CHRISTUS MOTHER FRANCES Hospital Tyler

MEDICAL STAFF BYLAWS:

Governance and Credentialing Manual

October 6, 2022

Accredited by The Joint Commission

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PREAMBLE

A. CHRISTUS Mother Frances Hospital – Tyler is a general acute care hospital organized a part of CHRISTUS Trinity Mother Frances Health System;

B. CHRISTUS Mother Frances Hospital – Tyler and CHRISTUS Trinity Mother Frances Health System are organized under the laws of the State of Texas and operate as an integrated health system throughout South Texas;

C. The principal objective of CHRISTUS Mother Frances Hospital – Tyler is to promote the delivery of health care services at a level of quality and efficiency consistent with accepted professional standards;

D. The Hospital's Governing Board has the ultimate authority and responsibility for the oversight and delivery of health care within the Hospital and relies on the Medical Staff to advise the Governing Board as to the qualifications and competence of practitioners, the overall quality of health care services, and to fulfill certain specified obligations described in these Bylaws;

E. The Medical Staff is self-governing, organized under these Bylaws, and is accountable to the Governing Board for the delivery and quality of medical care rendered by practitioners who are credentialed and granted clinical privileges through the Medical Staff process; and

F. These Bylaws set forth various procedures, requirements, and guiding principles by which practitioners at the Hospital are organized as a Medical Staff and fulfill their delegated responsibilities.

DEFINITIONS

The following definitions apply throughout the Medical Staff Bylaws, which include the Governance and Credentialing Manual, the Corrective Action and Fair Hearing Plan, and the Medical Staff Rules and Regulations, unless otherwise indicated. The use of capitalization when defining terms is intended for convenience purposes only and shall not affect the meaning or interpretation of such terms unless otherwise expressly addressed.

"Administration" or "Hospital Administration" means senior management of the Hospital.

"Advanced Practice Clinician" or "APC" means any licensed health care provider, excluding physicians, dentists, oral surgeons, and podiatrists, who has an independent or dependent scope of practice in a hospital setting within certain specified restrictions, and who is authorized by the Governing Board to exercise specified clinical privileges or provide direct patient care within the Hospital. APCs may include advanced practice nurses, certified nurse practitioners, certified

registered nurse anesthetists, certified nurse midwives, certified clinical nurse specialists, and physician assistants.

"Chief Executive Officer" or "CEO" means the individual appointed by the Governing Board to act on its behalf in the overall management of the Hospital or his/her designee.

"Chief Medical Officer" or "CMO" means the individual serving as the liaison officer between the Health System, Hospital Administration, and the Medical Staff in implementation of Health System and Hospital clinical, regulatory, and information technology policies and assists Medical Staff leadership with performance improvement and quality assurance activities.

"CHRISTUS Health" refers to the broader CHRISTUS Health organization that includes Health System, member hospitals including Hospital, and various CHRISTUS Health facilities elsewhere in Texas, Louisiana, New Mexico, and abroad.

"CHRISTUS Mother Frances Hospital - Tyler" means the Hospital facility and/or campus operating under a single hospital license and as a hospital member of the Health System.

"Clinical Privileges" means the permission granted to a practitioner recommended by the Medical Staff and granted by the Governing Board to render specific patient care services within their lawful scope of practice to patients at the Hospital, unless otherwise specified, and permission to use Hospital resources necessary to exercise granted clinical privileges.

"Credentialing Verification Organization" or "CVO" means the designated CHRISTUS Health credentialing verification resource.

"Days" means "calendar days" including Saturday, Sunday, and legal holidays unless otherwise referred to as "business days" which shall not include Saturday, Sunday, and legal holidays. When the word "Days" is used in reference to a deadline, in the event that the Day falls on a Saturday, Sunday or legal holiday, the deadline shall be the first (1st) day immediately following that Saturday, Sunday or legal holiday.

"Dentist" means a dentist duly licensed to practice dentistry in the State of Texas.

"Ethical and Religious Directives" means the most recent edition of the Ethical and Religious Directives for Catholic Health Care Services, as adopted by the United States Conference of Catholic Bishops or its successor and as formulated by applicable Archdiocese.

"Focused Professional Performance Evaluation" and/or "Ongoing Professional Performance Evaluation" ("FPPE" and/or "OPPE") means the evaluation of a practitioner's performance related to Medical Staff membership and/or clinical privileges as may be required by law and/or applicable accrediting body standards.

"Good Standing" means a practitioner who, during the current term of appointment to the Medical Staff and/or term of clinical privileges, has maintained all qualifications for Medical Staff membership and/or clinical privileges, his/her assigned category, and is in compliance or current

with all applicable responsibilities, including on-call coverage, medical record completion, and also is not currently subject to a clinical privileges limitation, suspension, restriction.

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

"Health System" means CHRISTUS Trinity Mother Frances Health System, a nonprofit corporation formed under the laws of the State of Texas, and its member hospitals.

"HCQIA" means the Health Care Quality Improvement Act of 1986.

"Hospital" means CHRISTUS Mother Frances Hospital – Tyler, including any on- or off-campus licensed locations of the Hospital.

"Medical Director" means a physician, dentist, oral surgeon or podiatrist who is responsible for monitoring the medical care provided at the Hospital, and who has general supervisory responsibility over practitioners providing medical care in a given area, section or department.

"Medical Executive Committee" or "MEC" means the Executive Committee of the Medical Staff.

"Medical Staff" means the Hospital's organized medical staff composed of all physicians, dentists, oral surgeons, and podiatrists who have been granted membership on the Medical Staff by the Governing Board.

"Medical Staff Bylaws" or "Bylaws" means the Medical Staff Bylaws of the Medical Staff, which includes the Governance and Credentialing Manual, the Corrective Action and Fair Hearing Plan, and Rules and Regulations.

"Medical Staff Development Plan" means any then current development plan, adopted by the Governing Board and recommended by the MEC for the purpose of identifying and evaluating the number and types of practitioners for strategic planning and recruitment. This may also include education, evaluation or training programs as deemed necessary by the Medical Staff.

"Patient Contact" means a face-to-face practitioner to patient encounter from which it is possible to make a meaningful evaluation of the member's clinical experience, competence, and care of the patient. A patient contact includes those activities commensurate with the scope of clinical privileges held by the practitioner for those patient contacts that do not involve practitioner-to-patient encounters, including collaborative care, pathology, radiology-related contacts, but excludes those activities that are solely academic teaching related. All patient contacts for purposes of fulfilling any contacts requirement must occur in the Hospital, unless by electronic medical record entry/access, telemedicine link, or an off-site laboratory procedure. To ensure this Contacts requirement represents an adequate measure of a given member's clinical competency and/or Medical Staff involvement, no patient admission, patient care activity, or Medical Staff activity will result in more than one (1) contact for any individual patient or assignment.

For purposes of category eligibility and/or assignment, in addition to any required patient contacts, Medical Staff "service contacts" may include specific activities related to Medical Staff

involvement, including fulfillment of Medical Staff assignments, meaningful participation in quality assessment and improvement activities, and such other activities as identified by the MEC and Governing Board that represent meaningful fulfillment of Medical Staff duties and responsibilities. Upon request and presentation of sufficient information, the MEC and Governing Board may in their sole discretion to accept appropriate documentation of patient care activities occurring at another CHRISTUS facility for purposes of meeting a contact requirement.

"Oral Surgeon" means a duly licensed physician or dentist under the laws of the State of Texas who is appropriate trained in dental surgery.

"Peer Review" refers to any and all activities and conduct involving efforts to further quality health care, improve patient care, evaluate practitioner credentials or competency, support practitioner professional development and well-being or engage in corrective action as needed through a formal or delegated process. These activities and conduct include but are not limited to evaluation of medical care; recommendations for credentialing and delineating clinical privileges for practitioners seeking or holding clinical privileges in the Hospital; addressing of the quality of care provided to patients; and evaluations of complaints, incidents, and other similar communications filed against the practitioners granted clinical privileges. These activities also include the receipt, review, analysis, action on and issuance of incident reports, quality and utilization review functions, and other related functions and activities referenced or described in any peer review policy, as may be performed by the Medical Staff, Hospital or the Governing Board directly or on their behalf by those individuals assisting the Medical Staff committees, Hospital committees or the Governing Board in such peer review activities, including , without limitation, employees, designees, representatives, agents, attorneys, consultants, investigators, experts, assistants, clerks, staff and any other person or organization who assists in performing peer review functions, conduct or activities.

"Peer Review Committee" means a Committee, Department or Section of the Medical Staff or Governing Board, as well as the Medical Staff and Governing Board as a whole, that participates in any peer review function, conduct or activity as permitted in these Bylaws or applicable Hospital policy or authority. "Peer Review Committee" includes any other persons or organizations, whether internal or external, who assist a peer review committee in performing its functions or activities, including its members or their employees, designees, representatives, agents, attorneys, consultants, investigators, experts, assistants, clerks, and/or staff. All reports, studies, analyses, recommendations, and other similar communications that are authorized, requested or reviewed by a peer review committee or persons acting on behalf of a peer review committee shall be treated as strictly confidential and not subject to discovery nor admissible as evidence consistent with those protections afforded under applicable Texas law. If a peer review committee or its designee deems appropriate, assistance may be obtained from other peer review committees, other committees, individuals, organizations or resources inside or outside the Hospital. For example, peer review committees shall include, without limitation, the MEC, all clinical Departments and Sections, the Credentials Committee, the Medical Staff Quality Committee, the Ethics Committee, the Utilization Management Committee, the Pharmacy and Therapeutics

Committee, a Hospital committee tasked with quality monitoring or improvement and the Governing Board when performing peer review functions, conduct or activities.

"Physician" means a duly licensed allopathic or osteopathic physician in the State of Texas.

"Podiatrist" means a duly licensed podiatrist in the State of Texas.

"Practitioner" means any particular physician, dentist, oral surgeon, podiatrist, or APC, who is seeking or granted Medical Staff membership and/or clinical privileges.

"Resident" or "Fellow" means a physician participating in an accredited graduate-training program whose practice requires supervision. Residents and/or Fellows are not members of the Medical Staff.

"Special Notice" means any notice required to be given under the Medical Staff Bylaws, unless otherwise stated. Such notice shall be in writing and shall be deemed given when personally delivered or sent by prepaid United States certified mail with return receipt requested, electronic mail, traceable courier services or confirmed facsimile. All Special Notices shall be considered received on the date actually received if given by personal delivery, electronic mail, traceable courier service or on the date shown as received on the certified mail receipt or fax confirmation sheet if given by such method. A refusal to accept delivery of service shall constitute effective delivery as of the date of any such refusal.

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

PURPOSE

The purposes of the Medical Staff shall be:

- To provide an environment where patients admitted to or treated in the facilities, departments or services of the Hospital receive appropriate, timely, quality medical care without discrimination on the basis of race, national origin, religion, color, creed, gender, sexual orientation, age, disability status, financial status, nature of illness, genetic information or other legally protected status.

- To promote an acceptable level of professional performance of all practitioners authorized to practice in the Hospital by the Governing Board, through the appropriate oversight of the clinical privileges that each practitioner has been granted and through an ongoing review and evaluation of each practitioner's performance in the Hospital by the Medical Staff, which is accountable to the Governing Board.

- To provide a means where issues concerning the Medical Staff and the Hospital may be discussed and resolved collaboratively among the Medical Staff, Governing Board, and Hospital Administration.

- To initiate and maintain Medical Staff Bylaws for the self-governance of the Medical Staff, which shall be reviewed periodically and revised as necessary subject to final review and approval by the Governing Board.

- To provide an appropriate setting to facilitate continuous professional development and advancement of practitioner professional knowledge and skill.

Nature of Medical Staff Membership and/or Clinical Privileges

Medical Staff membership and/or clinical privileges are privileges that shall be extended only to those practitioners who have demonstrated professional competence and meet and continue to meet the qualifications, standards and requirements set forth in the Medical Staff Bylaws and as may be established by the Medical Staff and Governing Board. Every patient admitted to the Hospital must be under the care of a member of the Medical Staff or appropriately privileged APC. APCs are not eligible for membership on the Medical Staff but must apply for and be granted appropriate clinical privileges through the processes specified in these Bylaws. No practitioner shall provide services to patients in the Hospital unless he/she has been appropriately granted clinical privileges to provide the services required by the patient. A Doctor of Medicine (MD) or Osteopathy (DO) shall be responsible for the care of each patient with respect to any medical or psychiatric condition that is not within the scope of practice and clinical privileges of a non-MD/DO. The Hospital and Medical Staff shall not discriminate on the basis of race, national origin, religion, color, creed, gender, sexual orientation, age, disability status, financial status, nature of illness, genetic information or other legally protected status.

All practitioners who are employed or engaged as an independent contractor to provide specified clinical and/or medico-administrative services at the Hospital are required to be qualified for and possess Medical Staff membership and/or clinical privileges recommended by the Medical Staff and granted by the Governing Board. The membership, clinical privileges, and contracted roles of such practitioners are subject to and may be superseded by the terms of their contractual agreement.

ARTICLE I

QUALIFICATIONS AND ELIGIBILITY FOR MEDICAL STAFF MEMBERSHIP AND/OR CLINICAL PRIVILEGES

Section 1.1. Qualifications for Medical Staff Membership and/or Clinical Privileges

1.1.1 General Standards

Only practitioners who can document their licensure, certification, background, education, training, experience, professional competence, health status, adherence to the ethics of their profession and Hospital and Medical Staff policies, good reputation, character, judgment, and ability to work with others shall be qualified for Medical Staff membership and/or clinical privileges. Additionally, to be considered for or to obtain membership and/or clinical privileges, all applicants are subject to any Hospital established contractual service line arrangement or Medical Staff Development Plan as may be developed and approved by the Governing Board.

1.1.2 Basic Qualifications

With the exception of Honorary Staff, only those practitioners who can continuously demonstrate or provide evidence of the following qualifications to the satisfaction of the MEC and Governing Board will be eligible for appointment or reappointment to the Medical Staff and/or the granting of clinical privileges:

(a) Current and valid, non-probationary and unrestricted Texas license or recognized permission to practice applicable to his/her profession;

(b) Current, valid, and unrestricted Drug Enforcement Administration registration, if applicable or required for exercising clinical privileges;

(c) Eligibility to actively participate in federal and Texas governmental health care programs, including Medicare and Medicaid;

(d) Professional liability insurance in the coverage, scope, amounts and/or limits established by the Governing Board after consultation with the MEC;

(e) Acceptable character, competence, training, experience, background, and judgment for all clinical privileges requested;

(f) Acceptable professional liability case frequency, judgment or settlement history;

(g) The physical and mental ability and health status necessary to perform the requested clinical privileges to the satisfaction of the MEC and Governing Board;

(h) Appropriate written and verbal communication skills;

(i) Current National Provider Identifier ("NPI") and NPI Attestation, if requested;

(j) Willingness and ability to properly discharge the responsibilities established by these Bylaws, the MEC, Hospital, and Governing Board; and

(k) Board certification, as required by Section 1.1.3 of these Bylaws.

No practitioner shall be entitled to membership on the Medical Staff and/or clinical privileges in the Hospital merely by virtue of licensure in Texas or in any other state; certification, fellowship, or membership in any professional organization, specialty body or society; similar clinical privileges at any other health care organization either in the past or currently. Consideration may be given for lapsed or expired licensure and certification due to documented delays attributed to the Texas Medical Board or Drug Enforcement Administration with appropriate safeguards.

1.1.3 Board Certification

Unless otherwise provided for in these Bylaws, all physician applicants for membership on the Medical Staff and/or requests for clinical privileges must be board certified or be actively pursuing and become board certified prior to the applicant's board certification eligibility expiration date in all areas in which they are seeking and /or granted clinical privileges. Acceptable specialty boards include member boards of the American Board of Medical Specialties, the specialty certifying board of the American Osteopathic Association, or any other specialty board approved by the MEC and Governing Board.

(a) The following practitioners are not required to meet or maintain the board certification requirement of this Section: 1) applicants who are seeking membership without clinical privileges; 2) applicants who are only seeking non-clinical and/or refer-and-follow privileges; or 3) applicants who are actively participating in a residency training program or whose clinical care is limited to providing "moonlighting," short term or special circumstance coverage under contract with the Hospital or Hospital affiliate.

(b) Physicians who were appointed to the Medical Staff as of January 1, 2023, and who are board certified or otherwise deemed to have satisfied a board certification requirement will not be required to maintain board certification as a condition of continued Medical Staff membership and/or clinical privileges, provided they otherwise meet the established competency requirements and other relevant criteria established by the MEC and Governing Board. If a physician who is otherwise grandfathered leaves the Medical Staff and then reapplies, the requirements of this Section apply.

(c) Once board certified for purposes of eligibility for appointment to the Medical Staff, practitioners are only required to maintain board certification if required for clinical privileges by a specific Department or Section.

1.1.4 Equivalent Qualifications in Exceptional Circumstances

In exceptional circumstances the Governing Board may accept alternative information to any qualification, including board certification upon recommendation of the MEC, if the practitioner demonstrates that he/she has equivalent training, education, experience, and ability to perform the clinical privileges requested, and in the case of board certification, has completed the training necessary to obtain board certification in the area of proposed practice and provides sufficient proof in the MEC and Governing Board's sole discretion of such equivalent training, education, experience, and ability to perform the clinical privileges requested. All requests for determining whether exceptional circumstances exist must include 1) relevant training and case logs and/or patient activity from the preceding two (2) years, 2) a copy of current FPPE/OPPE or equivalent reports from facilities where the physician held clinical privileges, 3) no fewer than three (3) peer references deemed acceptable by the Credentials Committee and MEC, and 4) documentation of ongoing professional improvement activities including CME hours, participation in clinical quality improvement programs, self-assessment exercises, and medical and community awards and leadership positions. The MEC and Governing Board will take into consideration those circumstances where an applicant is a member of the medical staff or an applicant at another hospital or facility affiliated with Health System or CHRISTUS Health. The MEC shall document the exceptional circumstances supporting any such recommendation and forward such documentation with its recommendation. An exceptional circumstances decision based on alternative information is not considered a waiver of criteria for Medical Staff membership or clinical privileges.

Section 1.2. **Conditions and Duration of Membership and/or Clinical Privileges**

1.2.1 Initial appointments and reappointments to the Medical Staff and/or the granting of clinical privileges shall be made by the Governing Board. The Governing Board shall act on appointments, reappointments, restrictions or revocations of membership or clinical privileges, and requests for clinical privileges after there has been a recommendation from the MEC as provided for in these Bylaws, except as otherwise provided for in the Corrective Action and Fair Hearing Plan.

1.2.2 Appointments and reappointments to the Medical Staff and/or clinical privileges shall be for a period established by the Governing Board up to a maximum of two (2) years. Membership and the granting of clinical privileges may initially be for a duration less than two (2) years as determined appropriate by the MEC or as appropriate to establish a uniform credentialing cycle for those applicants with medical staff membership or clinical privileges at one or more hospitals in the Health System. Appointment or Reappointment periods of less than two (2) years are not considered adverse actions as defined within the Corrective Action and Fair Hearing Plan.

1.2.3 Appointments and reappointments to the Medical Staff shall confer on the applicant/reapplicant only such clinical privileges as have been granted by the Governing Board in accordance with the Medical Staff Bylaws.

1.2.4 Every application for appointment and reappointment to the Medical Staff and/or clinical privileges shall be signed by the applicant/reapplicant. By submitting an application, each applicant/reapplicant acknowledges his/her obligation to provide continuous care and supervision of his/her patients and to abide by and be subject to applicable provisions of the Hospital's Bylaws, the Hospital's Compliance Plan, the Medical Staff's Code of Conduct, the Medical Staff Bylaws, and any other applicable policies of the Hospital, Medical Staff or Health System.

Section 1.3. **Leave of Absence**

1.3.1 A practitioner may submit a leave of absence request to the MEC or to the Chief of Staff, who shall forward the request to the Credentials Committee and the pertinent Department Chairperson. The Credentials Committee shall be responsible for the initial consideration of the request and for making a recommendation to the MEC. The MEC shall consider the request at its first regularly scheduled meeting following receipt of the recommendation from the Credentials Committee. The Governing Board or a committee thereof, shall make the final determination whether to grant or deny the request at its first regularly scheduled meeting following receipt of the recommendation from the MEC.

1.3.2 A request for a leave of absence must state the approximate duration of the leave of absence. A leave of absence may be granted for an interval of up to two (2) years. Failure to seek reappointment to the Medical Staff or renewal of clinical privileges shall result in the practitioner's voluntary resignation from the Medical Staff and/or relinquishment of clinical privileges.

1.3.3 During a leave of absence, the practitioner is not permitted to exercise clinical privileges in the Hospital but retains his/her membership on the Medical Staff, if applicable. No later than sixty (60) days prior to the termination of a leave of absence, the practitioner shall submit to the Credentials Committee a request for reinstatement of clinical privileges. The practitioner must submit a written summary of relevant activities during the leave if requested. The Credentials Committee shall make a recommendation to the MEC concerning the reinstatement. The MEC will make a recommendation which shall be forwarded to the Governing Board for review and final action. The practitioner's failure to submit a request for reinstatement shall result in the practitioner being removed from the Medical Staff or loss of clinical privileges, and thereafter application must be made as a new applicant.

1.3.4 Unless the practitioner has "occurrence form" of professional liability insurance, a practitioner on a leave of absence is required to maintain sufficient professional liability insurance, including requisite and appropriate extended reporting endorsement or prior acts coverage, as applicable.

ARTICLE II

RESPONSIBILITIES OF MEDICAL STAFF MEMBERS

Section 2.1. **Responsibilities of Medical Staff/APCs**

2.1.1 As initial and ongoing conditions for appointment/reappointment and responsibilities of membership and/or clinical privileges, each practitioner shall:

(a) Provide appropriate, timely, quality medical, dental or podiatric care without discrimination on the basis of race, national origin, religion, color, creed, gender, sexual orientation, age, disability status, financial status, nature of illness, genetic information or other legally protected status;

(b) Submit to and meaningfully participate in evaluations or reviews, including FPPE and/or OPPE, through peer review of professional competence, professional conduct, the evaluation of physician or mental health, and/or related quality assurance and improvement activities and policies, whether undertaken internally or externally;

(c) Accept committee assignments on a reasonable basis and make a good faith effort to attend Department and committee meetings;

(d) While exercising clinical privileges, comply with applicable provisions of the Medical Staff Bylaws, the Medical Staff's Code of Conduct, applicable Medical Staff policies, the Hospital policies (the foregoing documents not inconsistent with these Bylaws), other applicable policies including Hospital Compliance Program requirements and all applicable Federal and Texas laws, including the prohibition on inappropriate fee-splitting arrangements;

(e) Meaningfully participate in Hospital accreditation, licensing, and compliance education activities;

(f) As related to practitioner's clinical privileges, participate in the Hospital's emergency services on-call coverage and other Hospital coverage programs as established by the Chairperson(s) of the respective Department(s), MEC, and Governing Board, and consistent with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) as implemented by the MEC and Hospital. Participation in call coverage programs is a responsibility of eligibly practitioners and is not an assumed right of membership and/or clinical privileges;

(g) Comply in all respects with the Ethical and Religious Directives for Health Care Services;

(h) Comply with the Hospital's communicable disease surveillance program pursuant to the Hospital and Medical Staff policy;

(i) Submit to any pertinent type of health evaluation as requested by the Officers of the Medical Staff, CEO, and/or Department Chairperson when it appears necessary to protect the well-being of patients and/or staff, when requested by the MEC or Credentials Committee as part of an evaluation of the practitioner's ability to exercise privileges safely and competently or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and Hospital policies addressing physician health or impairment;

(j) Participate in any type of competency evaluation when determined necessary by the MEC and/or Governing Board in order to properly delineate a practitioner's clinical privileges;

(k) Successfully complete in a timely manner any Hospital sponsored training programs related to electronic medical record (EMR) and related clinical system implementation, pass any related program examination or opt-out examination, and submit required program documentation. Practitioners shall comply with all rules and regulations, and other applicable policies of the Medical Staff and Hospital related to such training programs or EMR systems;

(l) Appear before the MEC or designee upon request, including authorized quality or peer review committees; and

(m) Report to the Medical Staff Services Office, within five (5) business days of receiving notice of any of the following:

i. The initiation of any challenge or investigation by the Medical Licensing Board or other governmental agency of any professional license or certification and the scope and nature of any charges related to the challenge or investigation;

ii. The initiation of any investigation by the Office of the Inspector General (OIG), Centers for Medicare and Medicaid Services (CMS) or any other state or federal agency, including the scope and nature of any charges relating to the investigation, including any change in eligibility with third-party payers or participation in governmental health care programs, including Medicare and Medicaid, and any sanctions imposed or recommended by the OIG or CMS, and/or the receipt of a professional review organization citation and/or quality denial letter concerning alleged quality problems in patient care;

iii. The initiation of any challenge or investigation by the DEA or the voluntary or involuntary relinquishment of any state-controlled substance license or DEA registration;

iv. The involuntary loss, reduction in scope or termination of medical staff membership or clinical privileges;

v. The practitioner's involvement in a professional liability action, including the parties thereto and related allegations;

vi. The investigation, arrest, indictment or conviction with regard to any felony or criminal misdemeanor; or

vii. The suspension or lack of professional liability insurance at the scope, level or amount as determined by the Governing Board.

Section 2.2. **Ethics and Ethical Relationships**

Acceptance of Medical Staff membership and/or clinical privileges shall constitute the practitioner's agreement to strictly abide by the Ethical and Religious Directives for Catholic Health Care Services, and to comply with all applicable guidelines and opinions set forth in the Code of Medical Ethics of the American Medical Association, the Code of Ethics of the American Osteopathic Association, the Principles of Ethics and Code of Professional Conduct of the American Dental Association, the Principles of Ethics of the American Podiatric Association and the applicable ethical guidelines of the practitioner's licensing body.

Section 2.3. **Conflicts of Interest**

A Medical Staff member shall not participate or vote in any manner if the member has a conflict of interest in the matter being considered, acted upon or voted on by a Medical Staff committee or other body in which the member would ordinarily be involved, by virtue of the member's Medical Staff position, practice area or any other reason. A "conflict of interest" is any personal or business relationship or interest that the member has that might influence the member's decision or action on a matter, by causing the member to consider factors other than the best interests of the Medical Staff, the Hospital or the Hospital's patients. All practitioners shall disclose to the applicable committee or other appropriate Medical Staff body or representative any relationship which might be considered a conflict of interest by an objective person. Other members may also raise the question of whether a conflict of interest is present in a particular situation. Whether an actual conflict of interest is present shall be determined by the other members of the applicable committee. If the matter cannot be resolved in committee, the MEC in consultation with the CEO and CMO shall make the determination.

Section 2.4. **Confidentiality, Immunity, and Releases**

2.4.1 Authorizations and Conditions

By applying for or exercising Medical Staff membership and/or clinical privileges or by providing specified patient care services at this Hospital, each applicant and practitioner specifically authorizes the Hospital and Medical Staff, and their authorized representatives to consult with any third party who may have information bearing on the applicant or

practitioner's professional qualifications, credentials, clinical competence, character, mental and physical condition, ethics, behavior or any other matter related to the delivery of quality patient care.

This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of all third parties that may be relevant to the MEC and Governing Board's review and each applicant and practitioner specifically authorizes all third parties to release and provide such information to the Hospital, Medical Staff, and their authorized representatives upon request, and further:

(a) Authorizes Medical Staff and Hospital representatives to solicit, release, provide, disclose, and act upon information bearing on his/her competence, professional conduct, qualifications, patient care, and quality outcomes to and from health care entities and their agents, including resources and entities used by the Hospital for internal quality control and for evaluating and improving the quality of patient care;

(b) Agrees to be bound by the provisions of this Article II and to waive all legal claims against the Hospital, Medical Staff and any Medical Staff or Hospital representative who acts in substantial compliance with these Bylaws; and

(c) Acknowledges that the provisions of this Article II are express conditions to his/her application for and acceptance of Medical Staff membership and/or the continuation of such membership or the exercise of clinical privileges at the Hospital.

2.4.2 Confidentiality of Information

Information with respect to any applicant or practitioner that is submitted, collected, obtained or prepared by any Medical Staff or Hospital peer review committee or designee of such committee, or any other health care facility or organization or Medical Staff for the purpose of achieving, maintaining and improving quality patient care, reducing morbidity and mortality, contributing to clinical research or performing any peer review or peer review committee activity, shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a Hospital representative, nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to similar information that may be obtained from or provided by third parties. This confidentiality of information shall not be construed to limit the authorizations set forth in Section 2.4.1 above.

2.4.3 Immunity and Release from Liability

There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any act, communication, report, recommendation, or disclosure contemplated

by these Bylaws, even where the information involved would otherwise be deemed privileged. To the fullest extent permitted by law, all individuals requesting an application, and applicants for or granted appointment, reappointment, and/or clinical privileges, or any individual seeking to provide or providing patient care services in the Hospital releases from any and all liability, extends absolute immunity and agrees not to sue, the Hospital, the Medical Staff, their officers and authorized representatives, and any third party for any acts, communications, requests, reports, records, statements, documents, recommendations, or disclosures involving the individual, requested, sent or received by this Hospital or the Medical Staff, and their authorized representatives from or to any third party in furtherance of quality health care.

The acts, communications, reports, recommendations and disclosures referred to in this Article II may relate to an individual's professional qualifications, clinical competency, professional conduct, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

2.4.4 Substantial Compliance

These Bylaws are intended, in part, to create a framework to ensure compliance or consistency with Federal and Texas laws addressing the minimum procedures necessary with respect to Medical Staff membership and/or clinical privileges determinations concerning existing members of the Medical Staff and/or practitioners holding clinical privileges. These Bylaws are not intended in any fashion to create legally binding rights to strict adherence to its provisions. Accordingly, all practitioners agree that as a condition of requesting and exercising clinical privileges that these Bylaws shall not be interpreted as, nor construed to give rise to any type of legal action, claim, or proceeding for breach of contract related to strict compliance, except for the timeframe for a practitioner to request a hearing or appellate review (as set forth in the Corrective Action and Fair Hearing Plan).

2.4.5 Activities and Information Covered

The confidentiality and immunity provided by this Article II shall apply to all actions, information, communications, reports, recommendations or disclosures performed or made in connection with activities of the Hospital and Medical Staff concerning, but not limited to:

(a) Applications for appointment, clinical privileges or specified services;

(b) Periodic reappraisals for reappointment, clinical privileges or specified services;

(c) Patient care audits;

(d) Utilization reviews;

(e) Corrective action;

(f) Hearings and appellate procedures;

(g) Any peer review or peer review committee activity;

(h) Reports or disclosures to the National Practitioner Data Bank, other hospitals, medical staffs, medical associations, and licensing boards;

(i) Health System or Hospital-wide quality improvement activities; and/or

(j) Any information collected and/or reported to a Health System peer review or quality assurance committee or Patient Safety Organization in which the Hospital participates.

2.4.6 Releases

Each practitioner shall, upon request, execute any general or specific release as part and a condition of credentialing and/or privileging process. Failure to execute such releases shall in no way affect the immunity, release and consents made by the practitioner as described above.

2.4.7 Indemnification

The Hospital shall defend and indemnify any individual who was or is a party or is threatened to be made a party to or otherwise compelled to testify or give a deposition or answer discovery in any threatened, pending or completed action, lawsuit or proceeding, whether civil, criminal, administrative, or investigative (other than an action by or in the right of the Hospital). This obligation to defend and indemnify arises only where the individual is involved in the matter by reason of the fact that he/she is or was a director, officer, employee or agent of the Hospital or Medical Staff, or served as an agent or designee of a peer review committee and the claim, allegation, complaint, or charge is directly related to their assistance to or participation and role on a peer review committee or in a Professional Review Action. Such indemnification shall be for expenses (including attorneys' fees, but only for legal counsel appointed and directed by the Hospital), judgments, fines and amounts, whether paid in settlement actually and reasonably incurred by him/her in connection with such action, suit or proceeding if he/she acted in good faith, and in a manner consistent with his/her Medical Staff responsibilities. Notwithstanding the Hospital's obligation to indemnify, no indemnification shall be made with respect to any criminal action or proceeding unless the individual had no reasonable cause to believe his/her conduct was unlawful. Further, no individual shall be indemnified with respect to any claim, issue or matter in which such individual shall have been adjudged to be liable to the Hospital or which the individual acted with willful and wanton misconduct. The Hospital's obligation to defend and indemnify shall be limited to the insurance coverage it maintains for such matters provided such coverage is at the same level as the Hospital's corporate officers, and to the extent insurer determines the claim is eligible for indemnification.

2.4.8 HIPAA Compliance/Organized Health Care Arrangement.

As applicable, and in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Medical Staff (and its practitioners) and Hospital may agree to operate as an Organized Health Care Arrangement (OHCA) under which a joint notice of privacy practices would be issued, and the participating entities and/or practitioners in the OHCA would share protected health information with each other, as necessary to carry out treatment, payment, and health care operations related to activities of OHCA, such as quality assurance activities. In such case, the entities participating in the OHCA agree to abide by the terms of the joint notice with respect to protected health information created or received by a covered entity as part of its participation in the OHCA. The joint notice would be written, disseminated and maintained in compliance with all applicable regulatory requirements, as outlined in the HIPAA implementing regulations. Under the OHCA, the Medical Staff (and its practitioners) and Hospital, as participants in the OHCA, would separately retain all other obligations and responsibilities under the HIPAA regulations, including, but not limited to, the uses and disclosures of protected health information, fulfilling the patient rights and provisions and appointment of a privacy officer. Additionally, individual members of the Medical Staff and Hospital will retain individual liability for instances of non-compliance with the HIPAA regulations.

2.4.9 Reporting to Authorities

Any actions that occur as a result of applicant, practitioner, Medical Staff or Governing Board action that are reportable to the National Practitioner Data Bank and Texas Medical Licensing Board as required by applicable federal and Texas law shall be reported in the appropriate manner and required time periods.

2.4.10 Cumulative Effect

Provisions in these Bylaws and in applications relating to authorizations, confidentiality of information and immunity from liability shall be in addition to other protections afforded by applicable federal and Texas laws and not in limitation thereof, and in the event of conflict, applicable law shall be controlling.

ARTICLE III

CATEGORIES OF THE MEDICAL STAFF AND APCs

Section 3.1. **Medical Staff Generally**

The Medical Staff shall consist of the following categories, all of whom, but for Honorary Staff, must meet the basic qualifications and responsibilities set forth in Sections 3.1 and 3.2 and such other qualifications that are specific to each category. Based on the qualifications for each category, practitioners may be administratively reclassified to the category for which they are eligible should the practitioner's status or eligibility change during an appointment period.

Advanced Practice Clinicians are those licensed or certified individuals who the Governing Board has determined to be eligible to apply for clinical privileges consistent with the minimum eligibility and qualification requirements established by the Medical Staff and Governing Board as described in these Bylaws and applicable Medical Staff policy, which include their recognized scope of practice, licensure, certification, education, and demonstrated competency. APCs who are eligible for and granted clinical privileges will be classified as described in Section 4.13 below and are not eligible for Medical Staff membership.

APCs are credentialed and privileged pursuant to the process set forth in the Article 4 below.

Section 3.2. **The Active Staff**

The Active Staff is responsible to the Governing Board for the quality of medical care and treatment of inpatients and outpatients in the Hospital and the overall organization of the Medical Staff. Members of the Active Staff support the delegated responsibilities of the Medical Staff and provide organizational and administrative leadership within Hospital and Medical Staff.

3.2.1 Qualifications

(a) The Active Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who regularly admit, attend or treat patients in the Hospital within their scope of practice and granted clinical privileges, but does not include practitioners who only refer patients to Hospital. As part of the Hospital's ongoing effort to sustain medical and organizational excellence, in addition to those qualifications and responsibilities set forth in Sections 1.1 and 1.2 herein, members of the Active Staff must maintain no less than twenty-four (24) Contacts per two (2) year appointment period, prorated as necessary, to remain eligible for reappointment to the Active Staff. A Department or Section may require a minimum number of patient contacts for clinical privileges eligibility that is greater than what is required to maintain Active Staff membership. A Contact includes both a practitioner's "patient contacts" and "service contacts," (as more fully described in the Definitions of these Bylaws.).

3.2.2 Responsibilities

Members of the Active Staff shall:

(a) Make reasonable attempts to participate in meetings of the Department and/or committees to which the member is appointed;

(b) Meet established continuing medical education requirements;

(c) Actively participate in quality assessment and improvement activities of the Medical Staff;

(d) Maintain accurate, legible, timely, and complete medical records; and

(e) Demonstrate the capability to provide the continuous and timely care to the satisfaction of the MEC and Governing Board.

3.2.3 Prerogatives

Members of the Active Staff may:

(a) Exercise such clinical privileges as are granted by the Governing Board and may participate in Hospital and Medical Staff educational opportunities;

(b) Serve on Medical Staff, Department, and Section committees;

(c) Vote on all matters presented at general and special meetings of the Medical Staff and the Department, Section, and Medical Staff committees of which he/she is a member; and

(d) Hold office at any level of the Medical Staff organization.

Section 3.3. **The Associate Staff**

3.3.1 Qualifications

The Associate Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who are not eligible for or otherwise choose not to be assigned to the Active Staff. In addition to those qualifications set forth in Sections 1.1 and 1.2, members of the Associate Staff must maintain the minimum number of patient contacts per appointment period as established by the member's Department and approved by the Governing Board with respect to the clinical privileges sought or held.

3.3.2 Responsibilities

Members of the Associate Staff shall:

(a) Make reasonable attempts to attend and participate in meetings of the Medical Staff;

(b) Meet established continuing medical education requirements;

(c) Actively participate in quality assessment and improvement activities of the Medical Staff;

(d) Maintain accurate, timely and complete medical records; and

(e) Demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Governing Board.

3.3.3 Prerogatives

Members of the Associate Staff may:

(a) Exercise such clinical privileges as are granted by the Governing Board and participate in Hospital and Medical Staff educational opportunities;

(b) Vote on all matters presented at Department and Medical Staff committees of which he/she is a member, but may not vote during general and special meetings of the Medical Staff; and

(c) Serve on Medical Staff, Department, and Section committees, but not in leadership positions on those committees. Associate Staff members are not eligible to hold office in the Medical Staff.

Section 3.4. **The Affiliate Staff**

3.4.1 Qualifications

The Affiliate Staff shall consist of physicians, dentists, oral surgeons, and podiatrists: 1) whose practice at the Hospital will or does occur exclusively from a remote location, such as through a telemedicine or similar form; 2) who exclusively participate in the Hospital's teaching program; 3) who exclusively provide "moonlighting", short term, or special circumstance coverage under contract with the Hospital or Hospital affiliate; 4) military practitioners whose practice at the Hospital will occur exclusively through an external resource sharing arrangement; or 5) physicians functioning in a Hospital authorized medico-administrative role without clinical privileges. For the purpose of verifying clinical competence and in addition to those qualifications set forth in Sections 1.1 and 1.2 herein, members of the Affiliate Staff must maintain the minimum number of patient contacts per each appointment period as established by the member's Department and approved by the Governing Board with respect to the clinical privileges sought or held.

3.4.2 Responsibilities

Members of the Affiliate Staff shall, as applicable:

(a) Meet established continuing medical education requirements;

(b) Actively participate in quality assessment and improvement activities of the Medical Staff;

(c) Maintain accurate, timely and complete medical records.

3.4.3 Prerogatives

Members of the Affiliate Staff may:

Exercise such clinical privileges as are granted by the Governing Board. Affiliate Staff members are not eligible to serve on Medical Staff committees, vote or hold elective office in the Medical Staff.

Section 3.5. **The Honorary Medical Staff**

3.5.1 Qualifications

The Honorary Staff are those individuals who are recognized for their noteworthy contributions to the Medical Staff or the health and medical sciences. Honorary Staff members may be physicians, dentists, oral surgeons, or podiatrists who are retired from an active practice. Honorary Staff are not required to satisfy the qualifications or responsibilities set forth in Sections 1.1 and 1.2 herein.

3.5.2 Responsibilities

Members of the Honorary Staff have no responsibilities to the Medical Staff, provided however, that Honorary Staff participating in Medical Staff activities must do so in a constructive manner and not otherwise violate applicable codes of conduct or related policies.

3.5.3 Prerogatives

(a) Members of the Honorary Staff may attend any meeting of the Medical Staff or Department to which he/she was formerly appointed or would be appointed to if the member was active in the Hospital, unless otherwise excluded for good cause by Medical Staff or Department leadership. Honorary Staff may also participate in Hospital and Medical Staff educational opportunities;

(b) Honorary Staff members are not eligible to vote at general or special Medical Staff, Department, Committee meetings or hold elective office in the Medical Staff and may not serve on Medical Staff committees, unless by special invitation of the MEC; and

(c) Honorary Staff members are not eligible for clinical privileges.

Section 3.6. **Advanced Practice Clinicians**

Advanced Practice Clinicians are not eligible for Medical Staff membership but may exercise such clinical privileges as recommended by the MEC and granted by the Governing Board. APCs may participate in Hospital and Medical Staff educational opportunities; attend general and special meetings of the Medical Staff and serve on Department and Section Committees when appointed.

ARTICLE IV

CREDENTIALING PROCEDURES FOR MEDICAL STAFF MEMBERSHIP AND/OR CLINICAL PRIVILEGES

Section 4.1. **Pre-Application Procedures**

4.1.1 Form Preparation

The Medical Staff and Governing Board are responsible for reviewing and recommending any changes to pre-applications and applications, including application request, appointment, reappointment, and updating forms. All forms and revisions shall be reviewed and approved by the MEC and Governing Board and shall conform to any applicable Texas statutes and regulations that mandate the use of particular forms or specific content.

4.1.2 Application Request

Any individual seeking Medical Staff membership and/or clinical privileges must request in writing an application or application access from the Medical Staff Services Office or CVO and send a copy of his/her current curriculum vitae and any additional or supporting information requested as part of the Hospital's pre-application process. Application access will be e-mailed to qualified individuals. Once an application access link is sent, the individual will be considered an applicant. If the required application content is not submitted within thirty (30) days of the date the application access link was sent, the application shall be considered automatically withdrawn.

The Medical Staff Services Officer or CVO will make available a copy, or access to, these Bylaws, other Hospital and Medical Staff policies relating to clinical practices in the Hospital, including the Ethical and Religious Directives for Catholic Health Care Services, and the Hospital Bylaws and the applicable Compliance Plan.

Section 4.2. **Application for Initial Appointment and/or Clinical Privileges**

4.2.1 Application

Each application for appointment to the Medical Staff and/or clinical privileges shall be in writing, signed by the applicant and timely submitted to the designated application portal. An application will not be processed unless signed and complete.

4.2.2 Content

The Hospital uses the State of Texas Standardized Credentialing Application, which generally includes the following requests for information. The Hospital may supplement its application content by general or specific requests for information.

(a) Acknowledgment and Agreement

A statement that the applicant has received or has had access to the Medical Staff Bylaws and Hospital Bylaws, and any applicable Compliance Plan, and has read them and agrees to be bound by all applicable provisions in all matters relating to consideration of his/her request for initial or continuing Medical Staff membership and/or clinical privileges.

(b) Qualifications

Detailed information concerning the applicant's qualifications, demonstrated current competence and professional performance, including information regarding the qualifications specified in these Bylaws and of any additional qualifications established by the Medical Staff or Governing Board for the particular Medical Staff category, Department, and/or clinical privileges being requested.

(c) Requests

A request stating the Medical Staff category, Department, and clinical privileges for which the applicant desires to be considered.

(d) References

The names of at least three (3) practitioners of the same specialty who personally know and have recently worked with the applicant and directly observed his/her professional performance and conduct over a reasonable period of time, who can and will provide reliable information regarding the applicant's current clinical ability, ethical character, and ability to work with others. No reference may be a relative, and at least one (1) of which is not a partner or member of the applicant's clinical group and does not receive direct referrals from the applicant. For practitioners applying directly from a training program, at least one (1) reference must be the applicant's program director. For applicants who has been in practice for greater than one (1) year, one (1) reference must be the applicant's Department Chairperson, Section Chief, Chief of Staff or equivalent role.

(e) Professional Sanctions

Information regarding whether any of the following have ever been or are in the process of being denied, revoked, suspended, reduced, restricted, probationary, not renewed, voluntarily relinquished or voluntarily not exercised, shall be reported in detail:

i. Medical Staff membership status and/or clinical privileges at any other hospital or health care facility;

ii. Membership/Fellowship in local, state or national professional organizations;

iii. Board Certification or related Board Certification status;

iv. License to practice any profession in any jurisdiction; and

v. Drug Enforcement Administration (DEA) Registration

(f) Health Attestation

A statement affirming the practitioner's physical, mental, and emotional health to the extent relevant to the practitioner's ability to perform the requested clinical privileges without posing a risk to the safety or well-being of patients.

(g) Additional Disclosures

The applicant shall disclose:

i. Any and all pending and concluded professional liability suits, settlements, and judgments to which he/she is or has been a party during the past five (5) years (or two (2) years; if for reappointment);

ii. Any remedial, corrective or disciplinary action of any kind taken by any hospital, medical staff, professional organization, licensing body or governmental agency;

iii. Any circumstance where employment, medical staff membership and/or clinical privileges, were reduced, suspended, diminished, revoked, refused, voluntarily not exercised, or limited at any hospital or other health care facility, whether voluntarily or involuntarily;

iv. Any circumstance where he/she withdrew an application for appointment/reappointment, and/or clinical privileges, or resigned from a medical staff or clinical privileges to avoid an investigation before action by a hospital's or health facility's medical staff or board;

v. The results of any past or current FPPE and/or OPPE, if requested;

vi. Any past or current investigations due to inappropriate conduct, disruptive behavior, or unprofessional conduct (e.g., sexual harassment);

vii. Any past or current investigations, focused individual monitoring, review, or audits related to the quality of care or competency;

viii. All other information residing in the National Practitioner Data Bank;

ix. The previous five (5) years of health care related employment/appointments (work history);

x. All information related to the investigation, arrest, indictment or conviction with regard to any felony or misdemeanor. All applicants will be required to undergo a criminal background check; and

xi. Information as to the applicant's medical education and post-graduate training; and

xii. Any information requested on the supplemental form utilized as part of the Medical Staff membership and/or clinical privileges application process.

(h) Notification of Release of Immunity Provisions

Statement notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions in Section 2.4 herein.

(i) Administrative Remedies

A statement that the applicant agrees that if an adverse decision is made with respect to his/her Medical Staff membership status and/or clinical privileges, the applicant agrees to exhaust or waive the administrative remedies afforded by this Manual and/or the Medical Staff Fair Hearing Plan before attempting to resort to formal legal action.

(j) Financial Responsibility

Evidence that the applicant has secured or currently maintains professional liability insurance in amounts or limits as prescribed by the Governing Board in consultation with the Medical Staff.

(k) Practitioner Contact Information

The practitioner's current contact information for administrative and clinical communications.

(l) Current Identification Card

Evidence of identity issued by a state or federal agency.

(m) Obligation to Update

The application and reapplication includes a statement that the applicant acknowledges that he/she has the burden of providing any and all information necessary to process the application as determined in the discretion of the Credentials Committee, MEC or Governing Board; that he/she is solely responsible for supplementing his/her application during the application and reapplication process, in addition to the disclosure requirements set forth in these Bylaws, to ensure the completeness and accuracy of all statements and information contained therein as soon as this information becomes known but, in any event, before a final appointment or reappointment decision is made; and also notes that any false or misleading information provided by a pre-applicant, applicant, Medical Staff member, privileged practitioner, including APC during the pre-application, application, appointment, reappointment or renewal process may be treated as a voluntary relinquishment or otherwise serve as grounds for corrective action or termination of the credentialing process.

(n) Consent to Shared Information Policy

As a condition of membership and/or clinical privileges, the applicant agrees that any quality, peer review, and other related information that is collected as part of the appointment/reappointment or privileging process, as well as any peer review activities, may be shared with other healthcare organizations and entities, and their designees, including without limitation those that are administratively and clinically affiliated with the Hospital and practitioner, including hospitals in the Health System, for purposes related to credentialing, privileging, managed care participation or other Health System or CHRISTUS Health service line activities and any other healthcare facility or organizations at or for which the applicant seeks to practice.

Section 4.3. **Effect of Application**

By applying for appointment to the Medical Staff and/or clinical privileges, and in addition to any other conditions, commitments or releases contained throughout the Medical Staff Bylaws, each applicant:

4.3.1 Attests to the accuracy and completeness of all information on his/her application or accompanying documents and agrees that any inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. Each applicant acknowledges that if a material inaccuracy, omission or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the

individual's appointment and clinical privileges shall lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal. All determinations of whether information is material in nature shall be made by the MEC in its sole discretion;

4.3.2 Signifies willingness to appear for interviews in regard to his/her application;

4.3.3 Authorizes Hospital and Medical Staff representatives to consult with others who have been associated with him/her and/or who may have information bearing on the applicant's competence and qualifications;

4.3.4 Consents to Hospital and Medical Staff representatives inspecting all records and documents that may be material to an evaluation of professional qualifications and competence to carry out the clinical privileges requested, of physical and mental health status, and of professional ethical qualifications;

4.3.5 Releases from liability, extends absolute immunity to, and agrees not to sue all representatives of the Hospital, Medical Staff, Health System, and CHRISTUS Health Staff for their credentialing, privileging, peer review, and quality oversight activities, including the use, disclosure, and sharing of otherwise privileged or confidential information concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff membership and/or clinical privileges, performed in connection with the evaluation of and any decisions involving the applicant;

4.3.6 Releases from any liability, extends absolute immunity to and agrees not to sue all individuals and organizations who provide information to Hospital and Medical Staff representatives for credentialing, privileging, and other peer review or quality oversight activities concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff membership and/or clinical privileges;

4.3.7 Authorizes Hospital and Medical Staff representatives to provide other hospitals, medical associations, the National Practitioner Data Bank, licensing boards, hospitals in Health System, CHRISTUS Health affiliated entities (or its successor), other healthcare facilities, or organizations of health professionals with any information relevant to such matters that the Hospital may have concerning him/her, and releases Hospital and Medical Staff representatives from liability for so doing;

4.3.8 Agrees to execute any additional releases as requested and/or required to complete the application process consistent with the requirements of these Bylaws;

4.3.9 Attests that practitioner's conduct does not violate any applicable Hospital or Health System conflict of interest prohibitions or behavior expectations and agrees

to abide by the Code of Conduct, Ethical and Religious Directives, and any other applicable policies governing practitioner conduct; and

4.3.10 Attests that practitioner has been oriented or otherwise had access to the current Medical Staff Bylaws and agrees to abide by the provisions contained therein.

Section 4.4. **Processing the Application**

All applications for Medical Staff membership and/or clinical privileges will be processed according to this Article IV.

Requests for clinical privileges, scope of practice or permission to provide patient care services by practitioners whose professional license, scope of practice and/or Hospital policy prohibits an independent practice, limited direction or supervision will be processed and evaluated by the Hospital's Human Resources Department through its policies and procedures.

4.4.1 Applicant's Burden

The applicant shall have the burden to produce adequate information for a proper evaluation of the applicant's licensure status, experience, education, background, training, current competence, demonstrated ability, physical and mental health status, emotional stability, character, and judgment, and of resolving any doubts about these or any of the other specified qualifications as otherwise referenced or authorized by these Bylaws. All information required to be provided or disclosed, including supplemental requests by the Department Chairperson, Credentials Committee, MEC or Governing Board, must be submitted within thirty (30) days of the request or when otherwise required under this Article. If an applicant fails to meet this burden, the application will be deemed incomplete and the Medical Staff will have no obligation to further process the application, which may result in the application being deemed withdrawn and the applicant will not be eligible to submit a new application for a period of one (1) year from the date the initial application was deemed to be withdrawn.

4.4.2 Verification of Information

The applicant shall return an application that contains all requested information to Medical Staff Services Office or CVO, within thirty (30) days from the date the application was initially e-mailed; otherwise, the application shall be deemed automatically withdrawn. The Hospital and Medical Staff representatives, in conjunction with the Medical Staff Services Office or CVO shall, in timely fashion, seek to collect and primary source verify the applicant's licensure history, medical education and postgraduate training, professional liability insurance history, board certification status, sanctions and disciplinary actions, criminal history, employment/appointment history, professional references, and other qualification evidence submitted, including, but not limited to, National Practitioner Data Bank and List of Excluded Individuals/Entities. The Medical Staff Services Office or CVO will also request from the Texas Medical Board all information concerning the licensure status

and any disciplinary action taken against a practitioner's license. An applicant shall be notified of any problems or omissions in obtaining the information required, and it shall then be the applicant's obligation to obtain or provide the required information. Upon receipt of the completed application, Medical Staff Services Office or CVO shall transmit the application and all other supporting materials to the Chairperson of each Department in which the applicant requests clinical privileges. Any additional information and materials received will be transmitted to the Department Chairperson(s).

4.4.3 Department Action

The pertinent Department Chairperson or Section Chief shall initially review the application and all supporting materials furnished by the applicant. If by the Department Chairperson, this initial review may involve or follow a review by the pertinent Section Chief as established by each Department. The Department Chairperson has the discretion to call a meeting with the Credentials Committee or other members of the Department to assist the Chairperson in the credentialing and privileging process and conduct an interview with the applicant. As soon as practicable, the Chairperson shall make a recommendation, including delineated clinical privileges, to the Credentials Committee, or the APC Credentials Subcommittee in the case of an APC, that the requested appointment and/or clinical privileges be either granted, denied or modified, including whether there is any Department specific input for the Credentials Committee or MEC to consider. The APC Credentials Subcommittee or designee shall promptly review recommendations forwarded by a Department Chairperson and forward its recommendation to the Credentials Committee for further review.

4.4.4 Credentials Committee Action

(a) Within ninety (90) days of receiving a completed application, and following receipt of the recommendation from the Chairperson of the Department or the APC Credentials Subcommittee or designee, the Credentials Committee shall review the application, all supporting materials and the recommendation; conduct a personal interview (directly or through a Committee representative) with the applicant, if it deems an interview is appropriate; and/or conduct further investigation of the applicant as warranted.

(b) Once the Credentials Committee has considered the licensure status, training/education, professional competence, character, judgment, experience, health status, ethical standing of the applicant, and other applicable qualifications, it shall transmit its written report and recommendations to the MEC. If appointment to the Medical Staff and/or clinical privileges are recommended, and provided all other conditions of appointment are satisfied, the report shall state the Medical Staff category, Department affiliation, and any special considerations or condition(s), if any, to be attached to the appointment. The Credentials Committee may

recommend that the MEC defer action on the application, stating the reason for such recommendation.

4.4.5 Medical Executive Committee Action

The MEC at its next regular meeting or such other appropriate time, after receipt of the written report and recommendations of the Credentials Committee shall consider those reports and all such other relevant information available to it or otherwise requested. The MEC shall then determine whether to:

(a) Recommend to the Governing Board that the applicant be appointed to the Medical Staff and/or that specific clinical privileges be granted; or

(b) Recommend to the Governing Board that the applicant be denied for Medical Staff membership and/or that specified clinical privileges be denied; or

(c) Defer action on the application, but deferred action may not extend beyond such time necessary to process the application within the processing period designated in Section 6.4.8, at which time a recommendation to the Governing Board should be made.

All recommendations by the MEC to appoint an applicant to the Medical Staff and grant clinical privileges will include a recommended Department assignment in accordance with their qualifications. Each practitioner will be assigned to one primary Department.

The Chief of Staff or his/her designee shall present the MEC's written report and recommendations for Medical Staff appointment and clinical privileges, including clinical privileges requests for APCs, to the Governing Board for its consideration. The report shall state, as applicable, the Medical Staff category, Department affiliation, and/or whether the applicant's request for membership and/or clinical privileges is being recommended and any recommended special condition(s), if any.

4.4.6 Governing Board Action

Within sixty (60) days following a recommendation of the Credentials Committee, and upon receiving the application, supporting material, and recommendation forwarded by the MEC, the Governing Board or authorized subcommittee shall, in whole or in part, adopt or reject the recommendation of the MEC. Alternatively, it may refer the application back to the MEC for further consideration, stating the reasons for this action and setting a time limit within which any subsequent recommendation shall be made.

Whenever the Governing Board's decision is contrary to or materially different from the MEC's final recommendation, the Governing Board shall so notify the MEC. In such circumstances, if the MEC or the Governing Board so requests, the Governing Board shall first submit the matter to a Joint Conference Committee which shall report its

recommendation to the Governing Board within fourteen (14) business days of the action proposed by the Governing Board. Under such circumstances, the Governing Board shall consider the report of the subcommittee and then take its tentative final action. The Governing Board is responsible for the final decision, based on Medical Staff recommendations, regarding an individual's appointment, reappointment and/or renewal or revision of individual clinical privileges. In rendering its final decision on an application for reappointment, the Governing Board shall recognize the primary role of the Medical Staff in reviewing the qualifications of Medical Staff applicants and members. The Governing Board's decisions with respect to such recommendations shall be based on the information and recommendations submitted by the Medical Staff, and other relevant information, provided, however, that the recommendations of the Medical Staff shall be given their proper weight and authority given its expertise in these areas; and provided further that while the Governing Board has the ultimate authority with respect to such decisions, the Board's decision shall be guided by quality patient care and other relevant considerations.

4.4.7 Notice of Final Decision

(a) If the Governing Board's action is favorable to the applicant, it shall become effective as a final decision. Notice of final decisions shall be communicated to the Chief of Staff, the MEC, the applicable Department Chairperson, and the Medical Staff Services Office, who shall notify the applicant.

(b) If the decision of the Governing Board is adverse to the applicant with respect to appointment and/or clinical privileges, the CEO shall send a Special Notice of the adverse decision to the applicant. The notice will explain the reasons for the adverse decision, including any reasons based in whole or in part on the applicant's qualifications or any other factors. Initial applicants for appointment to the Medical Staff subject to an adverse determination are not entitled to a hearing or any other form of reconsideration, unless the decision is an adverse action, as that term is defined in the Corrective Action and Fair Hearing Plan. Adverse actions regarding the granting or renewal of clinical privileges for APCs are addressed in Sections 4.13 and 4.14 herein.

(c) Notice of the Governing Board's final decision shall be communicated to the Chief of Staff, the Chairperson of each Department concerned, and Medical Staff Services Office or CVO, who shall notify the applicant in writing.

(d) Notice of the final decision shall be provided to the applicant within sixty (60) days of the Governing Board's decision and shall include, as applicable, (1) the Medical Staff category to which the applicant is appointed; (2) the Department and Section to which he/she is assigned; (3) the clinical

privileges he/she may exercise; and (4) any special condition(s) attached to the appointment and/or clinical privileges.

4.4.8 All applicable Departments, Committees, and the Governing Board shall make reasonable efforts to ensure that each application is processed, and a final decision is rendered within one-hundred fifty (150) calendar days from the date that a completed application was received.

4.4.9 Reapplication after Adverse Appointment or Privileges Decision

An applicant who has received a final adverse decision regarding appointment and/or clinical privileges is not eligible to reapply to the Medical Staff or for clinical privileges for a period of two (2) years from the date of the decision. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the Medical Staff or the Governing Board may require.

Section 4.5. **Reappointment/Renewal Process**

4.5.1 Information Form for Reappointment

Medical Staff Services Office or CVO shall, not less than one hundred twenty (120) days prior to the expiration date of a Medical Staff appointment and/or expiration of clinical privileges, provide such practitioner with an appropriate reappointment or renewal application for use in considering reappointment and/or renewal of clinical privileges. Each practitioner who desires reappointment or renewal shall, not less than sixty (60) days prior to such expiration date, send a completed reappointment/renewal application to Medical Staff Services Office or CVO, as appropriate. Failure to return the application within the time required may be deemed a voluntary resignation from the Medical Staff and shall result in the automatic relinquishment of Medical Staff membership and/or clinical privileges at the expiration of the practitioner's current term. A practitioner who fails to comply with any of the reappointment or renewal requirements as specified in the Medical Staff Bylaws must reapply for Medical Staff membership or clinical privileges pursuant to the initial appointment process.

4.5.2 Content of Reappointment Application

The content of the reappointment/renewal application shall include, but not be limited to, the requested information set forth in Section 4.2 herein.

Section 4.6. **Processing of Reappointment and/or Renewal of Clinical Privileges**

4.6.1 Reappointment Burden

The practitioner shall have the same burden of producing adequate information and resolving doubts as provided in Section 4.3 herein.

4.6.2 Verification of Information

The Hospital and Medical Staff shall in a timely fashion, in conjunction with the Medical Staff Services Office or CVO, seek to collect and verify all information made available on each reappointment application and to collect any other materials or information required or deemed pertinent, including, but not limited to National Practitioner Data Bank, and information regarding the practitioner's professional activities, performance and conduct in the Hospital and fulfillment of Medical Staff membership and/or clinical privileges obligations, including fulfillment of Medical Staff, Department, and Committee responsibilities, as applicable. The Hospital shall also request from the Texas Medical Board information concerning the licensure status and any disciplinary action taken against a practitioner's license. The practitioner shall be promptly notified of any problems in obtaining the required information. Upon receipt of the completed reappointment/renewal application, the Medical Staff Services Office or designee shall transmit the form and all other supporting materials to the Chairperson of each Department in which the practitioner requests clinical privileges.

4.6.3 Department Action

The Department Chairperson or Section Chief shall review the prescribed recredentialing/renewal application, all supporting materials furnished by the practitioner and all such other information and materials as deemed appropriate, including any performance distinction and other quality or peer review reports pertaining to the practitioner. The Department Chairperson or Section Chief may interview the practitioner and/or consult with other members of the Department and the Credentials Committee to assist the Chairperson or Chief in this credentialing and privileging process. As soon as practicable after receiving the prescribed recredentialing/renewal application, the Chairperson or Chief shall transmit recommendations, including delineated clinical privileges, to the Credentials Committee that the requested reappointment and/or clinical privileges be renewed, or that the requested reappointment be renewed with modified Medical Staff category and/or Department affiliation and/or clinical privileges, or that the appointment and/or clinical privileges be terminated.

4.6.4 Credentials Committee, MEC and Governing Board

Thereafter, the procedures provided in Sections 4.4.4 through 4.4.8 shall be followed. For purposes of reappointment or renewal, the term "appointment" as used in those Sections shall be read as "reappointment."

4.6.5 Basis for Recommendations and Decisions

Each recommendation concerning the reappointment of a Medical Staff member and/or clinical privileges to be granted, including renewal of clinical privileges for an APC, shall be based on documented evidence of such practitioner's eligibility, professional ability and clinical judgment in the treatment of patients, professional ethics, discharge of applicable

Medical Staff, Department or Section responsibilities and clinical privileges obligations, compliance with these Bylaws, applicable Hospital policies and pertinent Compliance Plan requirements, the Ethical and Religious Directives, cooperation with other practitioners and with patients, the practitioner's health status, the practitioner's participation in continuing education activities relevant to their clinical privileges, and other matters bearing on ability and willingness to contribute to quality patient care in the Hospital. A practitioner's eligibility for reappointment of membership and/or renewal of clinical privileges will also be based on compliance with the minimum number of Contacts per each appointment/clinical privileges period as required by the applicable Medical Staff category qualifications and/or established by the member's Department or APC Credentials Subcommittee, and Governing Board for the purpose of verifying clinical activity, clinical competence, and engagement in Medical Staff affairs.

Section 4.7. **Requests for Modification of Membership Status or Clinical Privileges**

A practitioner may, either in connection with reappointment or renewal or at any other time, request modification of Medical Staff category, Department assignment or clinical privileges. A requested change in Medical Staff category or Department assignment shall be sent to the Medical Staff Services Office or designee. A requested change in clinical privileges shall be sent to the pertinent Department Chairperson and be accompanied by evidence of the practitioner's education, training, experience and competence to perform the specific clinical privileges requested. Such application shall be processed in substantially the same manner as provided in Section 4.4 herein.

Section 4.8. **Option to Expedite**

4.8.1 Expedited Review

In the event an applicant or reapplicant for Medical Staff membership and/or clinical privileges evidences or has demonstrated the basic qualifications set forth in these Bylaws, has submitted a complete application or reapplication and supporting documents, and otherwise meets all applicable criteria and any applicable regulatory and accrediting agencies' standards for expedited review, the Chairperson of the appropriate Department may initiate an expedited review process by assessing the application or reapplication and forwarding a recommendation directly to the Chairperson of the Credentials Committee, requesting that the application or reapplication be expedited. The Chairperson of the Credentials Committee may review the application or reapplication and, if recommending the application or reapplication for approval, may forward the application or reapplication directly to the Chief of Staff. The Chief of Staff, in conjunction with two (2) members of the MEC, may then review the application or reapplication, and if unanimously recommending the application or reapplication for approval, may forward the application or reapplication to the Governing Board or designee to review the application or reapplication and take final action thereon.

4.8.2 Restrictions and Objections

An applicant or reapplicant is usually ineligible for the expedited process if, at the time of appointment or granting of clinical privileges, or if since the time of last reappointment, any of the following has occurred: the applicant or reapplicant submits an incomplete application or reapplication; there is a current challenge or a previously successful challenge to licensure or registration; the applicant or reapplicant has received an involuntary termination of medical staff membership at another organization; the applicant or reapplicant has received involuntary limitation, reduction, restriction, denial, loss of clinical privileges or is otherwise under current focused peer review or investigation; there has been a final judgment that is adverse to the applicant or reapplicant in a professional liability action; or there is a reasonable concern about the applicant or reapplicant's health status.

If either the Chairperson of the Department, the Chairperson of the Credentials Committee, the Chief of Staff, the MEC or the Governing Board or designees do not believe an application or reapplication should be expedited, for any reason, the prescribed application and reapplication procedure set forth herein shall be followed. All applicants and reapplicants must satisfy the criteria and standards for Medical Staff membership and/or clinical privileges set forth through the Medical Staff Bylaws.

Section 4.9. **Exercise of Privileges**

Any practitioner providing direct clinical services at the Hospital shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Governing Board. While only physicians, dentists, oral surgeons, and podiatrists are eligible for Medical Staff membership, APCs may be granted clinical privileges in order to provide clinical services at the Hospital in accordance with the Bylaws and applicable Hospital policy. All clinical privileges and services must be within the scope of the practitioner's license, certificate or other legal authority authorizing him/her to practice in Texas and consistent with any applicable restrictions. The care of all patients treated by an APC, if permitted by their clinical privileges, must be under the care of a physician member of the Medical Staff as established by applicable Hospital and Medical Staff policy.

Section 4.10. **General Delineation of Clinical Privileges**

4.10.1 Requests

(a) Each application for appointment and reappointment to the Medical Staff and/or for clinical privileges must contain a request for the specific clinical privileges desired by the practitioner. Each request for clinical privileges must be supported by documentation of appropriate training and/or experience supportive of the request and must be consistent with all criteria delineated and established by the pertinent Department and Governing Board.

(b) Any request for clinical privileges for which there are no approved requirements may be tabled for a period of up to one hundred twenty (120) days. During this time, the Department(s), the Credential Committee, and the MEC will create requirements and formulate the necessary criteria for clinical privileges under which the request may be processed for approval by the Governing Board. All requirements for clinical privileges will consist of baseline criteria specifying the minimum amount of education, training, experience, and evidence of competency required. The Medical Staff is not required to establish qualifications or criteria for clinical privileges if such privileges relate to services not provided by the Hospital.

4.10.2 Basis for Clinical Privileges Determination

Requests for clinical privileges shall be evaluated based on the practitioner's education, training, certifications, experience, demonstrated ability, judgment, compliance with Medical Staff and Hospital policies, applicable privileging criteria, and also based on the capabilities of the Hospital, including sufficient space, equipment, staffing, license, beds, staff, and other resources required to support the privilege. The basis for clinical privileges determination shall also include satisfactory clinical performance from sources recognized by the Medical Staff and Governing Board, which include clinical performance as observed or reviewed by the Hospital's performance distinction and/or quality improvement programs. In addition, other factors to be considered shall be the results of FPPE and/or OPPE, other quality assurance activities, and whether the applicant meets applicable patient contact requirements, all as may be required by the Medical Staff and Hospital Bylaws and related policies. A clinical privileges determination may also be based on pertinent information concerning clinical performance obtained from other sources, such as peers of the practitioner, and/or from other CHRISTUS Health facilities where the practitioner exercises the same or similar clinical privileges being requested. This information shall be maintained in the credentialing and/or quality file established for each practitioner.

Section 4.11. **Special Conditions for Oral Surgery, Dental, and Podiatric Clinical Privileges**

4.11.1 Oral Surgery and Dental Clinical Privileges

Requests for clinical privileges from oral surgeons and dentists shall be processed in the same manner as any other applicant or reapplicant. Procedures performed by oral surgeons who are not MD/DOs and dentists shall be under the overall supervision of the Chairperson of the Department of Surgery or designee. A medical history and physical complete physical examination will be made and recorded by a duly privileged practitioner. The designated physician member shall be responsible for the care of any medical condition that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed procedure on the total health status of the patient. The oral surgeon or dentist will be responsible for the dental care of the patient, including the dental history and physical examination. Oral

surgeons and dentists may issue orders within their licensed scope of practice, granted clinical privileges, and consistent with applicable Medical Staff policies.

4.11.2 Podiatric Clinical Privileges

Requests for clinical privileges from podiatrists shall be processed in the same manner as any other applicant or reapplicant. Procedures performed by podiatrists shall be under the overall supervision of the Chairperson of the Department of Surgery or designee. A medical history and physical examination will be made and recorded by a physician who is a member of the Medical Staff. The designated physician member shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed procedure on the total health status of the patient. The podiatrist will be responsible for the podiatric care of the patient, including the podiatric history and physical examination. Podiatrists may issue orders within their licensed scope of practice, granted clinical privileges, and consistent with applicable Medical Staff policies.

Section 4.12. **Special Conditions for Residents and Fellows**

Residents and fellows in training in the Hospital may not normally hold membership on the Medical Staff and/or be granted clinical privileges, unless otherwise determined to be eligible by the MEC and Governing Board. Residents and fellows in training are subject to the written policies and training protocols developed by the CMO and/or program director in conjunction with the Hospital's then current residency or fellowship training program.

Section 4.13. **Special Conditions for Advanced Practice Clinicians**

4.13.1 Only those APC categories or professions defined in these Bylaws or otherwise approved by the Governing Board are eligible for clinical privileges. APCs may, subject to any licensure requirements or related supervision, and/or collaboration limitations, exercise independent judgment within their scope of practice, areas of professional competence, granted clinical privileges, and applicable Hospital policies. The clinical privileges of an APC shall terminate immediately, without right to procedural rights, in the event that: 1) the practitioner's employment by the Hospital or contractor affiliation is terminated for any reason; or 2) a required physician affiliation, supervision or collaboration arrangement is terminated for any reason. Provided, however, that the clinical privileges of an APC shall not terminate if timely arrangements are made for the Hospital to employ the APC or the APC's affiliation, supervision or collaboration arrangement is appropriately replaced, as required.

4.13.2 Employed APCs

Except as provided for below, employment of an APC by the Hospital shall be governed by the Hospital's employment policies and the terms of the individual's

employment relationship. If the Hospital's employment policies, or the terms of any applicable employment relationship are more restrictive, conflict with these Bylaws, the employment policies or terms of the individual's employment relationship shall apply.

Section 4.14. **APC Corrective Action**

4.14.1 No Entitlement to Medical Staff's Corrective Action and Fair Hearing Plan

APCs shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff's Corrective Action and Fair Hearing Plan or any other Hospital or Medical Staff policy except as provided for below.

4.14.2 Investigation and Committee Meeting

(a) When a question involving clinical competence or professional conduct of an APC is referred to or raised by the MEC, the MEC will review the matter and determine whether to investigate or to direct the matter to be handled pursuant to applicable Hospital policy.

(b) The MEC shall either investigate the matter itself or request the matter be investigated by a designee, which may include a standing committee, ad hoc committee, or an individual on its behalf ("Investigating Committee").

(c) The Investigating Committee will have the authority to review relevant documents, interview individuals, including the supervising or collaborating physician, and retain external consultants or peer reviewers. It will also have available to it the full resources of the Medical Staff and Hospital.

(d) The APC will have an opportunity to meet with the Investigating Committee before it makes its report. Prior to this meeting, the APC will be provided a written description of the issues being investigated and the reasons related thereto, that as a result of such investigation his/her clinical privileges may be modified, restricted or revoked or other action taken related thereto and will be provided any documents that support the medical staff's recommendation and a summary of any feedback from any individuals who have raised concerns about the individual. The APC will be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview will be prepared.

(e) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within thirty (30) days of the commencement of the investigation, provided that an external review is not necessary. When an external review is necessary, the Investigating Committee will make a reasonable effort to complete the investigation and

issue its report within thirty (30) days of receiving the results of the outside review. These periods are intended to serve only as guidelines.

(f) At the conclusion of the investigation, the Investigating Committee will prepare a report with its findings, conclusions, and recommendations.

(g) Upon preparation and review of the report, the MEC may accept, modify or reject any recommendation it receives from the Investigating Committee, which may include taking no action, issuing a letter of reprimand, recommending additional training or education, recommendation reduction, restriction, or termination of clinical privileges, or any other recommendation or action it determines to be appropriate under the circumstances.

4.14.3 Appeal following Denial, Modification, Restriction or Revocation

(a) In the event that an APC, excluding Hospital employees, is denied clinical privileges at the Hospital or whose clinical privileges are modified, restricted or revoked, the APC, and when applicable, his/her affiliated or collaborating member of the Medical Staff, shall have the right to appear personally before the MEC or other designated ad hoc committee to discuss the decision.

(b) If the APC desires to appear before the MEC or designated ad hoc committee, he/she must make such request:

1) in writing; and

2) within ten (10) days of the decision to deny, modify, revoke clinical privileges.

(c) Should the APC request an appearance in a timely manner, the APC will be informed of the general nature of the information supporting the decision to deny, modify, restrict or revoke prior to the scheduled meeting.

(d) At the meeting, the APC and, when applicable, his/her employing or supervising member, shall be invited to discuss the decision.

(e) Within ten (10) days following the meeting, the MEC or designated ad hoc committee shall notify the Governing Board of its recommendation.

(f) At its next scheduled regular meeting, the Governing Board shall make a final decision. The APC will be notified in writing in a timely fashion following the Governing Board's decision.

Section 4.15. **History and Physical Examination Requirements**

Practitioners granted clinical privileges to perform history and physical examinations must complete and document the results of a comprehensive history and physical examination no more than thirty (30) days before or twenty-four (24) hours after admission or registration of each patient, but prior to surgery or a procedure requiring anesthesia services. The MEC may adopt a policy to permit an appropriate assessment, in lieu a comprehensive medical history and physician examination, for patients undergoing specified outpatient surgeries or procedures at the Hospital. If adopted in the MEC's discretion, the policy will be based on a) patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure; b) nationally recognized guidelines and standards of practice for assessment of specific types of patients prior to specific outpatient surgeries and procedures; and c) applicable state and local health and safety laws.

When a history and physical examination is completed within thirty (30) days prior to admission or registration, a re-examination of the patient must be performed and any updates to the patient's conditions must be documented in the patient's medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

Additional requirements for the completion of history and physical examinations may be set forth in the Medical Staff Rules and Regulations, and/or applicable Hospital polices.

Section 4.16. **Telemedicine Clinical Privileges**

4.16.1 Applicants seeking clinical privileges to perform telemedicine services may, but need not, be processed pursuant to the complete appointment and privileging procedures described in Section 4.4 above. Alternatively, in the case of applicants located at the distant-site hospital or entity who intend to provide telemedicine services to patients at Hospital under a written agreement between the Hospital and a distant-site hospital or entity, the MEC may make recommendations to the Governing Board regarding such applicants in reliance upon the credentialing and privileging decision of the distant-site hospital or entity with whom the Hospital has an agreement for telemedicine services.

4.16.2 Applicants based at distant-site hospitals or entities who intend to provide telemedicine services to patients at Hospital under a written agreement with the Hospital may apply for clinical privileges provided each applicant meets the basic qualifications set forth in these Bylaws, applicable privileging criteria and by submission of the same application or application with equivalent content as specified herein. All determinations regarding equivalent content will be made by the MEC and Governing Board.

4.16.3 Upon confirmation by Medical Staff Services Office or CVO that an applicant's request for telemedicine privileges complies with the terms of the written agreement between the Hospital and the distant-site hospital or entity, including clinical privileges criteria adopted by the Medical Staff, the MEC may rely upon the

credentialing and privileging decisions made by a distant-site hospital or telemedicine entity when making its recommendation for clinical privileges provided the agreement between the Hospital and distant-site hospital or entity ensures the following:

(a) The distant-site hospital is a Medicare participating hospital or the distant-site telemedicine entity provides written assurances that its credentialing and privileging process and standards meet the Medicare Conditions of Participation for Hospitals;

(b) The practitioner is privileged at the distant-site hospital or distant-site telemedicine entity and a current list of equivalent privileges is provided;

(c) The distant-site practitioner holds a current license issued or recognized by the State of Texas;

(d) That upon being granted clinical privileges, the Hospital provides the distant-site hospital or entity evidence of an internal review of the practitioner's clinical performance for use in the practitioner's periodic appraisal and, at a minimum, the information must include all adverse events resulting from the telemedicine services provided by the distant-site practitioner as well as any registered complaints.

4.16.4 If a practitioner who has been granted clinical privileges to provide telemedicine services at the Hospital fails to utilize such clinical privileges or otherwise provide telemedicine services to Hospital patients at a satisfactory volume as determined by the practitioner's assigned Department for the purpose of reliably assessing the quality and performance of the practitioner's telemedicine services, such clinical privileges shall cease and expire either six (6) months following the date practitioner last provided telemedicine services at the Hospital or when otherwise notified by the Medical Staff.

4.16.5 If the Hospital has not entered into a written agreement for telemedicine services with a distant-site hospital or entity but has a pressing clinical need for telemedicine services and a distant-site practitioner can supply such services via a telemedicine link, the Hospital may evaluate the use of temporary clinical privileges for a distant-site practitioner as addressed in Section 6.17 below. In such cases, the distant-site practitioner must be credentialed and privileged to provide telemedicine services in accordance with Hospital standards and procedures applicable to the approved telemedicine services.

Section 4.17. **Temporary Clinical Privileges**

4.17.1 Circumstances

The CEO, acting on behalf of the Governing Board, may grant specific temporary clinical privileges in only the following circumstances. Unless otherwise provided by applicable Hospital and/or Medical Staff policy, temporary clinical privileges may not be granted unless an applicant successfully completes any Hospital sponsored training programs related to electronic medical record (EMR) and related clinical system implementation, pass any related program examination or opt-out examination, and submit required program documentation prior to review of request for temporary admitting and clinical privileges by a Department Chairperson, Credentials Committee Chairperson, and/or Chief of Staff of the Medical Staff. The requirements and process for reviewing and granting temporary clinical privileges may be further provided for in applicable Hospital and/or Medical Staff policy.

(a) Pendency of Application

Upon receipt of a signed and completed application for Medical Staff appointment and request for specific clinical privileges and after receiving a favorable recommendation by the Credentials Committee, an appropriately licensed physician, dentist, oral surgeon, podiatrist or APC may be granted temporary clinical privileges for a period not to exceed one hundred twenty (120) days.

(b) Care of Specific Patients/Important Patient Care Need

A duly licensed physician, dentist, oral surgeon, podiatrist or APC of documented competence who is not an applicant for Medical Staff membership may be granted temporary clinical privileges for the care of one or more specific patients for a period not to exceed one hundred twenty (120) days. Temporary clinical privileges shall be exercised in accordance with the conditions specified in Section 4.17.2 below.

(c) Locum Tenens

As an extension of important patient care need, upon receipt of a written request for locum tenens clinical privileges to the Chief of Staff, a duly licensed physician, dentist, oral surgeon, podiatrist or APC of documented competence who will serve as a locum tenens for a Medical Staff member and who is on the active medical staff of another hospital may, without applying for Medical Staff membership, be granted locum tenens clinical privileges for a period not to exceed one hundred twenty (120) days.

Temporary clinical privileges under this section (c) may not exceed his/her period of service as locum tenens, shall be limited to treatment of the patients of the practitioner for whom he/she is serving as locum tenens and shall be exercised in accordance with the conditions specified in Section 4.17.2 below. Practitioners with temporary clinical privileges for

locum tenens coverage are not entitled to admit his/her own patients to the Hospital.

4.17.2 Conditions

Temporary clinical privileges may be granted only where the individual requesting temporary clinical privileges meets the basic qualifications set forth herein. Any practitioner seeking temporary clinical privileges must have his/her qualifications appropriately verified and must be recommended by the pertinent Department Chairperson or Section Chief of the Department in which they are seeking temporary clinical privileges.

Special requirements of consultation and reporting may be imposed by the Department Chairperson responsible for supervision of a practitioner granted temporary clinical privileges. Before temporary clinical privileges are granted, the practitioner must acknowledge in writing that he/she has received, or been given access to, and read the Medical Staff Bylaws, the Ethical and Religious Directives for Health Care Services, the applicable Compliance Plan, and that he/she agrees to be bound by the terms thereof in all matters relating to temporary clinical privileges.

4.17.3 Suspension

On the discovery of any information or the occurrence of any event of a nature that raises questions about a practitioner's professional qualifications or ability to appropriately or safely exercise any or all of the temporary clinical privileges granted, such temporary clinical privileges may be summarily suspended consistent with the process identified in the Corrective Action and Fair Hearing Plan. In the event of any such suspension, the practitioner's patients then in the Hospital shall be assigned to a Medical Staff member(s) by the applicable Department Chairperson(s). The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. The substitute practitioner(s) shall have the right to refuse to accept such patient assignments, in which case the Chairperson shall assign the patients to another substitute practitioner(s).

4.17.4 Rights of a Practitioner with Temporary Clinical Privileges

By applying for temporary clinical privileges, all practitioners acknowledge the expected short-term nature of such status and that such status does not confirm an expectation of appointment to the Medical Staff and expressly agree that if granted temporary clinical privileges, the practitioner shall not be entitled to the procedural rights afforded by the Medical Staff Fair Hearing Plan, if a request for temporary clinical privileges is refused, or if all or any portion of the temporary clinical privileges are terminated or otherwise restricted.

Section 4.18. **Emergency Clinical Privileges**

For the purpose of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or bystander or in which the life of a patient or bystander is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling of any consultation necessary or desirable, regardless of his/her Department, Medical Staff status, or clinical privileges. The practitioner shall make every responsible effort to communicate promptly with the appropriate individuals concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, shall promptly yield such care to qualified members of the Medical Staff when it becomes reasonably available and once the emergency has passed or assistance had been made available, shall defer to the pertinent Department Chairperson with respect to further care of the patient.

Section 4.19. **Disaster Clinical Privileges**

4.19.1 Circumstances

Any individual intending to provide services during a disaster event, public health emergency, or other state of emergency where healthcare resources are deployed, must be granted clinical privileges prior to providing patient care. Disaster privileges are considered temporary in nature. Any practitioner may apply for disaster privileges but shall not be considered for membership on the Medical Staff.

4.19.2 Conditions

(a) The CEO or Chief of Staff or their designee, in circumstances of disaster in which the Hospital's emergency operation plan has been activated, shall have the authority to grant disaster privileges to a physician, dentist, oral surgeon, podiatrist or APC who is not a member of the Medical Staff subject to the following process and conditions. An appropriate designee may include an ad hoc or other stand-up committee necessary to address the circumstances of disaster and shall be considered a protected peer review process, as applicable.

(b) Decisions regarding the granting of disaster privileges are made on a case-by-case basis and the CEO or Chief of Staff or their designee is not required to grant privileges to any individual. Prior to granting such privileges, the CEO or Chief of Staff or their designee shall verify information regarding the individual upon presentation of a valid government issued photo identification care and at least one (1) of the following:

i. A current picture identification care from a healthcare organization that identifies the practitioner's professional designation;

ii. A current license to practice;

iii. Primary source verification of licensure;

iv. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;

v. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity; or

vi. Confirmation by a practitioner who is currently privileged by the Hospital with personal knowledge regarding the practitioner's ability to act as a licensed independent practitioner during a disaster.

(c) If appropriate under the circumstances, the process established under these Bylaws for verification of credentials and privileges for granting temporary privileges shall begin as soon as the immediate emergency is under control, but no later than seventy-two (72) hours. In extraordinary circumstances, verification of credentials may occur later than seventy-two (72) hours and as soon as possible. In such case the Hospital shall document: 1) the reasons for any delay; 2) evidence of the practitioner's demonstrated ability to continue to provide adequate care, treatment and services; and 3) evidence of the Hospital's attempt to perform credentialing verification in a timely manner.

(d) The MEC or designee will oversee the performance of individuals granted disaster privileges by either direct observation, mentoring or medical record review as may be more fully described in the Hospital's emergency operation plan.

(e) The CEO or designee will determine within seventy-two (72) hours of each practitioner's arrival whether granted disaster privileges should continue.

4.19.3 Notwithstanding anything in these Bylaws to the contrary, during a disaster or other state of emergency, the CEO, Chief of Staff, and designee shall be empowered to effectuate the full scope of available legal and regulatory authority for the duration of the disaster.

ARTICLE V

STRUCTURE OF THE MEDICAL STAFF

Section 5.1. **Officers and Members-at-Large**

5.1.1 Medical Staff Officers

The Officers of the Medical Staff are members of the Active Staff who fulfill necessary governance and leadership functions of the Medical Staff and who represent the needs and interests of the entire Medical Staff and Hospital. The Officers consist of:

(a) Chief of Staff;

(b) Chief of Staff-Elect;

(c) Chief of Staff Emeritus; and

(d) Secretary

5.1.2 Qualifications

Each Officer and Member-at-Large must be a current member of the Active Staff at the time of nomination and election, must have been a member of the Active Staff for (5) years, and must remain members of the Active Staff in good standing during their term of office. Each Officer and Member-at-Large must be willing and able to faithfully discharge the duties of the office held or service on the MEC, as applicable. Each Officer must have demonstrated executive ability and be recognized for their high level of clinical competence.

No member under consideration by the Nominating Committee for an Officer or Member-at-Large position may be under current investigation by the Medical Staff or have had significant or repeated quality of care or professional conduct issues. Nominees should have a reputation for leadership and excellent patient care services and be willing to serve in a leadership position and must not otherwise be disqualified under the then current conflict of interest policy. Failure to maintain such status shall immediately result in the member's disqualification to serve. The Nominating Committee will have the discretion to determine if a member desiring to hold office or serve as a Member-at-Large meets these qualifying criteria. Any member who is nominated must disclose to the Nominating Committee his/her ineligibility to hold office when considering the qualifications in this Section 5.1.2.

Officers may not simultaneously hold a medical staff leadership position at a non-Health System hospital's medical staff or in a non-CHRISTUS Health facility that is located in the Hospital's service area. Noncompliance with this requirement will result in the Officer being automatically removed from office unless the Governing Board determines in consultation

with the MEC that allowing the Officer to maintain his/her position is in the best interest of the Hospital. The Governing Board in consultation with the MEC shall have discretion to determine what constitutes a "medical staff leadership position" at another hospital or facility and determinations of a disqualifying conflict of interest.

5.1.3 Nominations

(a) By Nominating Committee. No sooner than sixty (60) days before the annual Medical Staff meeting, the Nominating Committee shall select from one (1) to three (3) candidates for each of the positions of Chief of Staff-Elect and Member(s)-at-Large. All notices shall be distributed by electronic notice and posted at least thirty (30) days before the 4th quarter Medical Staff meeting.

(b) By Petition. Nominations may also be made by a petition signed by at least twenty-five (25) Active Medical members and filed with the Nominating Committee at least sixty (60) days prior to the 4th quarter Medical Staff meeting. These nominations shall be distributed by electronic notice to the Active Staff at least forty-give (45) days before the 4th quarter Medical Staff meeting.

5.1.4 Election of Officers and Members-at-Large

(a) Chief of Staff-Elect/Secretary/Members-at-Large

The Chief of Staff will attain office by automatic succession from the office of Chief of Staff-Elect. The Chief of Staff-Elect, and three (3) Members-at-Large are elected by the Active Staff by ballot immediately prior to the annual meeting of the Medical Staff, as provided below.

i. No sooner than twenty (20) days prior to the annual Medical Staff meeting, an electronic ballot shall be delivered to all Active Staff members for voting for Officer positions at the Hospital. All completed ballots that are tallied by or returned to the Medical Staff Services Office at least seven (7) days prior to the date of the 4th quarter Medical Staff meeting shall be counted.

ii. The candidate receiving a majority of the votes on the returned ballots shall be elected and the results announced at the 4th quarter Medical Staff meeting. If there are three (3) or more candidates and no candidate receive a majority, successive ballots shall be conducted with the name of the candidate receiving the fewest votes eliminated with each successive ballot. In the event of a tie, the MEC will vote by secret ballot.

5.1.5 Terms

The term of office for all Officers and the three (3) Members-at-Large is two (2) years, with the office or role beginning on the first day of the Medical Staff Year except that an individual elected or appointed to fill a vacancy assumes the position immediately upon election or appointment. Each Officer or Member-at-Large serves until the end of his/her term and until a successor is elected or appointed, unless he/she sooner resigns or is removed from office.

5.1.6 Resignation and Removal

Officers may resign by submitting a written resignation to the MEC and the Governing Board. Officers shall serve at the pleasure of the Medical Staff and the Governing Board. An Officer may be removed on written petition of fifteen percent (15%) of the Active Staff members and a subsequent two-third (2/3) affirmative vote of the returned ballots, provided that at least fifty-one percent (51%) of the Active Staff vote. Conditions for removal include resignation or loss of Medical Staff membership, failure to comply with obligations of Medical Staff membership, or failure to perform the responsibilities of the Office. Removal shall be immediate but must be ratified by the Governing Board to become final. The Governing Board may also remove an Officer, but only after recommendation by the MEC including specific reasons for the removal or non-removal. Removal of an Officer or Member-at-Large shall not, by itself, affect that individual's Medical Staff appointment or privileges.

5.1.7 Vacancies

The Chief of Staff-Elect shall fill a vacancy in the office of Chief of Staff. A vacancy in the office of Chief of Staff-Elect shall be filled by a special election. The successor elected by special election shall serve for the balance of the remaining term. A vacancy by a Member-at-Large will be selected by the MEC.

5.1.8 Duties

(a) Chief of Staff

The Chief of Staff shall serve as the elected leader of the Medical Staff. His/her duties shall be to:

i. Act in coordination and cooperation with the CEO, CMO, and the Governing Board in all matters of mutual concern within the Hospital;

ii. Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff;

iii. Serve as a voting member and the Chairperson of the MEC and an ex officio member of all other Medical Staff committees, unless otherwise stated in the committee description;

iv. Enforcement of the Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures;

v. When necessary, serve as a mediator should a conflict arise among Medical Staff units;

vi. Recommend, in consultation with the MEC, appointments to all committees and submit reports on behalf of all committees which report directly to the MEC as well as any ad hoc or specially appointed committees requiring Medical Staff representation, unless otherwise provided in these Bylaws;

vii. Represent the views, policies, needs and grievances of the Medical Staff to the CEO and Governing Board;

viii. Receive and interpret the policies of the Governing Board to the Medical Staff and report to the Governing Board on the performance, maintenance and quality with respect to the health care services provided by the Medical Staff;

ix. Represent the Medical Staff before the Governing Board;

x. Be a spokesperson for the Medical Staff in its external professional and public relations; and

xi. Perform such other duties as required by the Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures.

When undertaking these responsibilities, the Chief of Staff is acting at all times on behalf of and subject to the MEC's authority.

(b) Chief of Staff-Elect

The Chief of Staff-Elect shall be a voting member of the MEC and shall be authorized to perform the duties of the Chief of Staff in his/her absence.

(c) Chief of Staff Emeritus

The Hospital Chief of Staff Emeritus shall be a voting member of the MEC and shall perform any other duties requested by the Chief of Staff.

(d) Secretary

The Secretary shall be a voting member of the MEC. The Secretary shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the Chief of Staff, attend to all correspondence, and perform such other duties as ordinarily pertain to the office. Where there are funds to be accounted for, the Secretary also shall act as Treasurer.

(e) Members-at-Large

The Members-at-Large shall be voting members of the MEC and shall perform those duties as assigned by the Chief of Staff.

5.1.9 Use of Designees

Any Officer may delegate certain tasks and activities to various designees, including the CMO and CEO, to assist the Officer in fulfilling his/her duties and responsibilities, which may include activities related to credentialing, privileging, and peer review.

Section 5.2. **Clinical Departments and Sections**

5.2.1 Organization of Clinical Departments and Sections

Each Clinical Department shall be organized as a separate unit of the Medical Staff and shall have a Department Chairperson and Vice Chairperson, if selected, who shall be responsible for the overall supervision and administrative work within the Department. All practitioners granted membership on the Medical Staff and/or clinical privileges shall be assigned to the appropriate Departments and Sections.

The Medical Staff is organized into the following Departments and Sections:

<u>Medicine Department</u>

Family Practice
Cardiology
Internal Medicine
Neonatology
Neurology
Pediatrics
Psychiatry
Radiology
Critical Care
Oncology
Nephrology
Gastroenterology
Pulmonology

Department of Emergency Medicine

Department of Surgery

General Surgery
Anesthesiology
Cardiothoracic and Vascular Surgery
Oral and Maxillofacial Surgery/Dentistry
Neurosurgery
Obstetrics/Gynecology
Ophthalmology
Otolaryngology
Orthopedics
Pain Management
Pathology
Plastic Surgery
Podiatry
Trauma
Urology

5.2.2 Qualifications, Appointment, and Terms of Department Chairpersons, Vice Chairpersons, and Section Chiefs

(a) Qualifications. Each Department shall have a Chairperson and Vice Chairperson, if selected, and each Section a Chief, who must be members of the Active Staff and members of the pertinent Department in good standing, be board certified in their specialty or possess comparable training and possess sound judgment and appropriate administrative skills.

(b) Selection. Unless addressed by contractual arrangement, Department Chairpersons and Section Chiefs shall be nominated by the MEC and appointed by the Governing Board. The Department Chairperson shall solicit a nomination and make a recommendation for the position of Vice Chairperson to the MEC in consultation with the Department.

(c) Term of Office. Each Department Chairperson, Vice Chairperson, and Section Chief shall serve a term as set forth in his/her contractual arrangement with the Hospital, or if not under contract, for a two (2) year term that coincides with the Medical Staff year and may be reappointed for consecutive or subsequent terms. Department officers may resign by submitting a written resignation to the MEC. Removal of a Chairperson or Vice Chairperson may be accomplished on written petition of fifteen percent (15%) of the Active Staff members assigned to the Department and a subsequent two-thirds (2/3) affirmative vote of the returned mail ballots or by e-mail, provided that at least fifty-one percent (51%) of the Active

Staff in the Department vote. Once ratified by the Governing Board, the removal shall be immediate. Vacancies shall be filled by the MEC in consultation with and approved by the Governing Board.

5.2.3 Functions of Department Chairpersons

Each Chairperson shall directly or through a designee:

(a) Coordinate and oversee all professional, clinical, and administrative activities within his/her Department;

(b) Advocate for Department interests to the MEC and provide guidance on the clinical policies of the Medical Staff and Hospital pertinent to the Department;

(c) Participate in the continuing review of the professional performance of all practitioners with clinical privileges in his/her Department and report as appropriate to the Credentials Committee and/or MEC;

(d) Oversee the patient care review required by the Bylaws and applicable policies and advocate for the continuous assessment and improvement of the quality of care and services provided in the Department;

(e) Assist with implementation of quality related or peer review activities within his/her Department or as delegated by the Governing Board or MEC;

(f) Assist in enforcement of the Medical Staff Bylaws and applicable provisions of the Hospital Bylaws, the applicable Compliance Plan and other Medical Staff and Hospital policies and procedures, as they pertain to his/her Department and practitioners assigned to it;

(g) Be responsible for implementation of Department-related actions taken by the MEC or Governing Board;

(h) Delineate and recommend clinical privileges for practitioners in his/her Department, with the assistance of Department committees where applicable, including a review of each practitioner's quality or peer review record;

(i) Be responsible for recommending to the Medical Staff the criteria for clinical privileges that are relevant to the patient care provided in the Department;

(j) Assist in coordination of teaching, continuing education, and research programs in his/her Department;

(k) Integrate the Department and its services into the various functions of the Hospital;

(l) Coordinate and integrate interdepartmental and intradepartmental services;

(m) Preside directly or through a designee at all meetings of the Department and its committees;

(n) Develop and implement policies and procedures that guide and support the provision of care, treatment and services;

(o) Assist in the determination of the qualifications and competence of Department or service personnel who are not licensed independent practitioners and who provide care, treatment and services in the Department;

(p) Provide recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services in the Department;

(q) Monitor the orientation and any required continuing education of all practitioners in the Department;

(r) Assess and recommend resources for needed patient care services;

(s) Communicate and coordinate with the Residency Program Director(s) to ensure alignment of Department's activities with any graduate medical education programs administered and overseen by the Designee;

(t) Assist in the budgetary planning (i.e., equipment, space, sufficient number of qualified and competent individuals, etc.) pertaining to his/her Department as requested by the MEC, CEO or Governing Board; and

(u) Establish, as approved by the Hospital in consultation with the MEC, the Emergency Department specialty and unassigned call schedule consistent with Hospital, Health System and CHRISTUS Health policy and in compliance with applicable federal and Texas requirements.

When undertaking these responsibilities, the Department Chairperson may act on behalf of a Department level peer review committee and/or the MEC, as may be directed by the Chief of Staff or Department policy.

5.2.4 Responsibilities of Section Chiefs. Section Chiefs are responsible for Section level activities of their respective Department.

5.2.5 Functions of Departments and Sections

The primary responsibility delegated to each Department and Section is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Department or Section and among related Departments or Sections. To carry out this responsibility, each Department and Section shall, through their respective Chairperson and Chief:

(a) Monitor and evaluate specific aspects of the quality and appropriateness of patient care, investigate trends or problems referred to it, and send to the appropriate committee written reports of the Department's or Section's findings, conclusions, recommendations, actions and follow-up with respect to all patient care and peer review matters;

(b) Conduct ongoing monitoring and evaluation of all clinical aspects of patient care as required by the applicable regulatory and accreditation agencies or as required by law, including but not limited to FPPE and/or OPPE. Each Department and Section shall review, in collaboration with other Departments, as appropriate, all clinical work performed under its authority, including those instances where a practitioner may be a member of more than one Department or Section or whether any particular practitioner whose practice is subject to such review is a member of that Department or Section. Practitioners shall be subject to review by each Department and/or Section in which they exercise clinical privileges;

(c) Establish guidelines and/or criteria for membership in the Department or Section and for the granting of clinical privileges and the performance of specified services within the Department or Section and submit to the Credentials Committee the recommendations required under these Bylaws regarding appointment and reappointment of Medical Staff members or the granting of clinical privileges. In making recommendations for reappointment or the granting of clinical privileges, consider the practitioner's quality assessment and improvement record;

(d) Conduct, participate in, and make recommendations regarding the need for continuing medical education programs pertinent to changes in the standard of care or state-of-the-art, and to findings of review, evaluation and monitoring activities;

(e) Monitor, on a continuing and concurrent basis, adherence to: (1) Medical Staff and Hospital policies and procedures including any and all OPPE or FPPE; (2) requirements for alternate coverage and for consultations; (3) sound principles of clinical practice and judgment; (4) regulations designed to promote patient safety;

(f) Coordinate the patient care provided by the Department's or Section's members and other practitioners with patient care service obligations, other ancillary services and administrative support services, including the patient care rendered by Residents and/or Fellows as part of a graduate medical education program;

(g) Submit written or verbal reports to the MEC on a regularly scheduled basis concerning: (1) findings of the Department's or Section's review, evaluation and monitoring activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the Hospital; and (3) such other matters as may be requested from time to time by the MEC or Hospital;

(h) Meet as often as necessary, but no less than annually or as often as necessary, for the purpose of reviewing the findings and results of ongoing or focused evaluations and quality monitoring activities as well as the reports of other Medical Staff committees as set forth in the Medical Staff Rules and Regulations and related policies; and

(i) Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

5.2.6 Department/Section Committees

Committees within a Department or Section may be established at the discretion of the Department Chairperson or Section Chief on a standing or ad hoc basis to assist the Department or Section in the performance of its functions, duties, and responsibilities, including, but not limited to, committees related to peer review or quality improvement activities. The Department Chairperson and Section Chief shall be the Chairperson of any established Department or Section committee, unless otherwise assigned a chairperson. Composition of Department and Section committees may be determined in accordance with the Medical Staff Rules and Regulations or as determined by the Chief of Staff or MEC.

5.2.7 Department Policies and Procedures

Each Medical Staff Department or Section may adopt and implement various policies and procedures that apply to its membership to fulfill the Department or Section's obligations and function within the Medical Staff as described herein provided such policies and procedures do not conflict with these Bylaws, the Hospital Bylaws, Hospital, Health System, or CHRISTUS Health policies, applicable accreditation standards, and applicable Federal and Texas law. Any Department or Section policy or procedure that conflicts or is otherwise inconsistent with these conditions as determined by the MEC or Governing Board, shall be considered void and without effect.

5.2.8 Department Subspecialties/Sections

A Section is an organized specialty within a Department as may be recognized by a national specialty board and which meets the minimum size or composition requirements established by the MEC. Sections will perform functions assigned to it by the Department and may include but not limited to peer review, quality review, credential review, privileges delineation and continuing education programs. Each Section may hold meetings of which a report will be transmitted to the Department. Each Section will have a designated Section Chief.

5.2.9 Section Chiefs

Section Chiefs shall be directly responsible and report to the Chairperson of the Department under which the Section functions. Section Chiefs shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the Section and appointed by the process stated in Section 5.2.2 above. Section Chiefs are responsible for the professional performance of practitioners assigned to the Section and shall perform such other duties commensurate with the position as may be reasonable requested by the responsible department Chairperson

Section 5.3. **Standing Medical Staff Committees**

5.3.1 Standing Medical Staff committees

The following are considered standing committees of the Medical Staff:

(a) Medical Executive Committee

(b) Credentials Committee

(c) Nominating Committee

(d) Bylaws Committee

(e) Blood Utilization Committee

(f) Multispecialty Peer Review Committee

(g) A committee or committees that fulfill or contribute to the Hospital committee functions of utilization review, medical records, quality, pharmacy and therapeutics, mortality, tissue, transfusion, disasters, infection control, medication use, and continuing medical education.

These and other standing committees may be more fully described in the Medical Staff Rules and Regulations or MEC approved charter or policy.

5.3.2 Appointment, Meetings, and Record

Medical Staff committee members and Chairpersons, unless otherwise specified, will be appointed by the Governing Board upon MEC recommendation. The term of service shall for a term of two (2) years. Each Medical Staff committee, unless otherwise specified, shall:

(a) Meet pursuant to a schedule commensurate to its responsibilities, but no less frequent than quarterly;

(b) Maintain a record of its proceedings and actions;

(c) Transmit a copy of its meeting minutes or similar report to the MEC; and

(d) Make recommendations as appropriate to the Chief of Staff and/or other Medical Staff committees.

5.3.3 Removal and Vacancies

The Chairperson of a committee with concurrence of the Chief of Staff, upon good cause, may remove any member of the committee prior to the expiration of the member's term. The Chief of Staff, upon good cause, may remove any member of a Medical Staff committee and Chairperson appointed by him/her and fill such vacancy by appointment, unless otherwise specified. The Chief of Staff will promptly notify the MEC of any appointments and removals. If the MEC disagrees with one of more appointments or removals, the issue will be voted upon by the Medical Staff at the next general Medical Staff meeting and decided by simple majority.

5.3.4 Ad Hoc Committees

Ad Hoc Committees as may be required to carry out activities of the Medical Staff to fulfill other requirements may be appointed by the Chief of Staff. Such Ad Hoc Committees shall be limited to a term as established by the Chief of Staff appointing them and shall confine their activities and duration to the purpose for which they were appointed. The composition and duties of Ad Hoc Committees, unless otherwise specified in these Bylaws, shall be specified by the Chief of Staff upon establishment.

5.3.5 Medical Executive Committee

(a) Composition

The MEC shall consist of the following voting and non-voting members:

i. Chief of Staff, Chairperson;

ii. Chief of Staff-Elect, Vice Chairperson;

iii. Chief of Staff Emeritus;

iv. Secretary;

v. Three (3) Members-at-Large;

vi. Chairperson of the Credentials Committee; and

vii. CEO, ex-officio;

The CMO, Chief Nursing Officer, and Medical Staff Services Director or designees shall serve as standing invitees of the MEC.

(b) Duties and Authority

The duties of the MEC shall be to:

i. Represent and act on behalf of the Medical Staff subject to any limitations in the Medical Staff Bylaws in the intervals between Medical Staff meetings;

ii. Receive and act on committee reports and recommendations from Medical Staff committees, peer review activities, Medical Staff Departments and assigned activity groups. Implement policies of the Medical Staff Departments and coordinate the activities and general policies of the various services;

iii. Serve as a liaison between the Medical Staff, CEO, and the Governing Board; recommend action on medico-administrative and Hospital policy and management matters and act on behalf of the Medical Staff, subject to any limitations in the Medical Staff Bylaws in the intervals between Medical Staff meetings;

iv. Be accountable to the Governing Board for the review of health care rendered to patients in the Hospital;

v. Review, investigate and make recommendations to the Governing Board on Medical Staff appointments, assignments to Departments and delineation of clinical privileges;

vi. Receive recommendations, review, and make recommendations to the Governing Board regarding Medical Staff appointments, assignments to Department, delineation of clinical privileges, the performance and clinical competence of practitioners, reappointment, renewal or changes in clinical privileges, and corrective action;

vii. Promote professional and ethical conduct and competent clinical performance by all practitioners, including the initiation of and/or participation in corrective action or review measures when warranted;

viii. Coordinate performance improvement quality assurance teams and committees relative to the Medical Staff on an ongoing basis; identify issues and problems relating but not limited to the quality and safety of patient care and Hospital and Hospital operations;

ix. Receive reports and make recommendations as necessary on the performance improvement quality assurance teams and committees relative to the Medical Staff on an ongoing basis; identify issues and problems relating but not limited to safety of patient care and Hospital operations;

x. Recommend to the Medical Staff amendments to the Medical Staff Bylaws and Rules and Regulations;

xi. Delegate to the Hospital's Medical Staff Services representative the responsibility for reporting, as required, to the National Practitioner Data Bank;

xii. Ensure Medical Staff compliance with all regulatory and accreditation requirements;

xiii. Review and approve the Department/Section recommendations regarding on-call policies and responsibilities;

xiv. To enforce Bylaws, Rules and Regulations, and Medical Staff and Hospital policies and implement corrective and other actions not otherwise the responsibility of the services;

xv. To participate in the Hospital's accreditation processes and enlist Medical Staff support;

xvi. Recommend to the Governing Board the organized Medical Staff's structure;

xvii. Implements a process to identify and manage matters of individual wellness and health for practitioners which is separate from actions taken for disciplinary reasons;

xviii. Recommend revisions to the Governing Board to the Medical Staff Bylaws and/or Rules and Regulations; and

xix. Perform such other duties as required by the Medical Staff Bylaws or requested by the Governing Board.

Notwithstanding the establishment of peer review policies for implementation of various quality assurance and performance improvement activities within the Hospital, the MEC and Governing Board retain the authority at all times to undertake such peer review activities they deem appropriate under the circumstances.

5.3.6 Credentials Committee

(a) Composition. The Credentials Committee consists of no fewer than six (6) members appointed by the Chief of Staff and who have served at least two (2) years as members of the Active Staff with selection based on representation of the major clinical specialties, the general Active, and the Chief Nursing Officer or designee.

The CMO, Chief Nursing Officer, Medical Staff Services Director, and Quality Department Director or designees shall serve as standing invitees of the Credentials Committee.

(b) Duties and Authority. The duties of the Credentials Committee shall be to:

i. Review and make recommendations to the MEC and Governing Board regarding the minimum or threshold criteria for clinical privileges by Departments or Sections;

ii. Recommend practitioners for Medical Staff membership;

iii. Recommend delineated clinical privileges for each eligible practitioner; and

iv. Review qualifications of Advanced Practice Clinicians and make recommendations on appointment, reappointment, and delineation of clinical privileges and/or designated scope of practice.

5.3.7 Nominating Committee

(a) Composition. The Nominating Committee shall consist of the following members.

i. Chief of Staff-Elect, Chairperson;

ii. Chief of Staff;

iii. One representative from each Department to be selected by the chairperson;

iv. CEO/CMO or designee

(b) Duties and Authority. The duties of the Nominating Committee shall be to select and post nominees for each Office pursuant to Section 5.1.3 above.

5.3.8 Composition and Duties of Other Committees

With the exception of the foregoing committees, the composition, duties and authority of all committees are set forth in the Medical Staff Rules and Regulations or policy manual. By a consensus of the MEC, additional members may be appointed to the committees specified in the Medical Staff Rules and Regulations.

5.3.9 Committee Policies and Procedures

Each Medical Staff committee may adopt and implement various policies and procedures to fulfill its obligations and function within the Medical Staff as described herein provided such policies and procedures do not conflict with these Bylaws, the Hospital Bylaws, CHRISTUS Health policies, applicable accreditation standards, and applicable Federal and Texas law. Any committee policy or procedure that conflicts or is otherwise inconsistent with these conditions shall be considered void and without effect.

5.3.10 Use of Designees/Invitees

Any Medical Staff committee may delegate certain tasks and activities to various designees, whether a committee or individuals, including the CMO and CEO, to assist the committee in fulfilling its duties and responsibilities, which may include activities related to credentialing, privileging, and peer review. The Chairperson of Medical Staff committees may invite individuals in their official capacity to contribute to committee meetings on a standing or regular basis.

Section 5.4. **Medical Staff Meetings**

5.4.1 Regular Meetings

(a) At the 4th quarter meeting, voting members shall elect Officers, and address all other pertinent matters as established by the Chief of Staff.

(b) Regular meetings shall be held quarterly or as needed. The date, time, and place of such meetings shall be designated by the Chief of Staff. Electronic notice stating the date, time, and place of any regular meeting shall be given to each member not less than thirty (30) days prior to the meetings or posted as determined by the MEC.

(c) Regular meetings shall be open to all members of the Medical Staff and practitioners granted clinical privileges at the Hospital.

5.4.2 Special Meetings

(a) The Chief of Staff or MEC may call a special meeting of the Medical Staff at any time. The Chief of Staff shall schedule a special meeting within fourteen (14) days of receiving a written request signed by not less than fifteen percent (15%) of the Active Staff and stating the purpose of such meeting. The MEC shall designate the date, time, and place of any special meeting.

(b) Written or electronic notice stating the date, time, and place of any special meeting of the Medical Staff shall be provided electronically to the Active Staff and posted in appropriate places in the Hospital.

5.4.3 Quorum

A quorum at any regular or special meeting of the Medical Staff is a majority of the Active Staff in good standing, provided no fewer than three (3) voting members participate in the vote.

5.4.4 Action

Except as otherwise provided by these Bylaws, an action will be approved if a majority of those present and eligible at a meeting in which a quorum exists votes to support the action. A member who is eligible to vote, but who cannot be present at a meeting, may transmit their vote electronically to the Medical Staff Services Office prior to or during the meeting provided the voting results have not otherwise been tallied.

5.4.5 Minutes

Minutes or a record of all Medical Staff meetings shall be taken and prepared by the Medical Staff Services or his/her designee and shall include a record of attendance, quorum, and the vote taken on each matter. Copies of minutes shall be signed by the Chief of Staff as soon as practicable after they are prepared and shall be forwarded to the Governing Board and the MEC for review. Minutes shall be deemed final when transmitted to the Governing Board, subject, however, to such corrections as may be made at the next regular or special meeting of the MEC. A permanent file of the minutes of all Medical Staff meetings shall be maintained by the Medical Staff Services Office consistent with the Hospital's record retention schedule and practices.

5.4.6 Mode of Meeting

Any regular or special meeting may be organized via any mechanism available to allow all eligible individuals to participate. Such mechanisms include but are not limited to any

electronic or virtual platform including, video or telephone. Eligible members may vote during any meeting regardless of the mode of the meeting.

Section 5.5. **Medical Staff Committee and Department Meetings**

5.5.1 Regular Meetings

Medical Staff committees and Departments shall meet as often as necessary to fulfill their responsibilities and at such date, time, and place as is designated by the Chairperson. Written or electronic notice stating the date, time, and place of any regular meeting shall be given to each member of the Medical Staff committee or Department.

5.5.2 Special Meetings

A special meeting of any Medical Staff committee or Department may be called by the Chairperson, the Chief of Staff or one-third (1/3) of the committee or Department's members, but not less than two (2) members. Written or electronic notice stating the date, time and place of any special meeting shall be given to each member of the Medical Staff committee or Department as soon as practicable before the time of such meeting, unless waiver of notice is agreed to by all members of the Medical Staff committee or Department concerned.

5.5.3 Quorum

Fifty percent (50%) of the voting members of the MEC, Credentials Committee, and any committee where a final recommendation can be made to the Governing Board shall constitute a quorum. For all other Medical Staff committees and Departments, a quorum shall consist of those present and eligible to vote provided no fewer than three (3) voting members are present.

5.5.4 Manner of Action

Except as otherwise provided by these Bylaws, an action by a committee or Department will be approved if a majority of those present and eligible at a meeting in which a quorum exists votes to support the action. For purposes of being present at Department and committee meetings, members may participate by telephone conference or any other electronic or virtual platform by which they can meaningfully participate. Committee action may also occur by e-mail correspondence provided there is voting record of all eligible members. All Medical Staff committee and Department actions and recommendations are subject to the review and approval by the MEC.

5.5.5 Rights of Ex officio Members

Unless otherwise provided in the Medical Staff Bylaws, individuals serving as ex officio members of a Medical Staff or Department committee shall have all rights and privileges

of regular members, except ex officio members shall not have the right to vote nor be counted in determining the existence of a quorum.

5.5.6 Attendance Requirements

Attendance at Medical Staff and Department committee meetings may be a factor when considering the reappointment of Active and Associate Staff members Active participation is viewed favorably and strongly recommended, but not otherwise required.

5.5.7 Minutes

Minutes or a record of each regular and special meeting of a Medical Staff and Department committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes or record shall be signed by the presiding Chairperson as soon as practicable after they are prepared and shall be forwarded to the Chief of Staff. Each committee shall maintain minutes or records consistent with the Hospital's record retention schedule and practices.

5.5.8 Executive Session

An executive session is a meeting of a Medical Staff or Department committee, including the MEC, which only members of the committee may attend, unless others are requested to attend by the Chief of Staff or Chairperson. Executive sessions may be called by the committee's Chairperson and at the request of any Medical Staff committee member and shall be called by the Chairperson following a duly adopted motion of the committee. Circumstances appropriate for an executive session include peer review matters, personnel issues or other sensitive issue(s) requiring confidentiality or limited attendance. The CEO may participate in all executive sessions.

ARTICLE VI

MISCELLANEOUS PROVISIONS PERTAINING TO THE MEDICAL STAFF

Section 6.1. **Medical Staff Year**

The Medical Staff Year is from January 1 to December 31.

Section 6.2. **Exclusive Contracts/Department Closing**

In the event the Governing Board contemplates entering into an exclusive agreement for certain services for the purpose of securing the continued availability of a given service line, and/or to ensure that care provided at the Hospital is efficient, effective, consistent, and of appropriate quality, the Governing Board will consult with and notify the Medical Staff during the decision-making process. If the Hospital closes membership in the Medical Staff, any portion of the Medical Staff or a Department over the objections of the Medical Staff, then the Hospital shall provide a detailed written explanation for the decision to the Medical Staff prior to the effective date of any

closure as required by Texas law. The matter may first be referred to a Joint Conference Committee, as appropriate.

Section 6.3. **Related Medical Staff Documents**

6.3.1 Adoption of Related Documents

In addition to this Manual, the Medical Staff and Governing Board have adopted the following documents that shall, collectively, make up the Medical Staff Bylaws, which exist to support the Medical Staff: The Medical Staff Corrective Action and Fair Hearing Plan, which shall specify categories of corrective action and hearing and appeal procedures.

6.3.2 Rules and Regulations

The MEC will recommend to the Governing Board a Medical Staff Rules and Regulations document or policy compilation that implements the general principles found within the Medical Staff Bylaws and relates to the proper conduct of Medical Staff organizational activities, as well as the responsibilities of practitioners related to their professional and clinical activities at the Hospital. The MEC shall have the authority of the Medical Staff to adopt and amend the Rules and Regulations Manual as may be necessary to carry out the Medical Staff's functions consistent with these Bylaws. Any changes to the Rules and Regulations Manual shall become effective when approved by the Governing Board. All Rules and Regulations and amendments under consideration by the MEC must first be communicated to the Medical Staff for review and comment prior to the proposed Rules and Regulations or amendment being adopted and forwarded to the Governing Board for approval. Any Rules and Regulations adopted by the MEC and approved by the Governing Board shall be communicated to the Medical Staff in a timely manner.

Rules and Regulations may also be proposed directly to the Governing Board by a petition signed by twenty-five percent (25%) of the Active Staff. All proposed Rules and Regulations must be presented to MEC for review and comment before such Rules and Regulations is voted by the Active Staff. Proposed Rules and Regulations become effective only after approval by the Governing Board.

6.3.3 Medical Staff Policies

The MEC, subject to Governing Board approval, may also adopt and amend various policies and procedures to fulfill its obligations and functions as described herein, provided such policies do not conflict with these Bylaws, the Hospital Bylaws, Health System or CHRISTUS Health policies, and applicable Federal and Texas law. Any Medical Staff policy or procedure that conflicts or is otherwise inconsistent with these documents or laws shall be considered void and without effect. All policies and policy amendments adopted by the MEC and approved by the Governing Board shall be communicated to the Medical Staff in a timely manner.

Policies may also be proposed directly to the Governing Board by a petition signed by twenty-five percent (25%) of the members of the Active Staff. All proposed policies must be presented to MEC for review and comment before such policy is voted by the Active Staff. All proposed policies and related amendments become effective only after approval by the Governing Board.

Section 6.4. **Conflict Resolution**

If a conflict or dispute arises or is reasonably expected to arise between the Medical Staff and MEC regarding the adoption, amendment or deletion of Bylaws, recommendations to adopt or change Rules and Regulations, policies, or any other issues in dispute between or among the Medical Staff, Governing Board, and/or Hospital administration, then the Medical Staff, the MEC, Hospital Administration, and the Governing Board should work collegially to manage the conflict or dispute. All conflict resolution should initially occur through informal steps. An informal approach may include the use of external resources or a Hospital representative trained in conflict management to help facilitate the process. If a resolution cannot be reached through informal means, the matter may be referred to a Joint Conference Committee comprised of either representatives of the Medical Staff and Governing Board or Medical Staff and MEC, as appropriate.

If the conflict is between members of the Medical Staff and the MEC, the disputed matter shall be submitted to a Joint Conference Committee upon a petition signed by twenty-five percent (25%) of the Active Staff.

Section 6.5. **Joint Conference Committee**

6.5.1 Composition: If the conflict or dispute is between or among the Medical Staff, Governing Board, and/or Hospital Administration, the Joint Conference Committee shall consist of three (3) members of the Governing Board and three (3) members of the Active Staff as selected by Chief of Staff. If the conflict or dispute is between the Medical Staff and the MEC, the Joint Conference Committee shall consist of the three (3) members of the MEC as selected by the Chief of Staff and three (3) members of the Active Staff as designated by the Active Staff submitting the petition. The Chairperson of the Committee shall either be the Chairperson of the Governing Board or the Chief of Staff, depending on whether the Governing Board is represented on the Committee. The CMO and Hospital CEO shall serve as ex-officio members of the Committee without vote.

6.5.2 Duties: The Joint Conference Committee shall gather information regarding the conflict, meet to discuss various issues in dispute, and work in good faith to resolve the matter in a manner that protects safety and quality throughout the Hospital and Health System.

Section 6.6. **Amendments to Medical Staff Bylaws**

All proposed amendments and/or a restatement to the Medical Staff Bylaws, except the Rules and Regulations, should be reviewed for comment and consultation by a designated physician-led Health System resource, then reviewed and recommended for approval by the MEC prior to consideration by the Active Staff. Amendments and/or a restatement may be recommended to the MEC by the Bylaws Committee or recommended by the Active Staff to the MEC following timely receipt by the Chief of Staff of a written petition signed by at least twenty-five percent (25%) of the Active Staff in good standing. Proposed amendments and/or restatements, whether by the MEC or a petition of the Active Staff, may be considered at any regular or special meeting of the Medical Staff after the proposed amendments or restatements have been published for no less than thirty (30) days. As an alternative procedure for adopting amendments and/or restatements to the Bylaws, the MEC may offer the Active Staff the opportunity to vote by electronic ballot. In such case, Active Staff members in good standing will receive an electronic ballot to be submitted within fourteen (14) days of the meeting. To be adopted, amendments or a restatement require a simple majority vote of the Active Staff in good standing are present at a meeting or who return an electronic ballot.

In the event there is a documented need for an urgent amendment to the Medical Staff Bylaws to comply with a law, regulation or similar requirements, the MEC may provisionally approve, and the Governing Board may provisionally adopt an urgent amendment without prior notice to the Medical Staff. In such case, the Medical Staff shall be notified by the MEC of such amendment. The Active Staff may dispute or submit comments regarding the provisional amendment to the MEC within ten (10) days of receiving notice. The amendment will stand if there is no conflict or dispute. If twenty-five percent (25%) of the Active Staff dispute the amendment, a Joint Conference Committee shall be formed pursuant to Section 6.5 above. Technical corrections or changes made by the MEC related to reorganization, renumbering, section heading, punctuation, spelling or grammar, changes necessary to comply with law or changes for clarification, phrasing or matters of expression are not considered amendments requiring advance notice or vote by the Active Staff. Such corrections or changes may be undertaken by the MEC without publication and vote as is otherwise required under this Article VI.

Neither the Medical Staff nor the Governing Board may unilaterally amend these Bylaws, which consist of this Governance and Credentialing Manual and the Medical Staff Corrective Action and Fair Hearing Plan.

Section 6.7. **Parliamentary Procedure**

Any procedural matter not clarified in the Medical Staff Bylaws shall be evaluated and acted upon by the Officers or Chairperson, as appropriate, in conjunction with either the Standard Code of Parliamentary Procedure or Robert's Rules of Order, whichever has been adopted by the Medical Staff.

Section 6.8. **Adoption**

The Medical Staff Bylaws, excluding the Medical Staff Rules and Regulations, shall be adopted at any regular or special meeting of the Medical Staff and replace any previous Medical Staff Bylaws, effective immediately upon approval by the Governing Board.

Section 6.9. **Unified Medical Staff**

8.9.1 Opt-In.

Should Health System and certain of its member hospitals form a shared and unified medical staff that reports to Health System's Board of Directors. This Medical Staff may opt-in to Health System's shared and unified medical staff by a majority vote of the Active Staff who are eligible to vote and upon approval by the Governing Board. The effective date of integration will be subject to necessary governing document, operational or procedural matters.

8.9.2 Opt-Out.

No more frequently than every two (2) years, members of the Medical Staff who are eligible to vote on adopting, amending or repealing these Bylaws and who also have clinical privileges exclusively at this Hospital may decide to opt-out of the unified and integrated medical staff and to establish an independent self-governing medical staff at this Hospital. Prior to voting on opting-out, the eligible voting members shall prepare a written explanation of their proposed decision that addresses the reasons, anticipated benefits and requested self-governing features proposed to be included in replacement governing documents. This written explanation must be presented to Hospital Administration no fewer than thirty (30) days prior to any scheduled vote on opting-out. A decision to opt-out of the unified and integrated medical staff requires an affirmative majority vote by written ballot of the medical staff members who are eligible to vote or by action at a meeting at which a quorum is present. The effective date for establishing a medical staff independent of the unified and integrated medical staff will be effective upon completion of appropriate governing documents that are duly adopted by the medical staff and the Governing Board.

RECORD OF REVISIONS

Date of Governing Board Approval	Manual	Article/Section Modified
12/15/22	Governance Manual	
12/15/22	Corrective Action and Fair Hearing Plan	