membership or activities within the Hospital give rise to the right to a Fair Hearing under the Bylaws.
- 5.11 Allied Health Staff Practice: The practice and the assignment of supervised activities to Allied Health Staff shall at all times be in writing and reviewed bi-annually and subject to any conditions or limitations as set forth by Minnesota State Licensing Board stated therein. In addition to the foregoing, the following requirements shall apply:
- (a) The practice and appointments of Allied Health Staff shall be subject to the same criteria and standards of review and privilege delineation as outlined in Articles 1, 2, and 3 of this policy.

- (b) Each Allied Health Staff's practice is determined by the specific role's scope of practice and the policies and regulations of the Department or Section to which he or she is assigned.
 - (c) Allied Health Staff shall document the care they render by means of records, reports, and progress notes entered in to patients' hospital charts.
 - (d) Allied Health Staff with delineated protocols shall practice within their protocols and keeping with their scope of practice as defined by state law.
 - (e) RN delineated protocols will be reviewed by Professional Staff Credentials Committee every 2 years.
- 5.12 Dues: Dues or fee if any, for AHS with appointment at North Memorial Health shall be established from time to time by the Medical Executive Committee. Failure of any AHS to pay dues within 90 days of the designated date of payment shall constitute grounds for automatic forfeiture of appointment.
- 5.13 Professional Ethics: The professional conduct of each AHS shall be governed both by the principals of the professional ethics established by the profession and by law and applicable hospital policies.

ARTICLE 6 – INQUIRY AND REVIEW OF QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

- 6.1 Grounds for Inquiry and Review. An inquiry into the activities and professional conduct of any Medical Staff member or other practitioner may be requested, in accordance with paragraph 5.2 herein, whenever questions arise concerning the following:
- A. Clinical competence;
 - B. Care or treatment of a patient or patients;
 - C. Management of a case or cases;
 - D. Known or suspected violation of Bylaws, Policies, Rules and Regulations of the Medical Staff, or known or suspected violation of the responsibilities of staff membership set forth in the Bylaws;
 - E. Known or suspected noncompliance with the ethical rules of their profession;
 - F. Behavior or conduct adversely affecting patient welfare by reason of being below Hospital and/or Medical Staff standards or by reason of interfering with the orderly operation of the Hospital; and
 - G. Any conduct or activities adversely affecting patient care reasonably suspected of or reasonably believed to be either disruptive, below professional standards of practice (including standards relating to the provision of quality

and cost effective health care), or detrimental to the interests of proper patient care at the Hospital.

- 6.2 Initiation of Inquiry and Review. Any person may bring a concern regarding a Medical Staff member to the attention of the Quality Department, the Multispecialty Peer Review Committee or the Vice President of Medical Affairs, each of which shall address the concern as set forth in the Maple Grove Hospital Peer Review Policy.
- 6.3 Cooperation. It is the responsibility of every Practitioner or (Medical or Professional Staff member) who is privileged by the Medical Staff to cooperate with any inquiry or investigation under this Article and/or under the Maple Grove Hospital Peer Review Policy. Any Practitioner subject to an inquiry investigation must provide all information deemed by the inquiring body or investigating review committee to be relevant to any concerns regarding the Practitioner's qualifications for continued appointment and/or clinical privileges, including but not limited to details of any adverse action taken with respect to such Practitioner by any licensing or credentialing authority. A Practitioner's refusal or failure to provide necessary information shall be independent grounds for suspension of clinical privileges.
- 6.4 Multispecialty Peer Review Committee. The Multispecialty Peer Review Committee will review inquiries in accordance with the Maple Grove Hospital Peer Review Policy and may make a recommendation for disciplinary action(s) to the Medical Executive Committee. These recommendations may include but are not limited to the reduction, curtailment or suspension of clinical privileges, or the suspension or revocation of Medical Staff membership.
- 6.5 Medical Executive Committee. Upon receipt of a written request or recommendation for discipline or corrective action or other referral of a matter from the Multispecialty Peer Review Committee, the Medical Executive Committee shall take one of the following actions:
- K. Accept and ratify the request or recommendation;
 - L. Modify the request or recommendation;
 - M. Reject the request or recommendation;
 - N. Remand the matter to the Multispecialty Peer Review Committee for additional investigation, along with a request for answers to specific questions or inquiries; or
 - O. Appoint an investigative subcommittee of the Medical Executive Committee to further look into the matter.

The affected Practitioner shall be notified within five (5) working days of any adverse action or recommendation approved by the Medical Executive Committee.

- 6.6 Hearings and Appeals. In the event the Medical Executive Committee recommends disciplinary or corrective action that constitutes grounds for requesting a fair hearing as provided in the Fair Hearing Policy, the procedures set forth in the Fair Hearing Policy shall be followed.

6.7 Records. To ensure that complete and accurate records are maintained, the Hospital's Medical Staff Office shall be custodian of all documents, reports and records that arise out of proceedings conducted pursuant to this Article 6. The Chief of Staff, Medical Executive Committee and Departments shall forward true and complete originals of all documents, reports and records to the Medical Staff Office for the purpose of maintaining such records, and such records shall be kept by the Medical Staff Office for such time as is required by the applicable policy. Nothing in this Section shall preclude the Chief of Staff, Medical Executive Committee or Department from maintaining its own files and records.

6.8 Suspension, Restriction, Relinquishment of Privileges. In addition to the provisions governing suspensions and corrective action contained elsewhere herein, a Practitioner's privileges may be suspended, restricted, or relinquished in the following circumstances:

A. Precautionary Suspension or Restriction:

1. Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the Chief of Staff, the relevant Department Chief, the Vice President of Medical Affairs, the Medical Executive Committee, or the Board Chairperson is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed; or (2) suspend or restrict all or any portion of any individual's clinical privileges.
2. A precautionary suspension can be imposed at any time, including after a specific event, a pattern of events, or a recommendation by the Medical Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension will meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.
3. Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.
4. A precautionary suspension is effective immediately and will be promptly reported to the Chief Executive Officer and the Chief of Staff. A precautionary suspension will remain in effect unless it is modified by the Chief Executive Officer or Medical Executive Committee.
5. Within five days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any). The notice will advise the individual that suspensions lasting longer than 30 days must be reported to the National Practitioner Data Bank.

6. The relevant Collaborating Physician will be notified when the affected individual is a Professional Staff member.
7. In the event of a precautionary suspension, the Medical Executive Committee shall take the following steps:
 - i. Within a reasonable time, not to exceed 14 days of the imposition of the suspension, the Medical Executive Committee will review the reasons for the suspension and consider a formal investigative subcommittee.
 - ii. After considering the reasons for the suspension, the Medical Executive Committee will determine whether the precautionary suspension should be continued, modified or lifted. The Medical Executive Committee may also determine whether to begin an investigation.
 - iii. If the Medical Executive Committee decides to continue the suspension, it will send the individual written notice of the decision, including the basis for it.
 - iv. There is no right to a hearing based on the imposition or continuation of a precautionary suspension. The procedures outlined above are deemed to be fair under the circumstances.
 - v. Upon the imposition of a precautionary suspension, the Chief of Staff will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

B. Automatic relinquishment of privileges. A Medical Staff or Professional Staff members privileges and Medical Staff /Professional Staff membership shall be automatically relinquished upon the occurrence of any of the following events:

- i. Suspension, termination, limitation, or restriction of his or her state license through action of the Minnesota Board of Medical Practice, Minnesota Board of Dentistry, Minnesota Board of Podiatric Medicine, or other professional licensing board;
- ii. revocation, suspension, limitation, restriction, or probation of Federal Narcotics Registration Certificate (DEA number);
- iii. failure to maintain the specified amount of professional liability insurance;
- iv. termination or revocation of a Practitioner's Medicaid participating provider status, including termination of such status by the

Practitioner;

- v. disqualification of Practitioner by the Minnesota Department of Health or Minnesota Department of Human Services from providing direct contact to patients;
- vi. the Provider's employment with Maple Grove Hospital Corporation or North Memorial Health Care terminates;
- vii. upon an event triggering automatic relinquishment of privileges and/or membership as provided elsewhere in the Bylaws, this Credentialing & Discipline Policy, the Rules and Regulations of Maple Grove Hospital, or Department policy.

C. Temporary Suspensions. A temporary suspension of admitting privileges of a Practitioner who has already been appointed to the Medical Staff or Professional Staff shall be imposed for the following:

- 1. failure to continuing to satisfy Threshold Criteria in the Bylaws that are not grounds for automatic relinquishment of privileges in 5.8(b) above;
- 2. failure to complete medical records timely;
- 3. failure to provide information requested by the Credentials Committee, Medical Executive Committee or a peer review committee;
- 4. failure to attend a mandatory meeting; or
- 5. failure to comply with a request for fitness for practice evaluation

A temporary suspension shall be removed once the delinquency in record completion is corrected, the Practitioner attends such meeting, or provides such information or documentation, or otherwise satisfies the Threshold Criteria. If the conditions are not met within 30 days, this will result in automatic relinquishment of privileges or be considered as voluntary resignation of membership and privileges.

D. Effect of Termination or Relinquishment of all Privileges. In the event that all of a Practitioner's privileges are terminated or relinquished (whether automatically or otherwise), upon the conclusion of the appeal process related to the termination or relinquishment of such privileges, if any, Practitioner's membership with the Medical Staff or the Allied Health Staff shall be automatically relinquished without opportunity for hearing or appeal.

6.9 Review of Chief of Staff or Department. In the event that the Chief of Staff or the Chief of any Department is the Practitioner under review, then the following substitutions shall take place: If the Chief of Staff is under review, then the functions to be performed by the Chief of Staff under this Article 5 shall be performed by the Vice Chief of Staff. If a Department Chief is under review, then the functions of the

Department Chief under this Article 5 shall be performed by the Chief-Elect of the Department or, if there is none, the Past Chief of the Department.

- 6.10 Voluntary Limitation of Privileges. At any time during the discipline or corrective action process outlined in this Article 5, but prior to final action taken by the Medical Executive Committee pursuant to Section 6.5, the involved Practitioner may voluntarily limit his or her privileges at the Hospital. Any such voluntary limitations will be reviewed to determine whether a report to any licensing agency or databank is required.
- 6.11 Notice of Limitation of Privileges. Whenever a Practitioner's privileges are limited, either voluntarily or by action taken under this Policy, the Chief of Staff and the Chief Executive Officer of the Hospital, or their respective designees, shall see that appropriate written notice is provided to all potentially affected areas of the Hospital and Medical Staff, including, for example, Surgery, the Emergency Department, Nursing Administration, appropriate nursing stations, etc.

ARTICLE 7 – EXCHANGE OF CREDENTIALING INFORMATION ON MEDICAL AND ALLIED HEALTH STAFF

- 7.1 Purpose. Maple Grove Hospital desires to share information which is reasonably related to the qualifications, competency, ability, professional ethics and conduct of the Practitioners on the Medical Staff and the Professional Staff of the Hospital or another affiliated hospital, including North Memorial Medical Center and hospitals that are constituents of Fairview Health Services (collectively referred to as the "Medical/Professional Staff"). The hospitals believe that by sharing this information they can reduce the cost of administering the credentialing process, improve quality of care, reduce duplication of administrative procedures, professional peer reviews and investigations, and improve the quality of available quality assurance data by increasing the size of the data pool. The sharing of this information will also facilitate the development of consistency in the application of professional standards and quality assessment throughout the system. Therefore, the provisions set forth in this Article have been adopted to provide for the exchange of credentialing information among the hospitals.

Information, data and reports regarding the qualifications, competency or ability to practice, professional ethics and/or conduct of the applicants or members of the Medical/Professional Staff collected by any of the hospitals described above (the "Credentialing Information") is confidential and privileged and should be managed appropriately. The Credentialing Information may be exchanged among the hospitals in accordance with this Article.

- 7.2 Affiliated Hospitals. As it is used in this Article, "Affiliated Hospitals" shall mean this Hospital and all other hospitals, clinics, networks and organizations which are controlled by or under common control with North Memorial Health Care or Fairview Health Services.
- 7.3 Credentialing Information. As used in this Article, "Credentialing Information" includes all information, applications, references, data, and reports which

reasonably relate to the qualification, competency, ability to practice, professional ethics or conduct of an applicant or member of the Medical/Professional Staff. The Credentialing Information includes, but is not limited to, the following:

- A. Initial Application and all supporting materials for all applicants to the Medical/Professional Staff. In the event the applicant has been a member of the Medical Staff or Professional Staff of one of the Affiliated Hospitals, then all information specified under paragraph (b) below shall be exchanged for purposes of considering the application for membership in the Medical Staff or Professional Staff of another Affiliated Hospital.
- B. Application for reappointment or renewal of membership and all supporting materials for the Medical/Professional Staff, including but not limited to:
 - 1. quality assessment and improvement information;
 - 2. stipulations or conditions of the Board of Medical Practice, Minnesota Department of Health or other appropriate regulating agency;
 - 3. restrictions, conditions or limitations established by one of the Affiliated Hospitals;
 - 4. reports of peer review committees, proctors, monitors or consultants;
and
 - 5. administrative suspensions including medical records suspensions.
- C. Information regarding privileges or membership at any Affiliated Hospital which are requested, granted or denied for any Medical/Professional Staff applicant or member.
- D. Any reports or correspondence regarding an applicant for or member of the Medical/Professional Staff which are sent to a state licensing agency (for example, the Board of Medical Practice or Board of Nursing), the department of health, the National Practitioner Data Bank, the PRO authorized by Medicare or any other governmental agency to which reports are required.
- E. Reports, assessments, incident reports and other information gathered under peer review or by the administration of one of the Affiliated Hospitals shall be exchanged when such information reasonably relates to the quality of care, efficient delivery of care or the competency of the practitioner. Incident reports regarding disruptive and inappropriate behavior will be shared if a peer review committee believes that such conduct or a pattern of conduct interferes with the delivery of patient care or poses a threat to the safety of patients or staff members, or creates a hostile working environment.
- F. Information regarding attendance and participation at meetings conducted for,

by or on behalf of any of the Affiliated Hospitals or the Medical/Professional Staff of any Affiliated Hospital may be exchanged. In addition, information regarding other professional services provided to any of the Affiliated Hospitals which is recognized as an alternative service contribution for purposes of fulfilling the meetings/professional services requirements may be exchanged.

- G. Information regarding necessary accommodations or restrictions on the privileges, duties or work to be performed by a member of the Medical/Professional Staff due to any health condition or disability may be exchanged. Such information shall be treated as a confidential medical record of the applicant and access shall be limited to those individuals and committees with responsibility for supervision and management of the Medical/Professional Staff.

7.4 Conditions for Exchange of Credentialing Information.

- A. Authorization by Individual. Credentialing Information may be exchanged as provided in this Article upon receipt by any of the Affiliated Hospitals of a signed application for initial appointment or reappointment. Each applicant or member authorizes the release of Credentialing Information as a condition of consideration of the individual's application for membership, appointment, re-appointment or renewal to the Medical/Professional Staff.
- B. Exchange of Credentialing Information. If the Credentialing Information is exchanged, it shall be exchanged among the appropriate Medical Executive Committee of the Affiliated Hospitals or their designees for the purpose of performing an assessment of professional qualifications, granting of membership or privileges, or improving the quality of patient care, or another proper purpose of a review organization in accordance with Minnesota Statutes § 145.61, subd. 5 ("Peer Review Committee"). The committee receiving such Credentialing Information agrees to maintain the confidentiality of the information and to restrict the use of such information to the purposes set forth in Minnesota Statutes §§ 145.61-145.67.
- C. Patient-Specific Information. If the Credentialing Information which relates to the care of, treatment of, or relationship with a specific patient shall be exchanged only if all identifying information has been removed or such exchange otherwise complies with state and federal law. To the extent practical, patient data shall be exchanged in the form of aggregate data or summaries.
- D. Minutes/Discussion of Peer Review Committees. Minutes or actions of any Peer Review Committee shall be exchanged only if such materials are redacted to remove patient identification (if any), the identities of individuals participating in or providing information to the Committee and all comments, quotations or discussions made by the participants in the review. Only those assessments, findings and recommendations made by the Peer Review

Committee (rather than by its individual participants) may be exchanged. The purpose of this condition is to protect and facilitate frank and open discussions among Peer Review Committee participants.

- E. Required Statements. All Credentialing Information exchanged in accordance with this Article shall be labeled as "Confidential Credentialing Information" and shall be accompanied by the following statement:

The attached Credentialing Information is confidential health care review data under Minn. Stat. § 145.61 to § 145.67. Disclosure of all or any part of the attached information for any purpose other than a peer review purpose as defined by the statute is prohibited. The attached information is not subject to discovery by subpoena or otherwise, nor may it be introduced into evidence in any administrative or judicial proceeding except as required or permitted by law. The recipient is responsible for maintaining the confidentiality of the attached information.

- E. Security and Confidentiality. Each of the Affiliated Hospitals is responsible for taking adequate measures to protect the privileged and confidential nature of the Credentialing Information exchanged in accordance with this Article. The Affiliated Hospital providing Credentialing Information in accordance with this Article shall be entitled to rely on the receiving Affiliated Hospital to provide adequate security for the information and to use such information only as authorized under this Article.

- F. Coordination with Legal Counsel and/or Risk Management. Each of the Affiliated Hospitals shall be responsible for coordinating the exchange of information under this Article with its own hospital legal counsel and/or risk manager or other personnel responsible for reviewing and assessing potential liability for the Affiliated Hospital.

7.5 Entity Specific Determinations. Each of the Affiliated Hospitals shall be responsible for and shall have the authority to make any determinations regarding Medical Staff appointment or privileges at its facility. Nothing in this Article is intended to limit the authority of the Affiliated Hospital to take such actions as it may deem appropriate regarding the qualifications, competency or ability to practice of any applicant or any member in the Medical/Professional Staff.

7.6 Events Triggering Exchange of Information. Credentialing Information will be exchanged in accordance with this Article upon any of the following events:

A. upon the request of the Medical Executive Committee of any of the Affiliated Hospitals;

B. upon the determination of the Medical Executive Committee of any of the Affiliated Hospitals that it knows of information which it believes in its sole discretion should be exchanged to advance the purposes of this Article or to improve patient care;

C. upon the initial application for membership or privileges or the application for reappointment or renewal to the Medical/Professional Staff of any of the Affiliated Hospitals; or as a part of a joint peer review or quality improvement committee amongst two or more Affiliated Hospitals.

7.7 Peer Review Information. Nothing in this Article shall be construed to prohibit Hospital from sharing peer review information with other review organizations or other third party provided such sharing is done in accordance with the confidentiality and other requirements of applicable law.

ARTICLE 8 – CLINICAL PRIVILEGES

8.1 Clinical Privileges for New Procedures

- A. Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (“new procedure”) will not be processed until a determination has been made that the procedure will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.
- B. As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the department chairperson and the Credentials Committee addressing the following:
1. minimum education, training, and experience necessary to perform the new procedure safely and competently;
 2. clinical indications for when the new procedure is appropriate;
 3. whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;
 4. whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;
 5. whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and
 6. whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The department chairperson and the Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered at the Hospital.

C. If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold criteria to determine those individuals who are eligible to

request the clinical privileges. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

1. the minimum education, training, and experience necessary to perform the procedure or service;
 2. the clinical indications for when the procedure or service is appropriate;
 3. the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted; and
 4. the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.
- D. The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

8.2 Clinical Privileges That Cross Specialty Lines:

- A. Requests for clinical privileges that previously have been exercised only by members in another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.
- B. As an initial step in the process, the individual seeking the privilege will submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the clinical privilege at other similar hospitals, and the experiences of those other hospitals.
- C. The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairpersons, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
- D. The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the clinical privileges at issue. If it recommends that individuals from different specialties be permitted to request clinical privileges, the Credentials Committee may develop recommendations regarding:
 1. the minimum education, training, and experience necessary to perform the clinical privileges in question;
 2. the clinical indications for when the procedure is appropriate;

3. the manner of addressing the most common complications that arise, which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;
4. the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;
5. the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and
6. the impact, if any, on emergency call responsibilities.

E. The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

ATTACHMENT B
FAIR HEARING POLICY
OF
MAPLE GROVE HOSPITAL

APPROVED:

Medical Executive Committee	February 26, 2013
Medical Staff	April 6, 2013
Board of Directors	May 15, 2013
Medical Executive Committee	July 18, 2017
Medical Staff	July 20, 2017
Board of Directors	September 13, 2017
Medical Executive Committee	June 26, 2018
Medical Staff	August 19, 2018
Board of Directors	December 10, 2018

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PREAMBLE

This Fair Hearing Policy is adopted by the Medical Staff of Maple Grove Hospital ("Hospital") pursuant to the authority set forth in Section 8.2 of the Medical Staff Bylaws. This Fair Hearing Policy shall apply to only those recommendations and actions of the Medical Executive Committee of the Hospital ("Medical Executive Committee") (or its designee) or the Board of Directors of the Hospital ("Board") as specified herein.

ARTICLE 1 – GROUNDS FOR HEARING, NOTICE, AND REQUEST FOR HEARING

1.1 Grounds for Hearing.

A. Actions and Recommendations that are Grounds for a Hearing. An individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations:

1. Denial of initial appointment to the Medical Staff;
2. Denial of reappointment to the Medical Staff;
3. Revocation of appointment to the Medical Staff;
4. Denial of requested clinical privileges;
5. Revocation of clinical privileges;
6. Suspension of clinical privileges for more than 30 days; or
7. Mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance).

B. Actions and Recommendations that are Not Grounds for Hearing. None of the following actions or recommendations shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into their file:

1. Issuance of a letter of guidance, counsel, warning, or reprimand;
2. Imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
3. Termination of temporary privileges;
4. Automatic relinquishment of appointment or privileges;
5. Imposition of a requirement for additional training or continuing education;

6. Determination that an application is incomplete;
 7. Determination that an application will not be processed due to a misstatement or omission; or
 8. Determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.
- C. No recommendations except those enumerated in Section 1.1(A) shall entitle the individual to request a hearing.
- D. The affected individual shall 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 Medical Executive Committee, to take any action set forth in Section 1.1(A).
- E. Any Practitioner who is under contract with the Hospital, whether as an employee or independent contractor, to perform specific duties or to perform administrative functions and related clinical responsibilities shall be required to apply for membership on the Medical Staff and shall be entitled to the same procedural fairness accorded any other member when his or her Medical Staff privileges are terminated or otherwise adversely affected, except when, within the terms of the contract it is specifically stated that the practitioner is engaged for a particular function and upon termination of service in the functional area his or her Medical Staff appointment and privileges shall immediately terminate; or, the contract otherwise provides for immediate termination of the practitioner's Medical Staff appointment and/or privileges upon termination of the contract. Under these conditions, he or she shall not be entitled to the hearing and review procedures of this Fair Hearing Policy.

1.2 Notice of Recommendation or Action. When a recommendation is made or action taken by the Medical Executive Committee or the Board of Directors which, according to Section 1.1(A) entitles the Practitioner to a hearing prior to a final decision of the Board on that recommendation or action, the Practitioner shall be promptly given Notice by the Chief of Staff. This Notice shall contain:

- A. A statement of the recommendation made and the reasons for it;
- B. A statement that the Practitioner has the right to request a hearing on the recommendation;
- C. A copy of this Policy.
- D. A statement that the Practitioner may be represented by an attorney or another individual of the Practitioner's choice, if desired; and
- E. A statement that the request for a hearing must: (1) be in writing, (2) be delivered to the Chief of Staff within thirty (30) days of the Practitioner's receipt of the notice, and (3) state whether or not the Practitioner will be

represented by an attorney or another individual of the Practitioner's choice.

- 1.3 Request for Hearing. The Practitioner shall have thirty (30) days following the date of the receipt of such notice within which to request a hearing. The request shall be made in writing delivered to the Chief of Staff.
- 1.4 Waiver by Failure to Request a Hearing. If the Practitioner fails to request a formal hearing within the time and in the manner specified in 1.3, the Practitioner waives his or her right to a hearing on the matter involved.
 - A. When such waiver is in connection with a proposed or actual adverse action under 1.1(A) by the Board, it shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board.
 - B. When such waiver is in connection with an adverse recommendation or action under 1.1(A) by the Medical Executive Committee, it shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board. In this event, the Board shall consider the Medical Executive Committee's recommendation at its next regular meeting following waiver. In its deliberations, the Board shall review and consider the recommendation and supporting documentation of the Medical Executive Committee and may consider any other relevant information received from any source. The Board's action on the matter shall constitute final action.

ARTICLE 2 – HEARING PROCEDURES

- 2.1 Binding Effect. By requesting a hearing or appellate review under this Policy, the Practitioner agrees to be bound by the provisions of the Bylaws, this Policy, and the Rules and Regulations.
- 2.2 Establishment of Hearing Format.
 - A. Hearing Committee, Presiding Officer and Notice. The Chief of Staff shall recommend, and the Chief Executive Officer acting for the Board, shall appoint a hearing committee which shall generally be composed of not less than three members of the Medical Staff. The committee shall not include any individual who is in direct economic competition with the Practitioner. The committee shall not include any individual who actively participated in the matter at any previous level. The committee shall not include any individual who has an actual bias or prejudice or conflict of interest that would prevent him or her from fairly and impartially considering the matter. An employment or contractual arrangement with the Hospital or one of its affiliates does not disqualify a Medical Staff member from serving on the hearing committee. Counsel for the Hospital may act as Presiding Officer. Notice of the hearing committee composition shall be promptly given to the Practitioner.
 - B. Objections to Proposed Hearing Committee Members. Within seven (7) days after receipt of notice of the proposed hearing committee membership, the Practitioner shall be entitled to submit his or her written objections, if any, to those proposed members of the hearing committee which he or she believes are in direct

economic competition with him or her, actively participated in the matter at any previous level, or has an actual bias or prejudice or conflict of interest that would prevent him or her from fairly and impartially considering the matter. Such objections, if any, will be reviewed by the Chief Executive Officer, who shall determine in his or her good faith discretion whether or not the objections are meritorious. A physician or other person appointed to serve on a hearing committee shall not be disqualified from serving on the committee merely because he or she has knowledge of the underlying issues or concerns.

C. Hearing Officer. If a hearing committee of at least three volunteer persons cannot be constituted for reasons determined to be valid by the Chief Executive Officer, the Chief Executive Officer, after consulting with the Chief of Staff, may appoint one person to serve as hearing officer. The hearing officer shall not be in direct economic competition with the Practitioner or be related to the Practitioner. Notice of the appointment of a hearing officer shall be promptly given to the Practitioner.

D. Substituted Reference to Hearing Officer. In the event a hearing officer is appointed instead of a hearing committee, all references in this Article to the "hearing committee" or "Presiding Officer" shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

E. Waiver of Rights. In the event the Practitioner fails to raise objections to proposed members of the hearing committee, or to a proposed alternate hearing officer, within seven (7) days after receiving notice of the proposed members or hearing officer, the Practitioner shall be deemed to have waived his or her right to or make objections to the composition of the hearing committee or the selection of an alternate hearing officer.

2.3 Time and Place for Hearing.

A. Scheduling the Hearing; Notice of Hearing. The Presiding Officer shall schedule the hearing to be held as soon as practicable, but not sooner than thirty (30) days and not later than ninety (90) days from the date of receipt of the request for hearing, unless other timing has been specifically agreed to in writing by the parties. The Chief Executive Officer shall provide notice to the Practitioner within twenty (20) business days from the date the Practitioner's timely request for a hearing is received.

B. Postponements. The Presiding Officer may postpone any hearing, for good cause, upon the request of a party or upon the Presiding Officer's own initiative.

2.4 Content of Notice, Response and Witness Lists.

A. Hearing Notice. The notice of hearing, which shall be sent by certified mail, return receipt requested, shall specify:

1. Time and Location. The scheduled date, time and location of the hearing.

2. Statement of Reasons. As applicable, a statement of specific charges or issues under examination, a list of the specific or representative patient charts in question, and/or other reasons or subject matter forming the basis for the adverse recommendation or action.

3. List of Witnesses - A list of witnesses, if any, that the body which took or proposed adverse action (or its designated representative) believes will be called as witnesses at the hearing to testify in support of the recommendation or action.

B. Response and List of Witnesses of Practitioner. Within fourteen (14) days after receipt of the notice of the hearing, the Practitioner shall furnish to the Presiding Officer his or her written response to the Notice, including an answer to any charges or matters listed in the Statement of Reasons and a list of the names and addresses of the individuals who may or will be called as witnesses at the hearing to testify in support of the Practitioner's position. The Presiding Officer shall have the authority to limit the number of witnesses, especially character witnesses or witnesses whose testimony is merely cumulative.

C. Amendments. The Statement of Reasons, the response, or the list of witnesses of either party may be amended at any time by the party furnishing them, provided that the opposite party is given a reasonable period to prepare to meet the substance of the amendments. For the purpose of this provision, a time period of one week or more, shall be presumed to be a "reasonable period." The permissibility of a shorter period of notice shall be subject to the discretion of the Presiding Officer.

2.5 Pre-hearing Conference. The Presiding Officer shall require counsel for the individual and for the Hospital to participate in a pre-hearing conference for purposes of resolving all procedural questions in advance of the hearing. The Presiding Officer shall specifically require that:

A. all documentary evidence to be submitted by the parties be presented to each other prior to this conference and that any objections regarding the documents be made at this conference and resolved by the Presiding Officer;

B. evidence unrelated to the reasons for the unfavorable recommendation or unrelated to the individual's qualifications for appointment or the relevant clinical privileges be excluded;

C. the names of all witnesses and a brief statement of their anticipated testimony be submitted prior to this conference and that any objections regarding witnesses be made at this conference and resolved by the Presiding Officer;

D. the time granted to each witness' testimony and cross-examination be agreed upon, or determined by the Presiding Officer, in advance; and

E. witnesses and documentation not provided and agreed upon in advance of the hearing may be excluded from the hearing.

2.6 Conduct of the Hearing.

A. Physical Presence. The personal presence of the Practitioner shall be required at the hearing. A Practitioner who fails without good cause to appear and to proceed at such hearing shall be deemed to have waived all rights to review for the hearing, all rights under the Bylaws and under this Policy with respect to the matter involved.

B. Presiding Officer. The Presiding Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present appropriate oral and documentary evidence. The Presiding Officer shall determine the order of procedure during the hearing and shall make all rulings on the matters of procedure, the consideration of evidence, and all other matters pertaining to the conduct of the hearing.

C. Rights of Parties. During a hearing, each of the parties shall have the right to:

1. call and examine witnesses to the extent available;
2. present oral evidence, including cross-examination of witnesses called by the other party, presentation of witnesses and rebuttal of testimony, and documentary evidence, including exhibits;
3. submit a written statement at the close of the hearing;
4. question witnesses on matters relevant to the issues; and
5. rebut any evidence.

D. Evidence. There is no right to discovery in connection with the hearing. However, the individual requesting the hearing shall be entitled, upon specific request and in compliance with all applicable laws, to the following, subject to a stipulation signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

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 Review Committee, Medical Executive Committee, or the Board; and
3. copies of any other documents relied upon by the Review Committee, Medical Executive Committee, or the Board.

Neither the Practitioner nor his/her attorney may contact Hospital employees except as agreed to by Hospital counsel or directed by the Presiding Officer. The parties may offer such evidence as the Presiding Officer deems relevant

and material to the dispute, and shall produce such evidence as the Presiding Officer may deem necessary to an understanding and determination of the dispute. The Presiding Officer shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of all of the parties.

E. Admissibility of Evidence.

1. The hearing need not be conducted according to rules of evidence. Relevant information shall be admitted if it is the sort of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

2. In the event of a review of a denial of initial application for appointment or privileges, new information may not be presented at the hearing if such information was or would have been reasonably available for the applicant to provide to the Medical Executive Committee in its consideration of the application. This standard applies to initial appointments because the applicant has the burden to produce information deemed adequate by the Medical Executive Committee to resolve all doubts about the applicant's qualifications. Absent the good faith disclosure of information by the applicant, the Medical Staff has no investigative authority outside the Hospital. Therefore, it is important to the integrity of the process that the applicant have the burden of producing all information to the Medical Executive Committee.

3. In hearings on all matters other than those in Section 3(e)(2) above, new information may be presented at the hearing. The hearing committee shall determine the weight to be given to any information that could reasonably have been provided to the Medical Executive Committee or other review committee whose recommendation is the subject of the hearing.

F. Matters Considered. In addition to relevant evidence formally presented at the hearing, the hearing committee shall be entitled to consider any pertinent material contained on file in the Hospital and all other information which can be considered in connection with applications for appointments or reappointments to the Medical Staff and a request for clinical privileges. In this respect, relevant medical charts, investigative reports, pertinent correspondence, committee minutes, and the Statement of Reasons may be furnished by the Chief Executive Officer in his or her discretion to the hearing committee, provided the Practitioner is advised that these materials have been furnished to the hearing committee, and is given access to the same. The Practitioner may challenge relevance of such materials at the hearing. The hearing committee shall be entitled to conduct independent research and interviews, or retain an independent consultant to do so; however, the hearing committee may not utilize the products of such in its decision, unless the Practitioner is aware of the independent research and interviews, and has an opportunity to rebut the information.

G. Evidence by Affidavit and Posthearing Filing of Documents or Other

Evidence. The Presiding Officer may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the Presiding Officer deems it entitled to after consideration of any objection made to its admission.

H. Time Limit. Generally, the hearing shall be completed within one (1) day. The Presiding Officer, for good cause shown, may schedule an additional hearing session to be held within seven (7) days.

I. Burden of Proof. The Practitioner shall be responsible for providing convincing evidence that:

- (i) the grounds for the adverse recommendation or action are not supported by sufficient evidence; or
- (ii) the conclusions drawn from the adverse recommendation or action are arbitrary or capricious.

J. Record of Hearing. The hearing committee shall maintain a record of the hearing by a tape or video recording or by a stenographic reporter. The cost of such recording shall be borne by Hospital, but copies of the transcript tape shall be provided to the individual requesting the hearing at that individual's expense.

K. Attorneys.

1. Practitioner. The Practitioner shall have an unqualified right to be represented by an attorney at any hearing or appellate review appearance. If the Practitioner desires to be represented by an attorney at the hearing, the request for such hearing must so state. Notwithstanding the foregoing, the Practitioner may contact an attorney at appropriate times during the proceedings for advice, provided such contact does not unduly interfere with the conduct of a hearing as determined by the Presiding Officer.

2. The Hearing or Appellate Review Body or Chief Executive Officer. A hearing or appellate review body may, in its discretion, consult with legal counsel at any stage of the proceedings for advice on appropriate hearing conduct or drafting of report(s). Without limiting the right of any party, including the Medical Staff, to obtain outside counsel, Hospital counsel may serve as counsel to the Hospital, the hearing committee and the Medical Executive Committee or Board.

2.6 Waiver. If at any time after receiving of Notice of an adverse recommendation, action or result, the Practitioner fails to make a required request or appearance or otherwise fails to comply with this Policy, the Practitioner shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights under the Bylaws or under this Policy with respect to the matter involved.

2.7 Supplemental Hearing Rules. The Presiding Officer of any hearing or appellate review body may promulgate, with or without the advice of legal counsel, hearing rules to supplement those contained in this Policy. Such rules shall be fundamentally fair to all parties and generally consistent with the provisions of this Policy. The supplemental rules may set forth the order of presenting evidence and oral statements as well as time limits for

presentations. When such rules are promulgated by the Presiding Officer, they shall be furnished to the parties before the hearing.

2.8 Number of Reviews. Notwithstanding any other provision of the Bylaws or of this Policy, the Practitioner shall not be entitled to more than one hearing with respect to an adverse recommendation or action. The Medical Executive Committee and the Board may conduct additional hearings or reviews upon reapplication or request for reconsideration by the Practitioner, upon a clear and convincing indication of new or additional information which has a substantial probability of changing the outcome of the previous hearing or appeal.

2.9 Adjournments and Time Limit Modification. Any procedural rule or time limit specified in this Policy may be modified or waived by agreement between the body that took the adverse action (i.e., the Medical Executive Committee or the Board) and the Practitioner. Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone. The Board, the Presiding Officer or a hearing committee may grant an extension of any time limits when required for fundamental fairness to any party, to obtain new evidence, or for consultation.

2.10 Deliberations and Recommendation of the Hearing Committee or Presiding Officer.

A. Deliberations. Upon conclusion of the presentation of evidence, the hearing shall be closed. Both parties have the right to submit a written statement to the hearing committee at the close of the hearing. Within thirty (30) days after the closing of the hearing, the hearing committee shall privately conduct deliberations and consider the admitted evidence.

B. Contents of Report. The hearing committee shall prepare a report which shall contain a concise statement of recommendations and the reasons justifying the recommendations made. This report shall be delivered to the Chief of Staff and Chief Executive Officer.

2.11 Disposition of Hearing Committee Reports. Upon its receipt, the Chief Executive Officer shall forward the hearing committee report and recommendation, along with all supporting documentation, to the Medical Executive Committee for review and the Board for further action. The Chief Executive Officer shall also send a copy of the report and recommendation to the Practitioner, and to the Department or committee other than the Board, if any, that made the adverse recommendation.

2.12 Notice and Effect of Results. Upon receipt of the hearing committee's report pursuant to Section 3.12, the Board shall take action at its next regular meeting.

A. The Board may, before taking final action thereon, refer the matter back to the hearing committee, or to the Medical Executive Committee with respect to issues relating to Medical Staff policies, for further consideration or information. Any such referral back shall state the reasons therefor, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing or other review be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action.

B. If the Board's action on the matter is favorable to the Practitioner it shall inform the Medical Executive Committee of its right to request an appeal to the Board as provided in Article 4 of this Policy.

C. If the Board's action is adverse to the Practitioner (a decision to refer the matter shall not be deemed adverse) the Board shall inform the Practitioner of his or her right to request an appeal to the Board as provided in Article 4 of this Policy.

2.13 Good Faith. In addition to those duties imposed in the Bylaws, it shall be the duty of each Practitioner who requests a formal hearing to act with utmost good faith before and during the hearing process. Such good faith shall include, but shall not be limited to, timely compliance with requirements, cooperation in the receipt of required notices, and the exercise of procedures in this Policy without intent to cause undue delay.

ARTICLE 3 – APPEAL TO BOARD OF DIRECTORS

3.1 Notice to Parties. Promptly after the final decision of the Board, a copy of the Board's findings and decision shall be sent by certified mail, return receipt requested, to the Practitioner and a copy shall be delivered directly to the Chief of Staff. The certified letter shall notify the parties that they may appeal the Board's decision and of the right to appeal personally before the Board during the appeal conference. The certified letter shall also notify the parties that if they decide to appeal, then a notice of appeal must be delivered to the CEO within twenty (20) days after receipt of the certified letter.

3.2 Appeal to the Board of Directors. If neither party submits a notice of appeal within twenty (20) days after receipt of the certified letter of the Board's findings and decision, then the decision shall be final.

3.3 Grounds for Appeal. The grounds for appeal shall be limited to the following:

1. There was substantial failure by the Hearing Committee to comply with the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; and/or
2. The recommendations of the Hearing Committee were made arbitrarily or capriciously and/or were not supported by credible evidence.

3.4 Appeal to the Board of Trustees. Failure to appeal constitutes a waiver of the right to appeal and hearing. If a notice of appeal is submitted within the twenty (20) day period, then the party shall be entitled to appear before the Board or, at the discretion of the Board, before a committee comprised of not less than five members of the Board in accordance with this section. The appeal proceeding shall be limited to written statements and each party will be allotted 30 minutes for oral argument. The oral argument shall take place within forty-five (45) days of delivery of the notice of appeal. The party requesting the appeal will submit his or her written statement no later than 15 days prior to the oral argument. The other party will be given ten days to provide a written statement in response. Additional evidence will not be permitted to be introduced in written statements or at the oral argument unless the party seeking to admit it can demonstrate that it is new, relevant evidence or that the opportunity to introduce it at the hearing was improperly denied. The oral argument shall not be a hearing, or be subject to

hearing procedures such as are set out in this policy. The party requesting the appeal may be represented by counsel. A record of the appeal shall be kept, and the parties may obtain copies of the record. The Board may establish rules and limitations applicable to the appeal conference, in its discretion.

3.5 Appellate Report. Within a reasonable time after the conclusion of the oral argument, a report will be prepared by the body that heard the oral argument. If the oral argument was heard and conducted by a committee of the Board, the report of the committee will be submitted to the Board. The Board may remand the matter to the committee of the Board for reconsideration. After such remand or if the matter is not remanded, the Board shall make its final determination.

3.6 Final Decision of the Board of Directors. Following completion of the appeals procedures in Section 3.5, the Board shall by majority vote make its final decision. Within seven (7) days after the Board's final decision, the Board or its designees shall send a copy of the written report thereof to the Practitioner, by certified mail, return receipt requested. The Medical Executive Committee shall also be sent a copy of the written decision and the basis thereof. The decision shall take effect immediately. A Practitioner whose appeal is unsuccessful under this Article shall reimburse Hospital for reasonable attorney's fees incurred by Hospital in the course of the appeal.

3.7 Report to National Practitioner Data Bank. The Hospital's authorized representative shall, consistent with the Medical Staff Bylaws, rules and regulations, and policies, report information regarding a professional review action that adversely affects the clinical privileges of a Practitioner for a period longer than thirty (30) days when the Medical Staff accepts the surrender of clinical privileges by a Practitioner (i) while the Practitioner is under investigation by the Hospital relating to possible incompetence or improper professional conduct, or (ii) in return for not conducting such an investigation or proceeding. The authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the description set forth in the final action as adopted by the Board. The report will be made in accordance with applicable rules of the National Practitioner Data Bank within fifteen (15) days from the date the adverse action became effective. Within that time frame, the Practitioner will be afforded the opportunity to review the proposed report and suggest appropriate changes. The authorized representative 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. A Practitioner who was the subject of an adverse action report may request an informal meeting to dispute the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the Chief of Staff, the chair of the subject's Department, and the Hospital's authorized representative, or their respective designee.

3.8 Other Reports. Reports of any adverse action affecting a Practitioner may be made to any federal, state or local agency, body, or organization, as either may be required by any federal, state, or local law, regulation, ordinance or agreement.

ARTICLE 4 – AMENDMENTS

4.1 Amendments to the Policy. Amendments to this Fair Hearing Policy may be

proposed by the Medical Executive Committee. In the presence of a quorum, a majority vote of the Medical Executive Committee in attendance shall be necessary for adoption of an amendment to this Fair Hearing Policy. An amendment becomes effective when approved by the Board of the Hospital.

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ATTACHMENT C
RULES AND REGULATIONS
OF
MAPLE GROVE HOSPITAL

APPROVED:

Medical Executive Committee	February 26, 2013
Medical Staff	April 6, 2013
Board of Directors	May 15, 2013
Amendment approved Medical Executive Committee:	January 27, 2015
Revision approved Medical Executive Committee:	July 28, 2015
Medical Executive Committee	April 26, 2016
Medical Staff	July 21, 2016
Board of Directors	August 24, 2016
Medical Executive Committee	July 18, 2017
Medical Staff	July 20, 2017
Board of Directors	September 13, 2017
Medical Executive Committee	June 26, 2018
Medical Staff	August 19, 2018
Board of Directors	December 10, 2018

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The following Rules and Regulations have been adopted pursuant to the Bylaws of the Medical Staff of Maple Grove Hospital and are made a part of the Medical Staff Bylaws. Terms used in these Rules and Regulations that are not otherwise defined herein shall have the meaning set forth in the Medical Staff Bylaws.

ARTICLE 1 ORGANIZATION

Each member of the Medical Staff shall be assigned to a Department according to his or her area of specialty, pursuant to Section 6.2 of the Medical Staff Bylaws. The Medical Staff shall have the following Departments:

- Department of Surgery
- Department of Obstetrics
- Department of Medicine
- Department of Pediatrics

ARTICLE 2 ADMISSION OF PATIENTS

- 2.1. Who May Admit. Patients may be admitted to the Hospital only upon order of a member of the Active or Courtesy Medical Staff (or a member of the Provisional Medical Staff who is eligible for advancement to Active or Courtesy Medical Staff), or a Practitioner granted temporary admitting privileges. Certified Nurse Midwives may admit obstetrical patients provided the admitting Certified Nurse Midwife has consultative and surgical back-up agreements in place with two Obstetrician/Gynecologists who are members of the Hospital Medical Staff. No other Professional Staff members are allowed to admit patients to the hospital.
- 2.2. Membership on Medical Staff. Patients may be admitted to the Hospital only upon order of a member of the Active or Courtesy Medical Staff (or a member of the Provisional Staff who is eligible for advancement to Active or Courtesy Medical Staff), a Practitioner granted temporary privileges (e.g., locum tenens) or expedited privileges if such privileges include admitting privileges, or a Professional Staff member, if permitted under the Credentialing and Discipline Policy.
- 2.3. Admission Diagnosis. Practitioners admitting patients are responsible for giving the necessary information to protect other patients from those who are or may be a source of danger. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon as possible after admission.
- 2.4. Admission by Certain Members of the Medical Staff.
 - A. The Emergency Department physicians admit patients to the hospital and write admitting orders in collaboration with the Attending Physician. It is the responsibility of the Attending Physician to then evaluate the patient in a timely manner and in accordance with the Rules and Regulations and Hospital policy.

- B. Patients admitted to the Hospital by a dentist for dental care shall also be admitted to the service of an Attending Physician and must have a history and physical examination as set forth in Section 5.2. The dentist shall be responsible for writing all orders pertaining to the general dental management of their patients, and all orders pertaining to the medical management of the patient shall be written by Attending Physician.
- C. Patients shall be admitted to the oral surgery service only by an oral surgeon qualified under the Medical Staff Bylaws and Credentialing and Discipline Policy. Patients admitted to the Hospital for oral surgery care shall receive the same basic medical appraisal as patients admitted for other services whether the appraisal is performed by a physician member of the Medical Staff or an oral surgeon qualified to complete an admission history and physical examination and assess the medical risks of the procedure on the patient.

2.5. Admission and Transfer. The Hospital shall admit patients suffering from all types of diseases and conditions, insofar as its accommodations will permit. If, because of lack of appropriate facilities or qualified staff, patients cannot be adequately treated at the Hospital, stabilizing procedures and preparation for transfer to an appropriate facility will be given.

ARTICLE 3 MEDICAL RECORDS AND CHARTING

3.1 Medical Record Entries/Electronic Health Records.

- A. Entries into a patient's medical record are to be entered into the Hospital's electronic medical record. All references in these Rules and Regulations to a practitioner's signature shall include an electronic signature.
- B. All entries in the medical record must be dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided. A practitioner may not authenticate an entry that cannot be reviewed (e.g., one that is not yet transcribed). Each authentication/signature must be dated and timed.
- C. No delegation of a practitioner's login password is permitted.
- D. Co-signatures are required as set forth in the Policy on Co-Signature Requirements.

3.2 Medical Record Content. In addition to the items required by the Rules and Regulations and Hospital policy, each patient's medical record must include all practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, vital signs, and other information necessary to monitor the patient's condition, including but not limited to documentation of all complications, hospital-acquired infections, unfavorable reactions to drugs, and unfavorable reactions to anesthesia.

3.3 Admission; History and Physical Examination/Assessment.

- A. Upon admission, each patient will be assigned an Attending Physician, and the Attending Physician's name will be documented in the patient's medical record.
- B. The History and Physical (H & P) examination must be completed by a physician or physician extender with physician supervision and ultimate responsibility for completion. History and physical examinations may be performed by: a physician, a certified nurse midwife, and certain Allied Health Professionals when and to the extent permitted in the Credentialing and Discipline Policy.
- C. A complete history and physical examination of each patient shall be entered into the medical record within 24 hours of admission, and prior to any surgery or procedure requiring anesthesia. Patients admitted to a general medical/surgical unit from any site must be seen and evaluated in the Hospital by the Attending Physician (or other qualified professional with admitting privileges, per Hospital policies) in a timely manner after the patient's arrival on the unit, but under no circumstances more than 12 hours (24 hours for newborns) after admission or registration. If the patient is admitted with a complete history and physical and orders dated not more than 30 days prior to the date of admission, the history and physical and orders must be placed in the patient's electronic medical record within 24 hours of admission or registration, and prior to surgery or a procedure requiring anesthesia.
- D. Patients admitted directly to a Stepdown or Intermediate Unit must be seen by the Attending Physician (or such physician's designee) within 4 hours of arrival on the unit.
- E. Patients admitted to an intensive care unit must be seen and evaluated by the Attending Physician or such physician designee within two hours of arrival on the unit.
- F. Obstetric Admission Requirements:
 - 1. Patients admitted to Labor and Delivery from any site other than directly from a physician's office, must be seen and evaluated in the hospital by the Attending Physician (or such physician's designee) within 12 hours of the patient's arrival on the the unit; provided, however, that patients undergoing labor induction (ex. Cervical ripening) may be evaluated within 24 hours of the patient's arrival, but only if an H&P has been written, admission orders placed and the patient has been evaluated by the physician within the 7 days immediately prior to admission.
 - 2. For patients undergoing labor induction, a prenatal record may serve as the H&P examination. However, an update note to the prenatal record after admission and prior to procedure is required.
 - 3. For patients undergoing vaginal deliveries a prenatal record may serve as the H&P examination. However, an update note to the prenatal record, after admission and prior to procedure, is required.

4. A final progress note may serve as the discharge summary for those patients with problems and interventions of a minor nature who require less than a 48-hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetric deliveries.

G. The scope and intensity of the history and physical must be consistent with the patient care needs. The content of the history and physical will follow the guidelines (Medical History and Physical Examination) listed below as appropriate for each patient.

The MEDICAL HISTORY may include documentation of these elements:

- Patient Identification
- Chief Complaint
- History of present illness/indications/symptoms for hospitalization/surgical procedure
- Personal history of surgeries and medical conditions (tobacco, ETOH, habits)
- Family History
- Existing co-morbid conditions
- Current medications and dosages
- Any known allergies, including medication reactions
- Any applicable cultural or spiritual assessment(s)
- Review of systems
- The PHYSICAL EXAMINATION must be complete and appropriately related to the patient's condition. There should be an assessment of:
 - Mental status
 - Heart
 - Lungs
 - Abdomen
 - Head and neck

- Circulation (peripheral pulses)
- Mobility of extremities

For patients undergoing a procedure with no anesthesia, topical, regional block, or IV sedation, an exam specific to the proposed procedure must also be completed.

This information should be compiled together with such other information as may be required by the Medical Staff and/or the Hospital for the proper administration of patient care and for the protection of patients. This documentation must be entered into the medical record for all patients emergently admitted to an intensive care unit.

H. An admission history and physical must be performed on each dental patient by a member of the Medical Staff with appropriate privileges and recorded in the medical record. The responsible dentist must record the dental part of the history and physical. Where privileges have been granted, the history and physical may be performed by a qualified oral and maxillofacial staff member.

I. For H & P's performed greater than 24 hours prior to a planned procedure requiring an H & P, the anesthesia preoperative evaluation may serve as an update to the H & P when it applies. In other instances, the provider performing the procedure must document a durable, legible update to the patient's condition and this must be on the chart and signed by the physician prior to the procedure. In no case shall a history and physical performed more than 30 days prior to the procedure be accepted unless the patient has been continuously in the Hospital. The update must include a notation that:

1. the history has been reviewed and any changes or lack thereof are noted; and
2. the physical examination has been reviewed and any changes or lack thereof noted.

3.4 Pre-Surgical/Sedation History and Physical Requirements.

A. A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia within 24 hours immediately prior to an inpatient or outpatient procedure requiring anesthesia services.

B. The evaluation will be recorded in the medical record and will include:

1. A review of the medical history, including anesthesia, drug and allergy history;
2. An interview, if possible, pre-procedural education, and examination of the patient;
3. Notation of any anesthesia risks according to established standard of practice

(e.g., ASA classification of risk);

4. Identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);

5. Development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits, type of medications for induction, post-operative care); and

6. Any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

The elements of the pre-anesthesia evaluation in (1) and (2) above must be performed within the 24-hour time frame. The elements in (3) through (6) must be reviewed and updated as necessary within 24 hours, but may be performed during or within 30 days prior to the 24-hour time period.

3.5 Emergent Operative/Invasive Procedures.

A. For emergent operative and invasive procedures, appropriate patient care may preclude pre-procedure documentation. In such cases, all pre-procedure requirements may be temporarily waived. The practitioner and those health care workers with knowledge of the patient's condition, including pertinent history and laboratory information, will make every effort to pass this on to any others assuming patient care. At the earliest time possible, appropriate practitioner and healthcare workers will complete the documentation. This will include a statement reflecting the emergent status of the patient.

B. Laboratory tests for patients who are to have a general or major nerve block anesthesia should be accomplished within 10 days of surgery.

3.6 Informed Consent.

A. Informed consent, as appropriate, must have been completed within 30 days before admission. Procedures and treatments requiring written informed consent shall be set forth on the Informed Consent Policy.

B. Informed consent forms must be properly executed and included in the patient's medical record prior to the procedure or other treatment requiring informed consent.

C. The informed consent form must include the following elements, at a **minimum**:

- Maple Grove Hospital name;
- Name of the specific procedure or treatment for which consent is being given;

- Name of the responsible practitioner performing the procedure or administering the treatment;
- Statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies was explained to the patient or the patient's legal representative;
- Signature of the patient or the patient's legal representative; and
- Date and time the informed consent is signed by the patient or patient's legal representative.

D. Except in emergencies, the surgery or other procedure shall be cancelled or rescheduled if the completed informed consent form is not included in the patient's medical record prior to the surgery or other procedure requiring informed consent.

3.7 Standing Orders, Order Sets, and Clinical Protocols.

- A. For all order sets and clinical protocols, review and approval of the Medical Executive Committee or the appropriate Medical Staff committee, with input from nursing and the Hospital's pharmacy department when appropriate, is required. Prior to approval, the appropriate committee will confirm that the order set or clinical protocol is consistent with nationally recognized and evidence-based guidelines. The appropriate committee will also take necessary steps to ensure that there is periodic and regular review of such order sets and clinical protocols. All clinical protocols will identify clinical scenarios for when the protocol is to be used.
- B. If the use of an order set has been approved by the Medical Executive Committee or the appropriate Medical Staff committee, the order will be initiated for a patient only by an order from a practitioner responsible for or involved in the patient's care in the Hospital and acting within his or her scope of practice. Orders initiated by a clinical protocol will be deemed to have been initiated by a practitioner responsible for the patient's care in the Hospital and acting within his or her scope of practice.
- C. When used, order sets must be dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or the Attending Physician and is authorized to write orders by Hospital policy.
- D. For purposes of this Section, a clinical protocol is defined as a course of treatment which may be initiated by a member of the Hospital's clinical staff (e.g., a nurse) without a prior specific order from the treating physician/practitioner when a patient's condition meets certain pre-defined clinical criteria. An order set consists solely of menus of treatment or care options for common clinical scenarios designed to facilitate the creation of a patient-specific set of orders by a physician or other qualified practitioner authorized to write orders.
- E. All orders for treatment, including verbal orders, shall be signed ~~immediately~~ in a timely fashion or in accordance with Hospital policy if applicable by the issuing

Practitioner. Orders, including verbal orders, must be timed, dated, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient and is authorized to write orders by Hospital policy and in accordance with the time requirements set forth in these Rules and Regulations or applicable Hospital policy and in accordance with the time requirement set forth in these Rules and Regulations or applicable Hospital policy. Any Practitioner authenticating a verbal order in place of the ordering practitioner (and therefore responsible for the patient's care) must have knowledge of the patient's hospital course, medical plan of care, condition, and current status. Authentication may be written, electronic, or faxed.

- F. When using electronic order sets, the practitioner must date, time, and authenticate the final order that resulted from the electronic selection/annotation process.
- G. Verbal orders may be accepted in limited circumstances (emergency or procedural uses) with the further limitation that verbal or telephone orders are not to be accepted for chemotherapeutic agents. Verbal and telephone orders may be accepted and transcribed only by registered nurses, certified nurse-midwives, pharmacists, paramedics, physical therapists, occupational therapists, respiratory therapists, speech therapists, registered dietitians, or radiologic technologists. The person taking the verbal order must sign his/her name to the transcription of the verbal order and indicate the name of the practitioner and the date and time the order was received. In the interest of patient safety, all verbal and telephone orders will be read back or repeated back to the practitioner giving these orders. With the exception of orders for resuscitation status or restraint or seclusion, verbal and telephone orders shall be authenticated in a timely fashion or in accordance with Hospital policy as applicable by the practitioner issuing the order or, if the issuing practitioner is unable to authenticate the order, by the practitioner responsible for the patient's care and authorized to write orders by Hospital policy.
- H. The Practitioner who gives the verbal or telephone order assumes the responsibility for the accuracy of the order. When a practitioner other than the ordering practitioner signs a verbal order, that practitioner assumes responsibility for the order as being complete, accurate, and final. If there is a discrepancy between the order as given and as transcribed, the responsible practitioner will notify the nurse manager/designee as soon as discovered. The order will then be rewritten by the responsible practitioner. These orders may be signed by the practitioner giving the order, or the Practitioner responsible for the patient's care.
- I. Verbal/telephone orders for restraint, seclusion and resuscitation status must be signed ASAP, but not more than 24 hours after the order has been given. Verbal/telephone orders submitted for restraint and seclusion must conform to the Restraint Policy.
- J. Resuscitation status orders may not be given without a prior discussion and agreement with the patient or the patient's family if the patient is unable to

participate in the discussion.

- K. Additional rules regarding orders by Professional Staff are set forth in Article 4 of the Credentialing and Discipline Policy.
- L. Orders submitted by non-staff members may be accepted according to the Non-Medical Staff Ordering Tests and Treatment Policy.
- M. All verbal/telephone orders for Home Care including medication orders must be signed within 30 days.

3.8 Consultations/Progress Notes.

- A. Patients shall be seen by the Attending Physician or designee at least daily. The visit must be documented with a progress note that is sufficient to permit continuity of care and transferability. When there has been no practitioner or designee visit documented, the Chief of Staff or VPMA shall be notified by Hospital staff. Charts lacking progress notes will be considered incomplete. Attending Physicians (or their designees) who fail to see their patients daily may be subject to disciplinary action according to the Medical Staff Credentialing and Discipline Policy.
- B. A consultation may be initiated by a Medical Staff member, by the resident staff, or by a Professional Staff member. Other health care providers may request a consultation by a physician only after obtaining approval from a member of the Medical Staff and must submit the request in the approving Medical Staff member's name. Consultations from appropriate specialists must be obtained when the practitioner caring for the patient does not possess the knowledge and/or technical expertise to diagnose and/or manage the patient's medical condition. Direct provider to provider communication is recommended when requesting a consultation unless a provider cannot be available because they are involved in a life-threatening patient care situation. Consultation is required for the following situations:
 - 1. When the patient is not a good risk for a planned operative procedure (ASA III or greater);

ASA PHYSICAL STATUS CLASSIFICATION:

Class I	A normally health patient
Class II	A patient with mild systemic disease
Class III	A patient with severe systemic disease
Class IV	A patient with severe systemic disease that is a constant threat to life

Class V A moribund patient who is not expected
to survive without the operation

2. In unusually complicated situations where specific skills or other practitioners may be helpful; and
 3. For all patients who have attempted suicide or have self-administered chemical overdoses, psychiatric consultation will be provided.
- C. In most cases, consultations must be performed within 24 hours and documented immediately thereafter.
- D. Consultants shall be responsible for writing an immediate note and completing a full consultative report, both of which indicate pertinent findings and recommendations for therapy. Each consultation report should contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the medical record, and shall be part of the medical record. A satisfactory consultation includes an examination of the patient and the medical record. When operative procedures are involved, the results of the consultation, except in an emergency, shall be reported prior to the operative procedure.
- E. Consultation should be requested for valid medical or education reasons. The order and reason for the consultation should be documented in the medical record. All resource intensive specialized tests such as CT scans, MRI's, Angiograms, Myocardial Perfusion Scans, Echocardiography, and Holter monitoring must be approved by a physician with the Attending Physician's name included on the consult request.
- F. The Directors of Critical Care Units are responsible for developing written policies on consultations for patients in these units. These guidelines are available for review on the Hospital intranet.
- G. The OB department is responsible for developing written policies for consultation on obstetrical patients. These policies are available for review on the Hospital intranet.
- 3.9 Procedure Notes. The performance of any procedure requiring consent of the patient or the patient's legal representative whether for therapeutic or diagnostic purposes must be documented in the medical record.
- A. The following documentation must be completed (dictated or documented, and authenticated) by the surgeon immediately following any procedure. (Administration of blood products shall not be considered to be a "procedure.") The report should be documented and authenticated immediately following the procedure in its entirety before the patient is transferred to the next level of care. Documentation for all procedures must include, at a minimum:
1. date and times of the procedure;

2. name(s) of surgeon and assistant(s) and other practitioners who performed surgical tasks (even if performing the tasks under supervision);
3. pre-operative and postoperative diagnosis;
4. technical procedure used/performed;
5. description of the specific significant surgical tasks conducted by practitioners other than the primary surgeon/practitioner (incl. opening and closing; harvesting grafts; dissecting, altering, or removing tissue; implanting devices);
6. description of techniques, findings, and tissues removed or altered;
7. estimated blood loss;
8. complications;
9. type of anesthesia administered; and
10. prosthetic devices, grafts, tissues, transplants, or devices implanted.

B. In addition to the documentation described above, a detailed narrative description is required:

1. for all procedures done in the surgery department with the exception of ECTs, cardioversion or secondary anesthesia procedures including vascular access;
2. any procedure involving the removal of significant tissue or body fluid for laboratory or pathological evaluation;
3. for the permanent placement of an indwelling foreign body;
4. for any procedure that involves endoscopic instrumentation;
5. for any procedure requiring moderate or deep sedation; and
6. when there are complications from a procedure.

C. Detailed narrative description is not usually necessary for circumcision, lumbar punctures, placement of vascular lines for invasive monitoring and anesthetic procedures involving the neural axis or peripheral nerves.

D. Procedure notes may be included as part of a dictated admission or consultation note. All procedures still require an immediate post-procedure note.

- E. If a full operative report cannot be dictated and placed in the patient's chart before transfer to the next level of care, an immediate postoperative/post procedure note is required to be documented. (If this information is identified in nursing documentation, it is acceptable if authenticated as accurate by the attending surgeon.) The note shall include identification or description of, at a minimum:
1. the surgeon and assistants;
 2. pre-operative and postoperative diagnosis
 3. procedures performed;
 4. specimens removed;
 5. estimated blood loss (blood administered as needed);
 6. complications (if any);
 7. type of anesthesia;
 8. grafts or implants

3.10 Discharge/Signatures/Co-signatures.

- A. Patients shall be discharged only on the order of the attending practitioner, who must be a member of the Medical Staff, or designee. The designee must be another practitioner who works with the admitting practitioner, who is covering for the admitting practitioner's patients, and who is knowledgeable about the patient's condition, the patient's care during hospitalization and the patient's discharge plans.
- B. The attending practitioner or designee will be responsible for final diagnosis, discharge summary, and discharge instructions which should include diet, medications, activity and follow-up.
- C. At discharge from inpatient care, a discharge summary concisely summarizes the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the patient's condition on discharge, and any specific instructions on follow up care given to the patient and/or family, as pertinent.
- D. A final progress note is substituted for the discharge summary only for those patients with problems and interventions of a minor nature who require less than a 48 hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetric deliveries. The final progress note must include the outcome of the hospitalization, the case disposition, and any provisions for follow-up care.

- E. A transfer summary may be substituted for the discharge if the patient is transferred to a different level of hospitalization or residential care within the organization.
- F. Except as otherwise specifically permitted in these Rules and Regulations or elsewhere in the Bylaws, the signing of histories and physicals, operative reports and consultations must be by the documenting practitioner. Progress notes, orders and discharge summaries may be signed by associates in accordance with these Rules and Regulations.
1. Students/Interns. All medical record entries require a co-signature by the supervising physician or Allied Health Professional. Orders are not released until they are co-signed.
 2. Residents/Fellows. Residents/fellows must have a co-signature for the following (includes both licensed and unlicensed):
 - a. Consult
 - b. Discharge summary
 - c. History and physical exam (H&P)
 - d. Operative report
 - e. Procedure note
 - f. Patient status orders (e.g., inpatient, observation)
 3. Professional Staff.
 - a. Licensed Independent Practitioners (CNM, LICSW, LP, PsyD, PhD)
 - (1) H&Ps, discharge summaries, and all reports must be signed by the individual completing the documentation.
 - (2) There are no co-signature requirements.
 - b. Licensed Non-Independent Practitioners (NP, PA, CNS, CRNA)
 - (1) All medical record entries must be signed by the individual completing the documentation. H&Ps, charge summaries, operative reports, and patient status orders must be co-signed by a supervising physician.
 - (2) For dictated and transcribed documents, the co-signature functionality in Epic applies to all reports. TO be in co-signature compliance for H&Ps and discharge summaries, all transcribed documents will be co-signed in Epic.
 - c. Allied Health Staff
 - (1) In the case of Supervised Practitioners credentialed through the Medical Staff, as defined in Article 4.5 of the Credentialing and

Discipline Policy, documentation related to medical decision making and all orders must be co-signed within 24 hours.

(2) It is the responsibility of the supervised practitioner to check co-signature required in Epic.

(3) Supervised practitioners may provide such services only under the sponsorship and supervision of a member of the Medical Staff.

(4) Supervised practitioners include, but not necessarily limited to, the following:

- Registered nurses
- Perfusionists
- EMG technicians
- Sonographers
- Surgical technicians
- Orthotists
- Prosthetists
- OPA-C

3.11 Medical Record Completion.

- A. Medical records must be completed within thirty days of discharge. Health Information Management shall provide practitioners with regular reports on the status of incomplete charts.
- B. All Hospital privileges shall be denied to practitioners who have been notified by the Chief of Staff or designee that they have charts not completed by the 31st day post discharge. Privileges may be restored by the Chief of Staff or Vice President of Medical Affairs, in his or her discretion, upon completion of incomplete medical records.
- C. Practitioners who have been suspended more than three times in one year will be presented to the Medical Executive Committee for discussion of disciplinary action. Discipline may include loss of Medical Staff membership or privileges.
- D. All physical medical records, including x-rays, are the property of Maple Grove Hospital and may not be removed from the Hospital, except pursuant to a court order or as otherwise authorized by law. All prior medical records of current patients shall be available for use by the attending and consulting practitioners.
 1. A patient or his or her legal representative may receive copies of the patient's medical record in accordance with Hospital policy.
 2. Access to all medical records of patients will be afforded to members of the Medical Staff for bona fide study and research consistent with Hospital policy and

applicable federal and state law. All such projects will be approved by the Institutional Review Board (IRB).

3. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended to such patients in the Hospital provided such access is consistent with Hospital policy and applicable federal and state law.

- E. In situations where a Practitioner fails to complete charts prior to the end of their Medical Staff membership (including in the event of Practitioner's death or if the Practitioner leaves the practice of medicine), the Practitioner's partners in a group practice shall assume responsibility for the care of patients in the unfinished charts and shall work with Hospital to complete medical record documentation in accordance with Hospital policy and applicable state and federal law.

ARTICLE 4 AUTOPSY

4.1 Every member of the Medical Staff is encouraged to secure written permission for autopsies in all cases of unusual death and those of medical, legal and educational interest including the following cases:

1. All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty based on clinical grounds.
2. Deaths in which an autopsy may help explain unknown and unanticipated medical complications.
3. Cases in which an autopsy may help to allay concerns of and provide reassurance to the family and/or the public regarding the death.
4. Unexpected or unexplained deaths that are apparently natural and not subject to forensic medical jurisdiction.
5. Deaths resulting from infectious and contagious disease.
6. All obstetric deaths.
7. Deaths known or suspected to have resulted from environmental or occupational hazards.

4.2 All autopsies shall be performed by a Medical Center pathologist or delegated to an approved site. Gross provisional diagnosis must be in the record within 72 hours of the performance of an autopsy; final diagnosis shall be in the chart within sixty days of performance of autopsy. Consent must be obtained for autopsy on those who have died lacking a personal directive for autopsy unless the Medical Examiner has accepted jurisdiction of the case.

4.3 Documentation. In coordination with operation of the Post Mortem Care policy, the

expiration record form, and Organ, Tissue and Eye Donation policy, consent for autopsy may be obtained by the deceased's nurse caregiver staff or primary physician. Additional staff resources include administrative managers, nurse managers, and their designees. Obtaining consent through telephone contact of legal next of kin is permitted. When the Medical Examiner's office takes jurisdiction over a reported death, disposition of the body, organ/tissue/eye donation, and use of the consent for autopsy form is at the discretion of the Medical Examiner. All in-house deaths must be discussed with the Hennepin County Medical Examiner prior to discussing autopsy order(s).

ARTICLE 5 ACCESS TO MEDICAL STAFF MINUTES AND RECORDS

5.1 Confidentiality. Minutes of any peer review proceedings are confidential. Only authorized persons may have access to such records for permitted purposes under applicable law. Authorized persons include the Chief Executive Officer, Chief of Staff, Vice President of Medical Affairs, involved Department or Section Chiefs, involved Committee Chairpersons, current members of the Peer Review Committee and other persons as may be authorized by the Chief of Staff.

5.2 Access. Access to practitioner credential and quality improvement files shall be limited as follows:

1. A Practitioner may review his/her own file in the event of an adverse decision affecting his or her membership on the Medical Staff, privileges, or similar action taken by the Medical Executive Committee or other governing body, and such Practitioner access is sought through discovery in proceeding to challenge the action relating to the Practitioner's medical staff privileges or membership;
2. Chief of Staff or physician designee;
3. Chief Executive Officer;
4. Chief of the Department or Section of which the practitioner is a member or a physician designee
5. Vice President of Medical Affairs; and
6. Manager Medical Staff Office and his/her designees performing peer review functions.

All other persons requesting access to a Practitioner's file shall be directed to the Chief of Staff or Vice President of Medical Affairs.

ATTACHMENT D

Glossary

The following definitions apply to terms used throughout these Bylaws:

1. "Professional Staff" means Licensed Independent Practitioners and Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs).
2. "Allied Health Staff" means Supervised Practitioners credentialed through the Medical Staff.
3. "Attending Physician" means the physician medical staff member who is responsible for the coordination of care while the patient is an inpatient in the hospital.
4. "Board of Directors" means the Board of Directors of the Partnership, which shall act as the governing body of the Hospital.
5. "Bylaws" means these Bylaws of the Medical Staff of the Hospital.
6. "Dentist" means an individual licensed to practice dentistry.
7. "Designee" means any person charged by another person to carry out an act required hereunder, provided that such act is within the privileges, scope of practice, or other permission of such person charged to do the act.
7. "Hospital" means Maple Grove Hospital, a licensed hospital located in Maple Grove, Minnesota.
8. "Licensed Independent Practitioner" or "LIP" means a professional who, pursuant to applicable law, may practice independent of a physician and includes, but is not necessarily limited to, certified nurse midwives, independent clinical social workers, and psychologists.
9. "Medical Executive Committee" or "MEC" means the Medical Executive Committee of the Hospital's Medical Staff, as defined in Section 8.2 of these Bylaws.
10. "Medical Staff" or "Staff" means all duly licensed Physicians, Dentists, and Podiatrists who are appointed to the Medical Staff of the Hospital in accordance with these Bylaws.
11. "Medical Staff Bylaws and Policies" means, collectively, the Bylaws, Credentialing and Discipline Policy, Fair Hearing Policy, and the Rules and Regulations of the Medical Staff.

12. "OPPE" means ongoing professional practice evaluation, and is a process whereby the Medical Staff continues to evaluate the competence of its members, including the member's ability to act professionally or to provide safe, high-quality patient care.

13. "PA/APRN" means physician assistants, certified nurse anesthetists, nurse practitioners, and clinical nurse specialists.

14. "Physician" means an individual licensed to practice medicine or osteopathic medicine.

15. "Podiatrist" means an individual licensed to practice podiatry.

16. "Practitioner" means a duly licensed Physician, Dentist, or Podiatrist, and anyone else having clinical privileges at the Hospital, including Professional Staff, Allied Health Professionals, unless the context clearly indicates otherwise.

17. "Rules" means the Rules and Regulations of the Medical Staff, which are specifically made a part of these Bylaws.

18. "Chief Executive Officer" or "Administrator" means the individual appointed by the Board of Directors to act on its behalf in the overall administrative management of the Hospital.