Las Palmas Del Sol Healthcare

MEDICAL STAFF BYLAWS

July 28, 2020

MEDICAL STAFF BYLAWS [not revised]
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ARTICLE 1
NAME, PURPOSES AND RESPONSIBILITIES

1.A. NAME

The name of the Medical Staff shall be the "Las Palmas Del Sol Healthcare."

1.B. PURPOSES AND RESPONSIBILITIES

The purposes and responsibilities of the Medical Staff are:

(1) to provide a formal organizational structure through which the Medical Staff shall carry out its responsibilities and govern the professional activities of its Members and other Practitioners and to provide mechanisms for accountability of the Medical Staff to the Board of Trustees. These Bylaws, the Credentials Policy, and the Organization Manual shall reflect the current organization and functions of the Medical Staff;[1]

(2) to provide patients with the quality of care that is commensurate with acceptable standards and available community resources;

(3) to collaborate with the Hospital in providing for the uniform performance of patient care processes throughout the Hospital;[2]

(4) to serve as a primary means for accountability to the Board of Trustees concerning professional performance of practitioners and others with Clinical Privileges authorized to practice at the Hospital with regard to the quality and appropriateness of health care. This shall be provided through leadership and participation in Medical Peer Review activities including, but not limited to, quality assessment, performance improvement, risk management, case management, utilization review and resource management, and other Hospital initiatives to measure and improve performance;[3]

(5) to provide mechanisms for recommending to the Board of Trustees the grant of initial and renewed Medical Staff Membership to qualified practitioners, and making recommendations regarding Clinical Privileges for qualified and competent practitioners;

(6) to provide education that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills;

(7) to adopt, implement and enforce these Bylaws, Credentials Policy, Organization Manual, and Rules and Regulations to carry out its responsibilities, for the proper functioning of the Medical Staff, and for the integration and coordination of the Medical Staff with the functions of the Hospital;

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1 MS.01.01.01; LD.01.05.01; 42 C.F.R. §482.22(b)(1); 42 C.F.R. §482.22(c)(3); 42 C.F.R. §482.12(a)(3)

2 LD.04.03.07

3 MS.01.01.01; LD.01.05.01; 42 C.F.R. §482.22(b)(1); 42 C.F.R. §482.22(c)(3)

(8) to provide a means for communication with regard to issues of mutual concern to the Medical Staff, Administration, and Board of Trustees;[4]

(9) to participate in identifying community health needs and establishing appropriate institutional goals;[5]

(10) to assist the Board of Trustees by serving as a medical peer review committee, medical committee, and professional review body in conducting Medical Peer Review activities, which include, without limitation, focused professional practice evaluations, ongoing professional practice evaluations, quality assessment, performance improvement, and peer review;[6]

(11) to pursue corrective actions with respect to Practitioners, when warranted;

(12) to monitor and enforce compliance with these Bylaws, the Credentials Policy, the Organization Manual, the Medical Staff Rules and Regulations, other Medical Staff policies, and Hospital policies; and

(13) to maintain compliance of the Medical Staff with regard to applicable accreditation requirements and applicable Federal, State, and local laws and regulations.[7]

1.C. POWERS AND RESPONSIBILITIES OF THE BOARD OF TRUSTEES

(1) The Hospital is owned by the Corporation which retains all authority and control over the business, policies, operations, and assets of the Hospital via the Board of Directors. The Board of Directors is elected by the shareholders of the Corporation. The Board of Directors retains ultimate responsibility for the Hospital's compliance with all applicable Federal, State, and local laws and regulations.[8] The Board of Directors has delegated certain duties to the Corporation's officers and to the Board of Trustees. The rights and duties delegated to the Board of Trustees, acting in its capacity as the authorized agent of the Corporation and as the governing body of the Hospital, are described in these Bylaws, the Credentials Policy, the Organization Manual, the Medical Staff Rules and Regulations, and other Medical Staff policies.[9]

(2) The Board of Directors has appointed the Board of Trustees to assist and advise the Chief Executive Officer, the Corporation, the Board of Directors, and the Medical Staff. The primary function of the Board of Trustees shall be to assure that the Hospital and its Medical Staff provide quality medical care that meets the needs of the community. For

4 MS.01.01.01; LD.03.04.01
5 LD.02.01.01; LD.04.03.01
6 42 C.F.R. §482.12(a)(5); MS.05.01.01; MS.08.01.01; MS.08.01.03; MS.09.01.01
7 LD.04.01.01
8 42 C.F.R. §482.11; 42 C.F.R. §482.12; LD.04.01.01
9 LD.01.01.01

this purpose, the Board of Directors has delegated to the Board of Trustees the authority to receive and evaluate periodic reports from the Medical Staff and its officers, to make decisions in compliance with the Corporation's policies regarding Medical Staff Membership and the granting of Clinical Privileges, to oversee performance improvement, utilization review, risk management, and similar matters regarding the provision of quality patient care at the Hospital, and to establish policies regarding such matters.[10] All officers, Medical Staff Members, Advanced Practice Professionals, Hospital employees, non-employees who provide patient care under an approved scope of practice, and other agents of the Hospital are subject to the control and direction of, and removal by, the Board of Trustees. All Practitioners are subject to termination or modification of their Medical Staff Membership and/or Clinical Privileges by the Board of Trustees, based on factors deemed relevant by the Board of Trustees. Actions taken by the Board of Trustees may, but need not, follow the procedures outlined in the Medical Staff Bylaws, Credentials Policy, Organization Manual, Rules and Regulations, and other Medical Staff policies.

(3) In a manner mutually agreeable to the Corporation and the Board of Trustees, the Board of Trustees shall report any matters of concern to the Corporation. Any such matters that are within the scope of duties of the Board of Trustees, but exceed the scope of their authority, such as issues related to financial management, can be referred back to the Corporation and the Board of Directors.

(4) The Board of Directors, through its officers and the CEO, retains authority for the Hospital's business decisions, adherence to HCA Ethics and Compliance Policies, and financial management, including long-range and short-range planning and budgeting, but may request the advice of the Board of Trustees on such matters. The Board of Directors expressly reserves the right to amend, modify, rescind, clarify, or terminate at any time and without Notice any delegation of authority given to the Board of Trustees and, if deemed necessary by the Board of Directors, to overrule decisions made by the Board of Trustees.

[10] LD.01.03.01; 42 C.F.R. §482.12(a)

ARTICLE 2
GENERAL

2.A. DEFINITIONS

The definitions that apply to the capitalized and certain other terms used in the Medical Staff Bylaws, the Credentials Policy, and the Organization Manual are set forth in the Credentials Policy.

2.B. TIME LIMITS

Time limits referred to in these Bylaws, the Credentials Policy, and the Organization Manual are advisory only and are not mandatory, unless it is expressly stated. Medical Staff leaders will strive to be fair under the circumstances.

2.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital administration, by a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff Member is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

2.D. ORGANIZED HEALTH CARE ARRANGEMENT

The Hospital, all Members of the Medical Staff and other Practitioners shall be considered members of, and shall participate in, the Hospital's Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information promulgated by the U.S. Department of Health and Human Services pursuant to the Administrative Simplification provisions of HIPAA. An OHCA is a clinically integrated care setting in which individuals typically receive health care from more than one health care provider. An OHCA allows the Hospital to share information with the Practitioners and the Practitioners' offices for purposes of payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Physicians, Dentists, Oral Maxillofacial Surgeons, Podiatrists and Advanced Practice Professionals with Clinical Privileges, and non-employees who provide patient care under an approved scope of practice. All Practitioners and non-employees with an approved scope of practice agree to comply with the Hospital's policies as adopted from time to time regarding the use and disclosure of individually identifiable health information ("IIHI") and protected health information ("PHI"), as those terms are defined by HIPAA or as any similar terms are defined by more stringent state law (collectively, "IIHI/PHI").[11]

[11] 45 C.F.R. §164.500

ARTICLE 3
CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for Medical Staff Membership, as set forth in the Credentials Policy, are eligible to apply for Membership in one of the categories listed below. Requests for waivers related to the categories set forth in this Article will be processed in the same manner as requests for waivers of threshold eligibility criteria, as set forth in the Credentials Policy.

3.A. ACTIVE STAFF

3.A.1. Qualifications:

The Active Staff will consist of Members of the Medical Staff who demonstrate a commitment to fulfilling Medical Staff functions by completing at least two of the following types of activities during the previous term of Medical Staff Membership:

(1) serving as a Medical Staff officer, department chairperson or section director;

(2) membership on the Board of Trustees;

(3) Medical Staff committee chairperson;

(4) Medical Staff committee member;

(5) serving as a proctor to a practitioner under focused professional practice evaluation;

(6) serving as a Physician advisor or peer reviewer;

(7) serving on a Hospital committee or team/task group;

(8) supervisory duties, e.g., serving as the medical director of a Hospital department or Supervision of another practitioner;

(9) providing education to fellow Medical Staff Members, e.g., grand rounds, formal educational presentation, author of a Medical Staff newsletter article; or

(10) supervising participants in a Hospital-sponsored professional graduate education program.

3.A.2. Prerogatives:

Active Staff Members may:

(1) vote in general and special meetings of the Medical Staff and applicable department, section, and committee meetings; and

(2) hold office, serve on Medical Staff committees, and serve as department chairperson, section director, and committee chairperson.

3.A.3. Responsibilities:

Active Staff Members must assume all the responsibilities of the Active Staff, including:

(1) serving on committees, as requested;

(2) participating in the Medical Peer Review process including, but not limited to, professional practice evaluation and performance improvement processes; and

(3) accepting inpatient consultations, when requested.

3.B. AFFILIATE STAFF

3.B.1. Qualifications:

The Affiliate Staff shall consist of Members of the Medical Staff who:

(1) are newly appointed to Medical Staff Membership and have not yet met the qualifications for Active Staff Membership; or

(2) are not actively involved in Medical Staff affairs and not major contributors to the fulfillment of Medical Staff functions due to practicing primarily at another hospital or being in a specialty that has an office-based practice; and

(3) wish to remain affiliated with the Hospital for consultation, call coverage, referral of patients or other patient care purposes.

3.B.2. Prerogatives and Responsibilities:

Affiliate Staff Members:

(1) may attend meetings of the Medical Staff and applicable department and section meetings (without vote) and applicable committee meetings (with vote);

(2) may not hold office or serve as a department chairperson, section director, or committee chairperson, unless waived by the Medical Executive Committee and Board;

(3) must cooperate in the Medical Peer Review process including, but not limited to, professional practice evaluation and performance improvement process; and

(4) may request advancement to the Active Staff category if the Medical Staff activities required for Active Staff status are completed at any time within a term of Medical Staff Membership.

3.C. AMBULATORY STAFF

3.C.1. Qualifications:

The Ambulatory Staff will consist of Members of the Medical Staff who:

(1) desire to have Medical Staff Membership to satisfy a criterion for participation in a managed care panel or to pursue professional and educational opportunities, including continuing medical education, available at the Hospital;

(2) do not intend to establish a clinical practice at this Hospital, are not seeking and will not be granted Clinical Privileges, and are not subject to focused professional practice evaluation and ongoing professional practice evaluation; and

(3) satisfy the qualifications for Medical Staff Membership set forth in the Credentials Policy, but are exempt from the qualifications pertaining to Clinical Privileges, such as response time requirements, coverage, emergency call, clinical activity, and DEA registration.

3.C.2. Prerogatives and Responsibilities:

Ambulatory Staff Members:

(1) may attend meetings of the Medical Staff and applicable departments and sections (without vote);

(2) may serve on committees (with vote);

(3) may not hold office or serve as department chairperson, section director or committee chairperson;

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

(5) may refer patients to Members of the Medical Staff for admission and care;

(6) are encouraged to communicate directly with Active Staff Members about the care of any patients referred, as well as to visit any such patients and record a courtesy progress note in the medical record containing relevant information from the patient's outpatient care;

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

(8) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(9) are not granted inpatient or outpatient Clinical Privileges and, therefore, may not admit patients, attend patients, write orders for inpatients, perform consultations, assist in

surgery, or otherwise participate in the management of clinical care to patients at the Hospital;

(10) may refer patients to the Hospital's diagnostic facilities and order such tests; and

(11) must pay any fees, dues, and assessments associated with Medical Staff Membership or the submission of an Application.

3.D. HONORARY RECOGNITION

3.D.1. Qualifications:

(1) Honorary Recognition may be granted to former Members of the Medical Staff who:

(a) have a record of previous long-standing service to the Hospital and have retired from the active practice of medicine; or

(b) are recognized for outstanding or noteworthy contributions to the medical sciences.

Individuals who have been granted Honorary Recognition are not Members of the Medical Staff and are not granted Clinical Privileges, and, therefore, do not need to satisfy any of the threshold eligibility criteria associated with Membership and Privileges and will not be subject to focused professional practice evaluation or ongoing professional practice evaluation.

(2) Once an individual is granted Honorary Recognition, that status is ongoing. Honorary Recognition may be terminated by the Board, with no right to a hearing or appeal.

3.D.2. Prerogatives and Responsibilities:

Individuals who are granted Honorary Recognition may attend educational and social functions of the Hospital and its Medical Staff.

3.E. ADVANCED PRACTICE PROFESSIONALS

3.E.1. Qualifications:

Advanced Practice Professionals are those Practitioners who are listed in Appendix A to the Credentials Policy. Advanced Practice Professionals are not Medical Staff Members but are granted Clinical Privileges and permission to practice at the Hospital under a defined degree of direction, delegation and/or supervision by a Supervising/Collaborating Practitioner.

3.E.2. Prerogatives and Responsibilities:

Advanced Practice Professionals:

(1) may attend and participate in Medical Staff, department and section meetings (without vote);

(2) may not hold office or serve as department chairperson, section director, or committee chairperson;

(3) may be invited to serve on committees; and

(4) must cooperate in the Medical Peer Review process including, but not limited to, professional practice evaluation and performance improvement processes.

ARTICLE 4
OFFICERS

4.A. DESIGNATION

The Medical Staff will have the following officers:

(1) Chief of Staff – Las Palmas;
(2) Chief of Staff – Del Sol;
(3) Chief of Staff – Elect – Las Palmas;
(4) Chief of Staff – Elect – Del Sol;

(5) Immediate Past Chief of Staff – Las Palmas;
(6) Immediate Past Chief of Staff – Del Sol;

(7) Secretary/Treasurer – Las Palmas;

(8) Secretary/Treasurer – Del Sol;

(9) Member at large – Las Palmas; and

(10) Member at Large – Del Sol.

In addition to the above, there shall be the officer positions of President of the Medical Staff and Vice-President of the Medical Staff. In order to ensure appropriate representation of all Medical Staff members, the offices of President and Vice-President shall be filled by Medical Staff members from different primary practice campuses for alternating one-year terms. The Chief of Staff - Las Palmas will serve as President of the Medical Staff and the Chief of Staff – Del Sol as the Vice-President of the Medical Staff in the even years, and the Chief of Staff - Del Sol will serve as President of the Medical Staff and the Chief of Staff – Las Palmas as the Vice-President of the Medical Staff in the odd years. See Exhibits A and B.

4.B. ELIGIBILITY CRITERIA

Only those Members of the Medical Staff who satisfy the following criteria initially and continuously will be eligible to serve as an officer of the Medical Staff (unless an exception is recommended by the Medical Executive Committee and approved by the Board).[12] They must:

(1) have served on the Active Staff for at least five years;

(2) have no pending adverse recommendations concerning Medical Staff Membership or Clinical Privileges and be a Member in Good Standing;

(3) not be under investigation by the Medical Staff or any state or federal agency regarding clinical competence or professional conduct or any other aspect of professional practice;

[12] MS.01.01.01; §482.22(b)(3)

(4) not presently be serving as a medical staff officer, governing board member, or department chairperson at any other hospital and will not so serve during their terms of office;

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

(6) have experience in a leadership position or other involvement in performance improvement functions for at least two years;

(7) participate in Medical Staff Leadership training as determined by the Medical Executive Committee;

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

(9) not have a financial relationship (i.e., an ownership or investment interest) with an entity, other than an Affiliated Entity, that competes with the Hospital. This does not apply to services provided within a Practitioner's office and billed under the same provider number used by the Practitioner.

In addition to the above, the President and Vice-President of the Medical Staff must be Physicians.13

4.C. DUTIES[14]

4.C.1. President of the Medical Staff:

The President of the Medical Staff will:

(1) act in coordination and cooperation with the Chief Medical Officer, the Chief Executive Officer, and the Board in matters of mutual concern involving the care of patients in the Hospital;

(2) represent and communicate the views, policies and needs, and report on the activities, of the Medical Staff to the Chief Executive Officer, Chief Medical Officer, and the Board, and be accountable to the Board for the implementation of these Bylaws and related manuals and policies in the delivery of clinical services and professional performance of members of the Medical Staff;

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

13 25 Tex. Admin. Code Sec. 133.41(k)(2)(D)

14 MS.01.01.01

(4) serve as a voting member of and Chair of the Medical Executive Committee and an ex-officio member of all other Medical Staff committees without vote, unless otherwise specified;

(5) serve as an ex-officio member of the Board with vote;

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

(7) appoint committee members and chairpersons of Medical Staff committees (except the Medical Executive Committee), and ad hoc committees when needed, and appoint Medical Staff members to Hospital and Board committees, as further detailed in Article 6 of these Bylaws;

(8) establish ad hoc committees and appoint members to: (a) assist in the development of Hospital policies and procedures; and (b) to provide a forum for consideration of plans of future growth or change in the Hospital organization, and for discussion of problems that arise in the operation of the Hospital. Prepare a written record of the proceedings and recommendations of the ad hoc committees and send it to the Board of Trustees and to the Medical Staff;

(9) perform functions authorized in these Bylaws and other applicable policies, manuals, and the Rules and Regulations, including collegial intervention in the Credentials Policy, and as may be assigned by the Medical Executive Committee or Board of Trustees; and

(10) act as a representative of the Medical Staff to the public as well as to other healthcare providers, other organizations, and regulatory or accrediting agencies in external, professional and public relations.

4.C.2. Vice-President of the Medical Staff:

The Vice-President of the Medical Staff will:

(1) be a voting member and Vice-Chair of the Medical Executive Committee;

(2) assume the duties of the President of the Medical Staff and act with full authority as President of the Medical Staff in his/her absence;

(3) serve as an ex-officio member of all Medical Staff committees without vote, unless otherwise specified;

(4) serve as an ex-officio member of the Board with vote;

(5) assist the President of the Medical Staff in appointment of committee members as detailed in Article 6, and perform other duties as are assigned by the President of the Medical Staff or the Medical Executive Committee; and

(6) automatically succeed the President of the Medical Staff at the conclusion of the President of the Medical Staff's term or sooner should the office become vacated for any reason during the President's term of office.

4.C.3. Secretary/Treasurers:

The Secretary/Treasurers will:

(1) cause to be kept accurate and complete minutes of meetings of the Medical Executive Committee and Medical Staff, with each separately responsible for meetings held on his or her primary practice campus;

(2) give proper Notice of Medical Staff meetings;

(3) perform other duties as are assigned by the President of the Medical Staff or the Medical Executive Committee; and

(4) in the temporary or permanent absence of the Chief of Staff and Chief of Staff – Elect for the Secretary/Treasurer's primary practice campus, assume all duties and responsibilities and have the authority of the Chief of Staff until such time as a new Chief of Staff and/or Chief of Staff - Elect are selected.

4.C.4. Immediate Past Chiefs of Staffs:

The Immediate Past Chiefs of Staff will:

(1) serve as an advisors to other Medical Staff Leaders;

(2) serve as an ex-officio member of the Medical Executive Committee without vote, as well as other standing committees of the Medical Staff as specified in the Bylaws or Organizational Manual; and

(3) perform other duties as are assigned by the President of the Medical Staff or the Medical Executive Committee.

4.D. NOMINATION AND ELECTION PROCESS

4.D.1. Nominating Process:

(1) Not less than 90 Days prior to the end of every two Medical Staff Years, the Medical Staff Leadership Development and Nominating Committee will prepare a slate of nominees for the offices of Chief of Staff and Chief of Staff – Elect of the Medical Staff and Secretary/Treasurer for each campus and for the two at-large members of the Medical Executive Committee for each campus.

(2) Officers may only be nominated for positions from the campus each nominee designates as his or her primary practice campus, and may not change that designation during

nomination or the term of office. Nominations for the offices of Chief of Staff - Las Palmas, Chief of Staff – Elect - Las Palmas and Secretary/Treasurer - Las Palmas shall be presented from qualified members of the Medical Staff whose primary practice campus is the Las Palmas campus. Nominations for Chief of Staff - Del Sol, Chief of Staff – Elect - Del Sol and Secretary-Treasurer - Del Sol shall be presented from qualified members of the Medical Staff whose primary practice campus is the Del Sol campus. Nominees for the Chiefs of Staff shall always be selected with the thought that such individuals will assume the roles of President and Vice-President and must meet any criteria established through these Bylaws for those offices.

(3) Notice of the nominees will be provided to the Medical Staff at least 60 Days prior to the end of the Medical Staff Year.

(4) Additional nominations may be submitted, in writing, by a petition signed by at least 10% of the voting Members of the Medical Staff as set out below, along with receipt of a signed statement of willingness to serve by the nominee. A petition for the offices of Chief of Staff, Chief of Staff – Elect or Secretary/Treasurer for a campus must be signed by at least 10% of the voting members of the Medical Staff whose primary practice campus is the same as the nominee's campus. A petition nominating a member-at-large must be signed by at least 10% of the voting members of the entire Medical Staff. The petition must be presented to the Chairperson of the Medical Staff Leadership Development and Nominating Committee at least 45 Days prior to the end of the Medical Staff Year.

(5) In order for a nominee to be placed on the ballot, the candidate must be willing to serve and must, in the judgment of the Medical Staff Leadership Development and Nominating Committee, satisfy the qualifications in Section 4.B of these Bylaws.

(6) The election schedule and offices to be filled are detailed on Exhibits A and B.

4.D.2. Election:

(1) All Active Staff Members are eligible to vote for the nominees for Members-at-Large. For Chief of Staff, Chief of Staff – Elect, and Secretary/Treasurer, each voting Member shall vote only for the nominees from the Member's primary practice campus which shall be designated before the meeting or mail ballot.

(2) Voting at the annual meeting shall be by secret written ballot, and authenticated sealed mailed ballots may be counted. Written ballots shall include handwritten signatures for comparison with signatures on file, when necessary. At least 10% of the Active Staff Members must participate in the voting and voting by proxy shall not be permitted.

(3) In lieu of voting at the annual meeting, elections may be held by mail ballot if approved by the Medical Executive Committee and the Chief Executive Officer. For a mail ballot, the election process shall occur via electronic voting using a secure system. The ballot shall be sent out electronically to all Active Staff Members at their e-mail address of record at least 30 Days prior to the end of the Medical Staff Year. Active Staff Members

shall have seven Days to submit their votes. At least 25% of the Active Staff Members must participate in the voting.

(4) The candidates receiving a majority of the votes cast will be elected, subject to confirmation by the Board.

(5) If no candidate receives a simple majority vote on the first ballot, a run-off election will be held promptly between the two candidates receiving the highest number of votes. If a tie results, a Quorum of Medical Executive Committee members shall vote by secret ballot at its next meeting or a special meeting called for that purpose and at which a Quorum of the Medical Executive Committee members are present. The election shall become effective upon approval of the Board.15

4.E. TERM OF OFFICE, VACANCIES AND REMOVAL

4.E.1. Term of Office:

(1) Officers will assume office on the first day of the Medical Staff Year.

(2) Medical Staff officers will serve an initial two-year term and, except for at-large members, may not serve consecutive terms in the same office.

(3) At-large members of the Medical Executive Committee may be elected to serve one additional consecutive two-year term.

4.E.2. Vacancies:

(1) If there is a vacancy in the office of President of the Medical Staff, the President-Elect will serve until the end of the unexpired term of the President of the Medical Staff.

(2) If there is a vacancy in the office of Chief of Staff, the Chief of Staff – Elect will serve until the end of the expired term of the Chief of Staff.

(3) If there is a vacancy in the office of Vice-President, Secretary/Treasurer, or Chief of Staff – Elect, the Medical Executive Committee will appoint an individual, who satisfies the qualifications set forth in Section 4.B of these Bylaws, to the office until a special election can be held. The appointment will be effective upon approval by the Board of Trustees.

(4) If there is a vacancy in the office of the Immediate Past Chief of Staff, the office shall remain vacant until after the next election, resignation, removal or recall from office.

(5) If there is a vacancy in the position of an at-large member of the Medical Executive Committee, the Medical Executive Committee will appoint an individual, who satisfies the qualifications set forth in Section 4.B of these Bylaws, to the position until a special

15 MS.1.20

election can be held. The appointment will be effective upon approval by the Board of Trustees.

(6) In the temporary or permanent absence of both the President of the Medical Staff and the Vice-President, the Chief of Staff – Elect from the President's primary practice campus shall assume all the duties and responsibilities and have the authority of the President of the Medical Staff until such time as a new President and President-Elect are elected.

(7) In the temporary or permanent absence of all officers, the Board of Trustees shall appoint interim officers to fill these positions and an election shall be conducted within 90 Days. The Medical Staff Leadership Development and Nominating Committee shall convene as soon as possible to nominate candidates to fill the unexpired terms of office. Following the nomination of candidates, the Medical Staff shall hold a special meeting to conduct elections for these offices, using the election procedures described in these Bylaws.

4.E.3. Removal:

(1) Removal of the President or Vice-President of the Medical Staff or an at-large member of the Medical Executive Committee may be effectuated by a two-thirds vote of the voting members of the Medical Staff, a majority vote of the Medical Executive Committee or by a majority vote of the Board of Trustees for:[16]

(a) failure to comply with or enforce applicable Hospital policies, these Bylaws, the Credentials Policy, the Organization Manual, other Medical Staff policies, or the Rules and Regulations;

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

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

(d) an infirmity that renders the individual incapable of fulfilling the duties of that office; or

(e) failure to continue to satisfy any of the criteria in Section 4.B of these Bylaws.

For removal of a Secretary/Treasurer or Immediate Past Chief of Staff on the above grounds, a two-thirds vote of the voting members of the Medical Staff of the officer's primary practice campus is required, or a majority vote of the Medical Executive Committee, or a majority vote of the Board of Trustees.

(2) 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.

[16] MS.01.01.01

(3) 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, or the Board, as applicable, prior to a vote on removal.

(4) Removal will be effective when approved by the Board of Trustees.

4.E.4. Resignation:

Any Medical Staff officer including an at-large member of the Medical Executive Committee may resign at any time by giving written Notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

ARTICLE 5
CLINICAL DEPARTMENTS

5.A. ORGANIZATION

5.A.1. Organization of Departments:

(1) The Medical Staff may be organized into the clinical departments and sections as listed and described in the Medical Staff Organization Manual.[17]

(2) Subject to the approval of the Board, the Medical Executive Committee may create or eliminate departments create or eliminate specialty sections, or otherwise reorganize the department and section structure, including but not limited to the creation of service lines.

5.A.2. Assignment to Departments:

(1) At the time of initial Medical Staff Membership or the granting of initial Clinical Privileges, each Practitioner will be assigned to a clinical department and may be assigned to a section. Assignment to a particular department or section does not preclude a Practitioner from seeking and being granted Clinical Privileges typically associated with another department or section.

(2) A Practitioner may request a change in department or section assignment to reflect a change in the Practitioner's clinical practice.

5.A.3. Functions of Departments:

The departments shall perform the following functions:

(1) serve as a forum for the exchange of clinical information regarding services provided by department members;

(2) provide recommendations to the department chairperson and/or the Medical Executive Committee with regard to the development of clinical practice guidelines related to care and services provided by department members;

(3) provide recommendations to the department chairperson regarding professional criteria for Clinical Privileges designed to assure the Medical Staff and Board of Trustees that patients shall receive quality care.[18] The recommendations shall include:

(a) criteria for granting, withdrawing and modifying Clinical Privileges;[19] and

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17 MS.01.01.01; LD.04.01.05

18 MS.01.01.01

19 42 C.F.R. §482.22(c)(6)

(b) a procedure for applying these criteria to individuals requesting Clinical Privileges;[20]

(4) monitor that Practitioners provide appropriate and medically necessary care to patients of the Hospital;[21]

(5) monitor that the same level of quality of patient care is provided by all Practitioners within the department and across departments:[22]

(a) by establishing uniform patient care processes;[23]

(b) by establishing similar clinical privileging criteria for similar Clinical Privileges;[24] and

(c) by using similar indicators in performance improvement activities;[25]

(6) provide recommendations to the department chairperson and/or the Medical Executive Committee with regard to issues related to standards of practice and/or clinical competence;

(7) establish effective mechanisms for the Supervision of Advanced Practice Professionals, as required;

(8) provide information and/or recommendations to the department chairperson with regard to the criteria for granting Clinical Privileges within the department;

(9) verify that Practitioners within the department who admit patients have Clinical Privileges to do so;[26] and that all Practitioners within the department only provide services within the scope of Clinical Privileges granted;[27]

(10) provide information and/or recommendations to the department chairperson and/or the Medical Executive Committee with regard to Medical Staff policies;

(11) provide recommendations to the department chairperson and/or the Medical Executive Committee with regard to ensuring appropriate call coverage by department members;

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20 42 C.F.R. §482.22(c)(6)
21 MS.03.01.01
22 MS.01.01.01
23 LD.04.03.07
24 MS.01.01.01
25 MS.01.01.01
26 MS.03.01.01
27 MS.08.01.03

(12) perform ongoing professional practice evaluation, initial focused professional practice evaluation, for-cause focused professional practice evaluation, peer review and other Medical Peer Review activities relative to the performance of Practitioners in the department and report such activities to the Medical Executive Committee on a regular basis;

(13) provide leadership for activities related to patient safety Medical Peer Review activities, including proactive risk assessments, root cause analysis in response to an unanticipated adverse event, addressing patient safety alerts, and implementing procedures to comply with patient safety goals;[28]

(14) receive reports regarding Hospital performance improvement results that are applicable to the performance of the department and its members, and integrate the department's performance improvement activities with that of the Hospital by taking a leadership and participatory role in such activities, as outlined in the Hospital Performance Improvement Plan; and

(15) recommend medical educational programs to meet the needs of department members, based on the scope of services provided by the department, changes in medical practice or technology, and the results of departmental performance improvement activities.[29]

5.B. DEPARTMENT CHAIRPERSONS AND VICE CHAIRPERSONS

Each department shall have a chairperson from each campus unless otherwise provided by the Medical Executive Committee with the approval of the Board. The department chairpersons shall serve as co-chairpersons. The use of vice chairpersons (or co-vice chairpersons) is optional.

Department meetings may be held by campus for campus-specific issues; otherwise, department meetings shall include all department members regardless of primary practice campus.

5.B.1. Qualifications:

Each department chairperson and vice chairperson will:

(1) be an Active Staff Member;

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

(3) satisfy the eligibility criteria in Section 4.B.

[28] MS.03.01.01; 42 C.F.R. §482.22

[29] MS.12.01.01

5.B.2. Selection and Term of Department Chairpersons and Vice Chairpersons:[30]

(1) Department officers will be elected by majority vote of the eligible voting members at the last meeting of the department each year in which a vacancy is pending. Active Staff Members of the department may vote for the chairperson or vice chairperson for the campus which the department member has designated as his or her primary practice campus. The election of a chairperson or vice chairperson by the department will be forwarded to the Board of Trustees for final action.

(2) Except as may otherwise be provided by contract, a department chairperson and vice chairperson will serve a term of two years and may succeed themselves for two additional terms.

(3) Except as otherwise provided by contract, when there is a vacancy in a department chairperson position, the vice chairperson for that campus will assume office for the remainder of the term. If there is no vice chairperson or a new department is created, the Medical Executive Committee will recommend the name(s) of individual(s) eligible to serve as department chairperson. The recommendation of the Medical Executive Committee will be presented to the department for vote.

5.B.3. Duties of Department Chairpersons:[31]

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

(1) all clinically-related activities of the department;[32]

(2) all administratively-related activities of the department, unless otherwise provided for by the Hospital;[33]

(3) continuing surveillance of the professional performance of Practitioners in the department, including performing ongoing and focused professional practice evaluations;[34]

(4) recommending criteria for Clinical Privileges that are relevant to the care provided in the department;[35]

(5) evaluating requests for Clinical Privileges for each member of the department;[36]

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30 MS.01.01.01

31 MS.01.01.01; LD.04.01.05

32 MS.01.01.01; MS.06.01.07; LD.04.01.05

33 MS.01.01.01; LD.04.01.05

34 MS.01.01.01; LD.04.01.05

35 MS.01.01.01; MS.06.01.07; LD.04.01.05

36 MS.01.01.01; MS.06.01.07; LD.04.01.05

(6) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital;[37]

(7) the integration of the department into the primary functions of the Hospital;[38]

(8) the coordination and integration of interdepartment and intradepartment services;[39]

(9) the development and implementation of policies and procedures that advance quality and that guide and support the provision of care, treatment, and services;[40]

(10) recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;[41]

(11) determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;[42]

(12) continuous assessment and improvement of the quality of care, treatment, and services provided;[43]

(13) maintenance of quality monitoring programs, as appropriate;[44]

(14) the orientation and continuing education of persons in the department;[45]

(15) recommendations for space and other resources needed by the department;[46]

(16) performing functions authorized in the Credentials Policy, including collegial intervention efforts;

(17) presiding at all department meetings;

(18) serving as an *ex officio* member of all departmental committees, if any, without vote, unless specifically stated otherwise in these Bylaws or the Rules and Regulations;

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37 MS.01.01.01; LD.04.03.01; LD.04.03.09

38 MS.01.01.01; LD.04.01.05; LD.03.06.01

39 MS.01.01.01; LD.04.01.05; LD.03.06.01

40 MS.01.01.01; LD.04.01.05; LD.03.06.01; LD.04.01.07

41 MS.01.01.01; LD.04.01.05; LD.03.06.01

42 MS.01.01.01; LD.04.01.05; LD.03.06.01; LD.04.01.07

43 MS.01.01.01; LD.04.01.05; LD.03.06.01

44 MS.01.01.01; LD.04.01.05; LD.03.06.01

45 MS.01.01.01; LD.03.06.01

46 MS.01.01.01; LD.04.01.05; LD.03.06.01; LD.04.01.11

(19) serving as a member of the Medical Executive Committee and being accountable to the Medical Executive Committee with regard to the activities and functioning of the department; and

(20) appointing and removing one or more department vice chairpersons as deemed necessary, appointing section directors, subject to approval of the Medical Executive Committee, and appointing members to serve on department committees, if any.

5.B.4. Duties of Department Vice Chairperson:

The Vice Chairperson shall assist the department chairperson in the performance of the department chairperson's duties, and shall assume the duties of the department chairperson in his/her absence.

5.B.5. Removal of Department Chairpersons and Vice Chairpersons:[47]

(1) Removal of a department chairperson or vice chairperson may be effectuated by a two-thirds vote of the members of that department officer's primary practice campus, as applicable, or a majority vote of the Medical Executive Committee, or by the Board of Trustees for:

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

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

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

(d) an infirmity that renders the individual incapable of fulfilling the duties of that office;

(e) failure to continue to satisfy any of the criteria in Section 4.B of these Bylaws;

(f) failure to adhere to professional ethics; or

(g) failure to support the compliance of the Hospital and the Medical Staff with applicable federal and state laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services.

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

[47] MS.01.01.01

(3) 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 department or section, as applicable, the Medical Executive Committee, or the Board of Trustees, as applicable, prior to a vote on removal.

(4) Removal will be effective when approved by the Board of Trustees.

5.C. SECTIONS

5.C.1. Qualifications, Selection and Removal of Section Directors:[48]

(1) The relevant department chairperson may appoint qualified individuals to serve as director of each section, subject to the approval of the Medical Executive Committee and the Chief Executive Officer.

(2) Section directors must meet the same qualifications as department chairpersons.

(3) If requested by two-thirds of the Members assigned to a section, the department chairperson will evaluate the performance of a section director to determine whether the section director should be removed from office.

5.C.2. Duties of Section Director:

The section director will carry out the duties requested by the department chairperson. These duties may include:

(1) review and reporting on Applications for initial Medical Staff Membership and Clinical Privileges, including interviewing Applicants;

(2) review and reporting on Applications for renewal of Medical Staff Membership and Clinical Privileges;

(3) evaluation of Practitioners in order to confirm competence;

(4) participation in the development of criteria for Clinical Privileges within the section;

(5) review and reporting on the professional performance of Practitioners practicing within the section; and

(6) support the department chairperson in making recommendations regarding the coordination of section activities, as well as the Hospital resources necessary for the section to function effectively.

[48] MS.01.01.01

5.C.3. Functions of Sections:

(1) Sections may perform any of the following activities:

(a) continuing education;

(b) discussion of policy;

(c) discussion of equipment needs;

(d) development of recommendations to the department chairperson or the Medical Executive Committee;

(e) participation in the development of criteria for Clinical Privileges (when requested by the department chairperson); and

(f) discussion of a specific issue (related to credentialing, professional practice evaluation, and/or performance improvement or other Medical Peer Review activities), at the special request of a department chairperson or the Medical Executive Committee.

(2) No minutes or reports will be required reflecting the activities of a section, except when a section is making a formal recommendation to a department, department chairperson, Credentials Committee, or Medical Executive Committee.

(3) Sections are not required to hold regularly scheduled meetings.

5.D. SERVICE LINES

5.D.1 Organization of Service Lines

Service lines shall be comprised of administrative personnel and a multidisciplinary team of Practitioners who devote a significant portion of their practice to treating the medical condition, procedure, clinical service or patient population upon which the patients were classified and the service line defined.

5.D.2 Functions of Service Lines

Each service line shall:

(1) Provide or coordinate complete, comprehensive care related to the medical condition, procedure, clinical service or patient population upon which the patients were classified and the service line defined, including but not limited to inpatient and outpatient care, rehabilitation services and social services;

(2) Provide patient and family education and follow up;

(3) Measure outcomes, costs and processes using a common measurement platform;

(4) Meet as often as needed, to discuss patients, processes and results to assure that care is coordinated and evidence based protocols are followed; and

(5) Make recommendations to the Medical Executive Committee and the Chief Executive Officer regarding:

    a. Budget, equipment, personnel and facility needs;

    b. Clinical guidelines for the care of patients within the defined classification;

    c. Mechanisms to assess outcomes and costs;

    d. Clinical indicators for review; and

    e. Quality improvement activities;

ARTICLE 6
MEDICAL STAFF COMMITTEES

6.A. GENERAL

6.A.1. Appointment:

(1) This Article and the Medical Staff Organization Manual outline the committees of the Medical Staff that carry out Medical Peer Review activities including, but not limited to, ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board of Trustees, and contain a description of the committees' composition, duties and reporting requirements.

(2) The following shall occur within three months prior to the end of each Medical Staff Year except as otherwise provided by these Bylaws or the Medical Staff Organization Manual:

(a) The President of the Medical Staff, in consultation with the Vice-President of the Medical Staff, and subject to the approval of the Medical Executive Committee, will appoint the members and the chairpersons of each Medical Staff committee when such positions are due to be vacated at the start of the next Medical Staff Year. Committee chairpersons must satisfy the criteria in Section 4.B of these Bylaws.

(b) The President of the Medical Staff, in consultation with the Vice-President of the Medical Staff, and subject to the approval of the Medical Executive Committee, may appoint Physicians and other health care professionals who are not Members of the Medical Staff to be members of a standing committee of the Medical Staff upon determination that the committee's functions and operations necessitate the expertise.

(c) The President of the Medical Staff, in consultation with the Vice-President of the Medical Staff, will also appoint Medical Staff representatives to Hospital and Board committees unless the positions are *ex-officio* or otherwise directed by the Board.

(3) The Chief Executive Officer will make appointments of administrative staff to Medical Staff committees. Administrative staff will serve on Medical Staff committees without the right to vote.

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

(5) Chairpersons and members of standing committees and ad hoc committees may be removed, and vacancies filled at the discretion of the individual currently in the office or position that initially appointed them.

(6) The President of the Medical Staff and the Vice President of the Medical Staff will be *ex officio* members, without vote, on all Medical Staff committees unless otherwise specified. This includes attendance at executive or closed sessions.

(7) The Chief Medical Officer, Chief Executive Officer, and Chief Nursing Executive, as well as the Chief Medical Officers, Chief Executive Officers, and Chief Nursing Officers of the two campuses, will be *ex officio*[49] members, without vote, on all Medical Staff committees unless otherwise specified. This includes attendance at executive or closed sessions.

(8) Any Board member may attend and informally participate in, without vote, any meeting (including any executive or closed session) of the Medical Staff or its committees, departments, or sections.

6.A.2. Meetings, Reports and Recommendations:

Except as otherwise provided, committees will meet, as necessary, to accomplish their functions, and will maintain a permanent record of their findings, proceedings, and actions. Committees will make timely written reports to the Medical Executive Committee.

6.B. MEDICAL EXECUTIVE COMMITTEE

6.B.1. Composition:

(1) The Medical Executive Committee will include the following individuals, the majority of whom shall be Physicians actively practicing at the Hospital:[50]

(a) the President of the Medical Staff;

(b) the Vice-President of the Medical Staff;

(c) the Chief of Staff – Elect for Del Sol and the Chief of Staff – Elect for Las Palmas;

(d) the Secretary/Treasurer for Del Sol and the Secretary/Treasurer for Las Palmas;

(e) the Immediate Past Chief of Staff – Del Sol and the Immediate Past Chief of Staff – Las Palmas; and

(f) Two at-large members, one whose primary practice campus is Del Sol and the other whose primary practice campus is Las Palmas.

The Chief Medical Officer, Chief Executive Officer, and Chief Nursing Executive, as well as the Chief Medical Officers, Chief Executive Officers, and Chief Nursing Officers of the two

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49 MS.02.01.01

50 MS.01.01.01; C.F.R. §482.22(b)(2); MS.02.01.01; 25 Tex. Admin. Code Sec. 133.41(k)(2)(B).

campuses, will be *ex officio*[51] members of the Medical Executive Committee, without vote.

(2) No Active Staff Member is ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline, specialty, employment by an Affiliated Entity, or practice as a Hospital-based Physician, Dentist, Oral Maxillofacial Surgeon, or Podiatrist.[52]

(3) The President of the Medical Staff will serve as chairperson of the Medical Executive Committee, with vote.

(4) Other individuals may be invited to Medical Executive Committee meetings as guests, without vote.

6.B.2. Duties:

The Medical Executive Committee is delegated the primary authority over activities related to the Medical Staff and performance improvement activities. This authority may be removed or modified by amending these Bylaws, the Credentials Policy, the Organization Manual, the Rules and Regulations, and other Medical Staff policies, as applicable. The Medical Executive Committee is responsible for the following:

(1) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Medical Executive Committee meetings);[53]

(2) recommending directly to the Board on at least the following:[54]

(a) the Medical Staff's structure;

(b) the mechanism used to review credentials and to delineate individual Clinical Privileges;

(c) Applicants for initial and renewed Medical Staff Membership;

(d) delineation of Clinical Privileges for each eligible individual;

(e) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(f) the mechanism by which Medical Staff Membership may be terminated;

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51 MS.02.01.01
52 MS.02.01.01
53 MS.02.01.01
54 MS.02.01.01

(g) hearing procedures; and

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

(3) consulting with Administration on quality-related aspects of contracts for patient care services;

(4) providing oversight and guidance with respect to continuing medical education activities;

(5) reviewing or delegating the review of quality indicators to facilitate uniformity regarding patient care services;

(6) providing leadership in activities related to patient safety;

(7) providing oversight in the process of analyzing and improving patient satisfaction, patient engagement and patient-centered care;

(8) ensuring that, at least every three years, the Bylaws and applicable policies are reviewed and, if necessary, updated;

(9) providing and promoting effective liaison among the Medical Staff, Administration, and the Board;

(10) recommending clinical services, if any, to be provided by telemedicine;

(11) reviewing and approving all standing orders and clinical protocols for consistency with nationally recognized standards, evidence-based guidelines and clinical appropriateness criteria;

(12) implementing policies of the Medical Staff not otherwise the responsibilities of the Medical Staff;

(13) coordinating the activities and general policies of the departments;

(14) reviewing periodically Medical Peer Review information of Practitioners, including, but not limited to, focused professional practice evaluation data, ongoing professional practice evaluation data, peer review information and credentialing data, and, as a result of such reviews, making recommendations for renewal of, and modification to, Medical Staff Membership and Clinical Privileges;

(15) organizing the Medical Staff's Medical Peer Review activities, including the review of the safety, effectiveness, patient-centeredness, equitability, efficiency, and timeliness[55] of

[55] IOM, Crossing the Quality Chasm, six aims for improving healthcare

medical and surgical care and establishing mechanisms designated to conduct, evaluate and revise such activities;[56]

(16) collaborating with other leaders in Hospital planning;

(17) making recommendations to the Chief Executive Officer on matters of a medico-administrative nature when requested;

(18) ensuring that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;

(19) reporting at each general Medical Staff meeting; and

(20) performing any other functions as are assigned to it by these Bylaws, the Credentials Policy, the Organization Manual, the Rules and Regulations, or other applicable Hospital or Medical Staff policies.

6.B.3. Meetings:

The Medical Executive Committee will meet at least monthly and more often if necessary to fulfill its responsibilities, maintain a permanent record of its proceedings and actions, and report the activities of the Medical Staff and the Medical Executive Committee to the Board of Trustees.[57]

6.C. CREATION OF STANDING COMMITTEES AND SPECIAL TASK FORCES

(1) In accordance with the amendment provisions in the Medical Staff Organization Manual, the Medical Executive Committee may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. The Medical Executive Committee may also dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

(2) Any function required to be performed by these Bylaws, the Credentials Policy, the Organization Manual, the Rules and Regulations, or other Medical Staff policy, which is not assigned to an individual, a standing committee, or a special task force will be performed by the Medical Executive Committee.

(3) Special task forces or ad hoc committees will be created and their members and chairpersons will be appointed by the President of the Medical Staff and the Medical Executive Committee. Such task forces or ad hoc committees will confine their activities to the purpose for which they were appointed and will report to the Medical Executive Committee.

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56 MS.01.01.01; MS.02.01.01; MS.05.01.01; MS.05.01.03; MS.10.01.01

57 MS.02.01.01

(4) The chair of any standing committee may appoint a subcommittee to accomplish an assigned function within the scope of the duties of the standing committee. At least one member of the standing committee must be a voting member of the standing committee and that member shall serve as chair. The subcommittee shall not be authorized to take any action and shall report to the standing committee. Upon completion of the assigned function or on instruction of the standing committee chair, the subcommittee shall be terminated.

ARTICLE 7
MEETINGS

7.A. GENERAL

7.A.1. Meetings:

(1) Except as provided in these Bylaws or the Medical Staff Organization Manual, each department will meet tri-annually or more often as needed to perform its designated functions, and each committee will meet as often as needed to perform their designated functions.

(2) Meetings may be conducted by telephone conference or by other electronic means at the discretion of the applicable chairperson.

7.A.2. Regular Meetings:

(1) The President of the Medical Staff, the chairperson of each department and the director of each section, and the chairperson of each committee will schedule regular meetings for the Medical Staff Year.

(2) The meeting held in the fall of the Medical Staff at which voting for Medical Staff officers is conducted or announced will be considered the annual meeting of the Medical Staff.

7.A.3. Special Meetings:

(1) A special meeting of the Medical Staff may be called by the President or Vice-President of the Medical Staff, a majority of the voting members of the Medical Executive Committee, the Chief Executive Officer, the Chairperson of the Board, or by a petition signed by at least 10% of the voting Members of the Medical Staff.

(2) A special meeting of any department or committee may be called by the President of the Medical Staff, the relevant department or committee chairperson (or a department co-chairperson), section director, or by a petition signed by at least 10% of the voting members of the department or committee but in no event fewer than two members.

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

7.B. PROVISIONS COMMON TO ALL MEETINGS

7.B.1. Prerogatives of the Presiding Officer:

(1) The Presiding Officer of each meeting is responsible for setting the agenda for any regular or special meeting of the Medical Staff, department, section, or committee.

(2) The Presiding Officer has the discretion to conduct any meeting by telephone conference or videoconference.

(3) The Presiding Officer shall have the authority to rule definitively on all matters of procedure. While Robert's Rules of Order may be used for reference, in the discretion of the Presiding Officer, it shall not be binding. Rather, specific provisions of these Bylaws and Medical Staff, department, section, or committee custom shall prevail at all meetings and elections.

7.B.2. Notice:

(1) Medical Staff Members will either be provided with Notice of regular meetings of the Medical Staff and regular meetings of departments, sections, and committees or be alerted to the scheduling of those meetings through a posting placed in a designated location at least seven, but not more than 31, Days in advance of the meeting.

(2) When a special meeting of the Medical Staff, department, section, or committee is called, the Notice period will be 72 hours. In such cases, posting may not be the sole mechanism for providing Notice.

(3) Notices will state the date, time, and place of the meetings.

(4) The attendance of any individual at any meeting will constitute a waiver of that individual's Notice of the meeting.

7.B.3. Quorum and Voting:

(1) For any regular or special meeting of the Medical Staff, department, section, or committee, those voting members Present (but not fewer than two members) will constitute a Quorum. Exceptions to this general rule are as follows:

(a) for meetings of the Medical Executive Committee, the Presence of at least 50% of the voting committee members will constitute a Quorum;

(b) for meetings of the Credentials Committee and the Professional Practice Evaluation Committee, the Presence of at least 20% of the voting committee members will constitute a Quorum; and

(c) for any amendments to these Medical Staff Bylaws, the Presence (in case of a meeting) or participation (in case of a ballot) of at least 10% of the Medical Staff Members eligible to vote will constitute a Quorum.

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

(3) Recommendations and actions taken by the Medical Staff, departments, sections, and committees will be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority of the voting members.

(4) As an alternative to a formal meeting, the voting members of the Medical Staff or a department or committee may also be presented with an issue by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Presiding Officer by the method designated in the Notice.

(a) Except for amendments to these Bylaws and actions by the Medical Executive Committee, the Credentials Committee, and the Professional Practice Evaluation Committee (as noted in (a)), a Quorum for purposes of these votes will be the number of responses returned to the Presiding Officer by the date indicated. The issue will be determined by a majority of the responses returned.

(b) Whether to vote in a meeting or by mail ballot shall be determined by the chairperson of the department, section, or committee or, in the case of a vote of the Medical Staff, by the Medical Executive Committee.

(5) Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

(6) There shall be no proxy voting.

7.B.4. Minutes:

(1) Minutes of Medical Staff, department, section, and committee meetings will be prepared at the direction of and signed by the Presiding Officer.

(2) Minutes will include a record of the attendance of members, the vote taken on each matter and the recommendations made.

(3) Minutes of meetings of the Medical Staff, departments, committees and, where applicable, sections, will be forwarded to the Medical Executive Committee and a copy will be provided to the Chief Executive Officer.

(4) The Board will be kept apprised of and act on the recommendations of the Medical Staff.

(5) The Hospital is the custodian of all minutes (and other records and proceedings) and will maintain a permanent file of the minutes of all meetings.

7.B.5. Confidentiality:

(1) Medical Staff business conducted by committees, departments, and sections is considered confidential and proprietary and should be treated as such.

(2) Practitioners who have access to, or are the subject of, Medical Peer Review records and proceedings including, but not limited to, credentialing, performance improvement, peer review, and professional practice evaluation information must agree to maintain the confidentiality of the information.

(3) Medical Peer Review information including, but not limited to, credentialing, performance improvement, peer review, and professional practice evaluation documents, and information contained in these documents, must not be disclosed to any individual not involved in the credentialing, performance improvement, peer review, and professional practice evaluation processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy or as required by law.

(4) A breach of confidentiality may result in the imposition of disciplinary action.

7.C. ATTENDANCE

7.C.1. Regular and Special Meetings:

(1) Members of the Medical Staff are encouraged to attend Medical Staff and applicable department and committee meetings.

(2) At a minimum, each Active Staff Member is required to be Present at 25% of the applicable department and committee meetings each year. It is not necessary to prepare excuses for missed meetings because excuses will not be considered when compliance with this attendance requirement is reviewed. Failure to meet the attendance requirement will result in the Member's automatic relinquishment of voting rights for the following Medical Staff Year.

(3) Members of the Medical Executive Committee, the Credentials Committee, the Leadership Council and the Professional Practice Evaluation Committee are required to be Present at least 50% of the regular meetings. Failure to attend the required number of meetings may result in the Member being removed from the committee by the President of the Medical Staff. If removal concerns membership on the Medical Executive Committee, the removal procedures in Section 4.E. of the Bylaws must be used.

ARTICLE 8
BASIC STEPS FOR CREDENTIALING AND PEER REVIEW

The details associated with the following Basic Steps are contained in the Credentials Policy in a more expansive form.

8.A. QUALIFICATIONS FOR INITIAL OR RENEWED MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES[58]

To be eligible to apply for initial or renewed Medical Staff Membership or Clinical Privileges, an individual must submit, as applicable, a Request for Consideration ("RFC") Recredentialing Request for Consideration ("RRFC"), or Request for Increased, New Clinical Privileges, or Changes in Prescriptive Authority ("RFINCP"), or other request for Clinical Privileges and/or Application form and, through the RFC/RRFC/RFINCP and Application processes, demonstrate continuous satisfaction of all threshold criteria for appointment, as well as all other factors for consideration outlined in the Medical Staff Credentials Policy and other Hospital and Medical Staff policies, including appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the Clinical Privileges requested.

8.B. INITIAL PROCESS FOR CREDENTIALING AND PRIVILEGING

Once The Credentialing Processing Center has forwarded an RFC/RRFC/RFINCP or other request for Clinical Privileges to the Medical Staff Office, it will begin processing the RFC/RRFC/RFINCP or other request for Clinical Privileges as an Application. As a preliminary step, the Medical Staff Office will review the Application to make sure that all questions have been answered and that the applicant satisfies all threshold eligibility criteria set forth in the Credentials Policy.

8.C. PROCESS FOR CREDENTIALING AND PRIVILEGING[59]

(1) Complete Applications for Membership and Clinical Privileges will be transmitted to the applicable department chairperson or section director, who will review the Applicant's education, training, and experience and prepare a written report stating whether the Applicant meets all qualifications. The Chief Nursing Officer will also prepare a report for all advanced practice registered nurses (and other advanced practice professionals if requested by the Credentials Committee). The report(s) will be forwarded to the Credentials Committee .

(2) The Credentials Committee will review the chairperson's report, and the Chief Nursing Officer's report, if applicable, and make a recommendation. The recommendation of the Credentials Committee will be forwarded, along with the department chairperson's report, and the Chief Nursing Officer's report, if applicable, to the Medical Executive Committee for review and recommendation.

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58 MS.01.01.01

59 MS.01.01.01

(3) The Medical Executive Committee may accept the recommendation of the Credentials Committee, refer the Application back to the Credentials Committee for further review or specific questions, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Medical Executive Committee entitles the individual to request a hearing, the Chief Executive Officer will send notice of the recommendation and the hearing rights available under the Medical Staff Bylaws documents. If the recommendation of the Medical Executive Committee does not entitle the individual to request a hearing, the recommendation will be forwarded to the Board for final action.

(4) When the Hospital Emergency Operations Plan has been implemented, the CEO or President of the Medical Staff may use a modified credentialing process to grant disaster Privileges after verification of the volunteer's identity and professional license.

(5) When an important patient care need exists or when an Applicant has made an initial Application for the Clinical Privileges that is awaiting review by the MEC and Board, a subcommittee of the Board may use a modified credentialing process to grant temporary Clinical Privileges, for a period not to exceed 120 days, to certain qualified individuals.

8.D. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT[60] OF MEMBERSHIP AND/OR PRIVILEGES

(1) Membership and/or Clinical Privileges shall be automatically relinquished if a Practitioner:

(a) fails to do any of the following:

(i) timely complete medical records as required by these Bylaws, the Rules and Regulations or applicable policies;

(ii) satisfy threshold eligibility criteria as detailed in the Credentials Policy;

(iii) complete and comply with educational or training requirements adopted by the Medical Executive Committee or required by the Board as detailed in the Credentials Policy;

(iv) provide requested information as set forth in these Bylaws or as detailed in the Credentials Policy;

(v) attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration as detailed in the Credentials Policy; or

(vi) comply with a request for fitness for practice evaluation or clinical competency evaluation as detailed in the Credentials Policy;

[60] MS.01.01.01

(b) is arrested, charged, indicted, convicted, or pleads guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (iv) violence; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse; or

(c) makes a misstatement or omission on an Application.

(2) Automatic relinquishment will take effect immediately and will continue until the matter is resolved and the individual is reinstated, if applicable, as detailed in the Credentials Policy.

8.E. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION OR RESTRICTION[61]

(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 President of the Medical Staff, the chairperson of the relevant clinical department, the Chief Medical Officer, the Medical Executive Committee, or the Board chairperson is authorized to immediately suspend or restrict all or any portion of a Practitioner's Clinical Privileges pending an Investigation.

(2) A precautionary suspension or restriction is effective immediately and will remain in effect unless it is modified by the Chief Executive Officer or the Medical Executive Committee.

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

(4) The Medical Executive Committee will review the reasons for the suspension or restriction within a reasonable time under the circumstances, not to exceed 14 Days.

(5) As part of this review, the Practitioner will be given an opportunity to meet with the Medical Executive Committee.

8.F. INDICATIONS AND PROCESS FOR CORRECTIVE ACTIONS[62]

Following an investigation, the Medical Executive Committee may recommend corrective action including, but not limited to, suspension, restriction or revocation of Membership or Clinical Privileges, based on concerns about (a) clinical competence or practice; (b) violation of ethical standards or the Bylaws, policies, manuals, and Rules and Regulations of the Hospital or the Medical Staff; (c) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff; (d) ability to perform, with or without reasonable accommodation, the essential functions of Medical Staff Membership or Clinical Privileges; or (e) the Practitioner's qualifications for Membership and Clinical Privileges.

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61 MS.01.01.01

62 MS.01.01.01

8.G. HEARING AND APPEAL PROCESS[63]

The procedures in this Section and Article 7 of the Credentials Manual apply only to Physicians, Dentists, Oral Maxillofacial Surgeons, and Podiatrists. The details associated with the hearing and appeals processes are contained in the Credentials Policy and shall include at least the following:

(1) The hearing will begin no sooner than 30 Days after the Notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The hearing may be conducted by a Hearing Panel, which will consist of at least three members, or, in the alternative, may be conducted by a Hearing Officer.

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

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

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness; (d) to have representation by counsel who may call, examine, and cross-examine witnesses or present the case; (e) to submit a written statement at the close of the hearing; (f) to submit proposed findings, conclusions and recommendations to the Hearing Panel; (g) to receive the written recommendation of the Hearing Panel, including a statement of the basis of the recommendation; and (h) to receive the written final decision of the Board, including a statement of the basis for the decision.64

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

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

(8) The affected Practitioner and the Medical Executive Committee may each request an appeal of the recommendations of the Hearing Panel (or Hearing Officer) to the Board.**ARTICLE 9**

63 MS.01.01.01

64 HCQIA Sec. 11112(b)(3).

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

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

(2) Proposed amendments must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee will provide Notice of proposed amendments, including amendments proposed by the voting Members of the Medical Staff as set forth above, to the voting Members of the Medical Staff. The Medical Executive Committee may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff or at a special meeting called for such purpose.[65]

(3) The proposed amendments may be voted upon at any meeting if Notice has been provided at least 30 Days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting Members of the Medical Staff at the meeting.[66] See Section 7.B.3. For Quorum requirement.

(4) In the alternative, the Medical Executive Committee may present any proposed amendments to the voting Members of the Medical Staff by written or electronic ballot, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them, either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast. See Section 7.B.3. for Quorum requirement.

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

(6) Amendments will be effective only after approval by the Board of Trustees.

(7) If the Board of Trustees has determined not to accept a proposed amendment to the Medical Staff Bylaws approved by the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference will be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be

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65 MS.01.01.01

66 MS.01.01.01

scheduled by the Chief Executive Officer within two weeks after receipt of a request.[67] The final decision rests with the Board.

(8) Neither the Medical Executive Committee, the Medical Staff, nor the Board can unilaterally amend these Bylaws.[68]

9.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there will be policies, procedures, and Rules and Regulations that are applicable to Practitioners. Those policies, procedures and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but shall be amended in accordance with this Section.

(2) An amendment to the Credentials Policy, the Organization Manual, or the Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a Quorum exists. Notice of any proposed amendments to these documents will be provided to each voting Member of the Medical Staff at least 30 Days prior to the vote by the Medical Executive Committee. Any voting Member may submit written comments on the amendments to the Medical Executive Committee.[69]

(3) Other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee. No prior Notice is required.

(4) Amendments to the Credentials Policy, the Organization Manual, the Rules and Regulations, or any other Medical Staff policy may also be proposed by a petition signed by at least 25% of the voting Members of the Medical Staff. Notice of any such proposed amendment to these documents will be provided to the Medical Executive Committee at least 30 Days prior to being voted on by the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendment before it is forwarded to the Medical Staff for vote.[70] Any comments of the Medical Executive Committee shall be provided to the Medical Staff prior to the vote.

(5) The Medical Executive Committee and the Board will have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior Notice of the proposed amendments to the Medical Staff. Notice of provisionally adopted amendments will be provided to each Member of the Medical Staff as soon as possible. The Medical Staff will have 30 Days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the

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67 MS.01.01.01; LD.02.04.01

68 MS.01.01.03

69 MS.01.01.01

70 MS.01.01.01

Medical Executive Committee, the provisional amendments will stand. If there is conflict over the provisional amendments, the process for resolving conflicts set forth below will be implemented.[71]

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

(7) Amendments to Medical Staff policies are to be distributed or otherwise made available to Practitioners in a timely and effective manner.[72]

9.C. CONFLICT MANAGEMENT PROCESS[73]

9.C.1. Conflicts Between the Medical Staff and Medical Executive Committee:

(1) When there is a conflict between the Medical Staff and the Medical Executive Committee, supported by a petition signed by 25% of the voting Members of the Medical Staff, with regard to:

(a) a new Medical Staff Rule and Regulation proposed by the Medical Executive Committee or an amendment to an existing Rule and Regulation; or

(b) a new Medical Staff policy proposed by the Medical Executive Committee or an amendment to an existing policy,

a special meeting of the Medical Staff to discuss the conflict will be called. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the Rules and Regulations or policy at issue.

(2) If the differences cannot be resolved at the meeting, the President of the Medical Staff or the dissenting Members of the Medical Staff may request that the matter be referred to a Joint Conference Committee within 30 Days. The Joint Conference Committee shall consist of:

(a) three officers of the Medical Staff;

(b) three voting Members of the Medical Staff who signed the petition;

(c) the chairperson of the Board of Trustees; and

(d) the Chief Executive Officer and Chief Medical Officer.

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71 MS.01.01.01

72 MS.01.01.01

73 MS.01.01.01

(3) If the matter cannot be resolved by the Joint Conference Committee, the recommendations of the Medical Staff and Medical Executive Committee will be forwarded to the Board for final action.

(4) This conflict management Section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual Members of the Medical Staff.

(5) Nothing in this Section is intended to prevent individual Medical Staff Members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board of Trustees. Communication from Medical Staff Members to the Board of Trustees will be directed through the Chief Executive Officer, who will forward the request for communication to the Board Chairperson. The Chief Executive Officer will also provide notification to the Medical Executive Committee by informing the President of the Medical Staff of such exchanges. The Board Chairperson will determine the manner and method of the Board's response to the Medical Staff Member(s).

9.C.2. Conflicts Between the Medical Executive Committee and Board of Trustees:

(1) When there is a conflict between the Medical Executive Committee and the Board of Trustees with regard to:

(a) a new Medical Staff Rule and Regulation proposed by the Medical Executive Committee or an existing Rule or Regulation; or

(b) a new Medical Staff policy proposed by the Medical Executive Committee or an amendment to an existing policy,

either a member of the Board of Trustees or the Medical Executive Committee may submit a written request to the Chairman of the Board that the matter be referred to a Joint Conference Committee.

(2) The Joint Conference Committee shall consist of:

(a) three officers of the Medical Staff;

(b) one other Medical Executive Committee member;

(c) the chairperson, vice chairperson and secretary of the Board of Trustees or other designees of the Board of Trustees; and

(d) the Chief Executive Officer and Chief Medical Officer.

(3) If the Joint Conference Committee does not reach a resolution within 30 Days, the Board of Trustees shall take final action on the matter.

(4) This conflict management Section is limited to the matters noted above.

ARTICLE 10
ADDITIONAL PATIENT CARE PROVISIONS

10.A. HISTORY AND PHYSICAL EXAMINATION[74]

(1) Timing of the History and Physical Examination

(a) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services). The history and physical examination must be performed by a Practitioner who has been granted Clinical Privileges by the Hospital to perform histories and physicals.

(b) If a medical history and physical examination has been completed within the 30-Day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record, if the history and physical examination was performed by a Physician, oral maxillofacial surgeon, physician assistant, or advanced practice registered nurse. In such cases, within 24 hours after admission/registration or prior to surgery/invasive procedure, whichever comes first, the patient must be reassessed by a Practitioner who has been granted Clinical Privileges by the Hospital to perform histories and physicals. The purpose of this assessment is to identify any changes subsequent to the original examination. The Practitioner must update the history and physical examination to reflect any changes in the patient's condition since the date of the original history and physical or state that there have been no changes in the patient's condition.

(c) When the history and physical examination is not performed or recorded in the medical record before a surgical, diagnostic operative or invasive procedure, the operation or procedure will be canceled unless the attending Physician states in writing that an emergency situation exists. If it is an emergency situation and a history and physical has been dictated but has not been transcribed, there will be a statement to that effect in the patient's chart, with an admission note by the attending Physician. The admission note must be documented immediately prior to surgery (same day as surgery) and will include, at a minimum, an assessment of the patient's heart rate, respiratory rate and blood pressure.

(2) Scope of the History and Physical Examination

The scope of the medical history and physical examination will include, as applicable:

(a) patient identification;

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[74] MS.01.01.01; 42 C.F.R.§482.22(c)(5)

(b) chief complaint;

(c) history of present illness;

(d) review of systems, to include at a minimum:

- cardiovascular;
- respiratory;
- gastrointestinal;
- neuromusculoskeletal; and
- skin;

(e) personal medical history, including medications and allergies;

(f) family medical history;

(g) social history, including any abuse or neglect;

(h) physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;

(i) data reviewed;

(j) assessments, including problem list;

(k) plan of treatment;

(l) if applicable, signs of abuse, neglect, addiction or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion will be documented in the plan of treatment; and

(m) in the case of a pediatric patient: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

ARTICLE 11
IN-HOSPITAL DNR ORDERS

Article 11. Do Not Resuscitate (DNR) Orders

(1) Procedure for Issuance of DNR Orders in the In-patient setting

a. A valid DNR order for in-patients of the hospital must be issued by an attending physician, dated, and in compliance with at least one of the following:

i. Written and dated directive from a competent patient;
ii. Oral directive of a competent patient given before two witnesses, one of whom must not be an employee of the attending physician or an employee of the hospital providing direct patient care;
iii. Valid directive issued in another state;
iv. Valid Texas Form Advance Directive
v. Non-written directive of a competent adult patient with a terminal or irreversible condition, made in the presence of the attending physician and two witnesses, one of whom must not be an employee of the attending physician or an employee of the hospital providing direct patient care;
vi. Valid directive for a minor;
vii. Directive from the legal guardian or agent under a medical power of attorney;
viii. Mutual decision of the attending physician and a statutorily authorized surrogate decision-maker, if the patient is not competent and has a terminal or irreversible condition;
ix. When no statutorily authorized surrogate decision-maker is reasonably available and an attending physician has determined that (a) death is imminent (b) a DNR order is medically appropriate and (c) the order is not contrary to the known wishes of the patient.

A validly issued DNR order may be acted upon as soon as it is issued.

(2) Documentation and Notice Requirements for DNR Orders

A validly issued DNR order will be entered in the patient's electronic medical record as soon as practicable by any person authorized to enter orders in the record pursuant to hospital policy. Before entering a DNR order in the patient's medical record under (1) a. ix. above, the physician (or a physician's assistant, nurse or other person acting on behalf of the hospital) shall make a reasonably diligent effort to notify the patient of the issuance of the DNR order, or if the patient is not competent, to notify either the patient's legal guardian, agent under a medical power of attorney, spouse, any adult child or a parent. This notification, as described above, will be documented in the medical record.

When a non-written or oral directive serves as the basis for a DNR order, the names of the witnesses will be entered into the medical record.

(3) Revocation of DNR Orders

A validly issued DNR Order may be revoked by the patient's attending physician at any time.

Any physician providing direct care to a patient for whom a DNR order is issued shall cancel and revoke the patient's DNR order if (a) the patient, (b) the patient's agent under a medical power of attorney (if the patient is not competent), or (c) the patient's legal guardian expresses an intent to revoke the directive authorizing the DNR order or an intent to cancel the DNR order. A person providing direct care to a patient under the supervision of a physician shall notify the physician of the request to revoke a DNR order.

If a physician revokes a DNR order, the physician, or physician's designee shall record the time, date and place of the revocation in the medical record.

(4) Process to Resolve Disagreement Concerning DNR Orders

In the event of a disagreement between an attending physician and the patient or person authorized to make treatment decisions on behalf the patient, regarding the execution of or compliance with a DNR order, the patient or patient's decision-maker shall be notified of the benefits and burdens of cardiopulmonary resuscitation. If, after such conversation, there remains disagreement, the physician or hospital shall make a reasonable effort to transfer the patient to another provider willing to comply with the instructions of the patient or surrogate decision-maker. If an agent under a medical power of attorney or legal guardian directs that a validly issued DNR order be revoked, the physician or hospital may initiate a formal Ethics consultation pursuant to hospital policy.

ARTICLE 12
ADOPTION

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any previous Medical Staff Bylaws, and any inconsistent provisions of the Rules and Regulations, Medical Staff policies or manuals or Hospital policies pertaining to the subject matter contained herein.

Adopted by the Medical Staff: October 16, 2019

Approved by the Board of Trustees: October 29, 2019

EXHIBIT A

Medical Staff Officers of the Hospital

1. Election December – Every Two Years

2.1 In December every two years, all offices of the Medical Staff shall be subject to re-election.

2.2 **President and Vice-President:**

2.2.1 The Del Sol Campus shall elect a Chief of Staff-Del Sol to serve for a two (2) year term, beginning in January.

2.2.2. The Las Palmas Campus shall elect a Chief of Staff-Las Palmas to serve for a two (2) year term, beginning in January.

2.2.3The Chief of Staff-Las Palmas shall serve as President for a one (1) year term from January -December, in the even numbered years and the Chief of Staff-Del Sol shall serve as Vice-President during the same one (1) year term from January – December. From January – December, the Chiefs of Staff shall rotate offices, so that the Chief of Staff-Del Sol serves as President for a one (1) year term from January – December, in the odd numbered years, and the Chief of Staff-Las Palmas serves as Vice-President during the same one (1) year term from January – December.

2.3 **Chiefs of Staff-Elect:**

2.3.1.The Las Palmas Campus shall elect the Chief of Staff-Elect-Las Palmas to serve in such office for a term of two (2) years through December, and after such term the Chief of Staff-Elect-Las Palmas shall assume the office of the Chief of Staff-Las Palmas.

2.3.2 The Del Sol Campus shall elect the Chief of Staff-Elect-Del Sol to serve in such office for a term of two (2) years through December, and after such term the Chief of Staff-Elect-Del Sol shall assume the office of the Chief of Staff-Del Sol.

2.4 **Secretary-Treasurers:**

2.4.1 The Las Palmas Campus shall elect the Secretary-Treasurer-Las Palmas to serve in such office for a term of two (2) years through December.

2.4.2 The Del Sol Campus shall elect the Secretary-Treasurer-Del Sol to serve in such office for a term of two (2) years through December.

2.5 **Member at Large:** Two Members at Large, one from each Campus, shall be elected by the voting members of the entire Medical Staff, irrespective of primary practice campus designation, in December every two years.

EXHIBIT B
MULTI-CAMPUS GOVERNANCE

<table>
<tr><th colspan="2">December Election – Every Two Years</th></tr>
<tr><td colspan="2"><u>Hospital-Wide Election</u>
Medical Staff Member at Large
Del Sol as primary practice campus (two-year term)
Medical Staff Member at Large
Las Palmas as primary practice campus (two-year term)</td></tr>
<tr><td>Chief of Staff-Las Palmas (to serve for a 2 year term as Chief of Staff-Las Palmas)
President of the Medical Staff from January – December in the even numbered years
Vice-President of the Medical Staff from January December
Chief of Staff-Elect-Las Palmas
(to serve for a 2 year term)
Secretary-Treasurer-Las Palmas (to serve for a 2 year term)</td><td>Chief of Staff-Del Sol (to serve for a 2 year term as Chief of Staff-Del Sol)
Vice-President of the Medical Staff from January – December
President of the Medical Staff from January – December In the odd numbered years
Chief of Staff-Elect-Del Sol
(to serve for a 2 year term)
Secretary-Treasurer-Del Sol
(to serve for a 2 year term)</td></tr>
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